



AMERICAN ACADEMY OF  
FAMILY PHYSICIANS  
STRONG MEDICINE FOR AMERICA

August 20, 2012

Carolyn M. Clancy, M.D.  
Director  
Agency for Healthcare Research and Quality  
Attention: HIT-Enabled QM RFI Responses  
540 Gaither Road, Room 6000  
Rockville, MD 20850  
Sent via email: [HIT-PTQ@AHRQ.hhs.gov](mailto:HIT-PTQ@AHRQ.hhs.gov)

Re: Request for Information on Quality Measurement Enabled by Health IT

Dear Dr. Clancy:

On behalf of the American Academy of Family Physicians (AAFP), which represents more than 105,900 family physicians and medical students nationwide, I write in response to the Request for Information on Quality Measurement Enabled by Health IT as published in the July 20, 2012 *Federal Register*. In this request, AHRQ requests information from the diversified stakeholders regarding current successful strategies and challenges regarding quality measurement enabled by health IT.

*1. Briefly describe what motivates your interest in clinically-informed quality measures through health information technology. To what extent is your interest informed by a particular role (e.g., provider, payer, government, vendor, quality measure developer, quality improvement organization, standards organization, consumer advocate) in this area?*

-The AAFP has a longstanding interest in and commitment to serving the needs of our members to improve the health of patients, families, and communities. As such, we are most interested in the development and use of clinically-informed quality measures to improve patient care and the importance on health IT to inform and assist in this process at the point of care.

*2. Whose voices are not being heard or effectively engaged at the crucial intersection of health IT and quality measurement? What non-regulatory approaches could facilitate enhanced engagement of these parties?*

-Small primary care practices, whether serving urban or rural communities, have not been well engaged yet in this discussion. The AAFP advocates for the advancement of the Patient Centered Medical Home (PCMH), which emphasizes a “team” based approach to patient care. This approach requires a well-coordinated primary care system. The AAFP encourages an enhanced examination on ways to improve care coordination as it relates to health IT and quality improvement discussions.

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*3. Some quality measures of interest have been more difficult to generate, such as measures of greater interest to consumers, measures to assess value, specialty-specific measures, measures across care settings (i.e., measures enabled by health information exchange), and measures that take into account variations in risk. Describe the infrastructure that would be needed to ensure development of such measures.*

-Such measures are vitally important to a sustainable healthcare system, but the AAFP urges greater focus on meaningful, accurate, and efficient measures and measurement processes that lead directly to quality improvement actions. Effective infrastructures will likely not be simple, but must have simplicity as a cornerstone. The AAFP considers it paramount to build toward a clinically meaningful and extensible concept model, with effective tools for its visualization and understanding.

*4. What health IT-enabled quality measures, communication channels, and/or technologies are needed to better engage consumers either as contributors of quality information or as users of quality information?*

-Healthcare consumer engagement and empowerment will be most effectively influenced by the provision of patient-centered care within the context of the PCMH. Patients who feel empowered as a part of the care team will seek out tools to effectively fulfill their important role. Many of those tools already exist (personal health records, patient portals, rating sites like RWJF, etc.) but they are too often underutilized because many patients unfortunately have a marginalized role in their healthcare. Fundamental changes to the care paradigm will have much more impact on patient participation in their healthcare than another 'app', device, or quality measure. As strong advocates for the use of health IT within a medical practice, the AAFP will continue to encourage family physicians to engage and encourage their patients with health IT options so that patients are more empowered to take a role in their own healthcare.

*5. How do we motivate measure developers to create new health IT-enabled quality measures (which are distinct from existing measures which were retooled into electronically-produced quality measures) that leverage the unique data available through health IT? Please provide examples of where this has been successfully. What new measures are in the pipeline to leverage data available through health IT?*

-The quality measure "pool" has been tainted by evidence-poor structure and process measures. A precedent for multiple numerators and/or denominators and an overemphasis on exceptions and exclusions has driven the process away from a culture of quality improvement to a culture of "teaching to the test". New clinically-informed, improvement-focused, evidence-based, data-derived, outcomes-oriented measures must be set apart from what has come before. There is little, if any, reliable expectation of the "unique data" that may be available from any given set of health IT products. Measure developers must push past what health IT vendors currently make available to what health IT vendors can reasonably make available and hold them to delivering products that are not 10 years behind current technological capabilities.

*6. Describe how quality measurement and "real-time" reporting could inform clinical activity, and the extent to which it could be considered synonymous with clinical decision support.*

-Evidence-based quality improvement activities cannot be anecdotal in their origins. Current evidence, as it applies to populations, is thin in many spots and extending that evidence to individuals is not without hazard. Clinical decision support, particularly at the point-of-care, quality measurement/improvement/reporting, and evidence-based clinical/operational practice guidelines are three "legs" of the same high performance healthcare "stool". They are interdependent for outcomes but must find their own, independent footing.

*7. Among health IT-enabled quality measures you are seeking to generate in a reliable fashion, including the currently proposed Meaningful Use Stage 2 measure set, what types of advances and/or strategies for e-measure generation if pursued, would support more efficient generation of quality measures?*

-Measures must be clinically relevant and actionable for primary care physicians if they are to be asked to invest time and resources for implementation. Most current and proposed measures do not have a foundation to make them a by-product of usual care within the ambulatory setting and therefore the use of these measures places a significant burden on practices to collect, calculate, and report. The use of electronic health records has presented new opportunities for quality improvement, but has also decreased the capacity of many primary care practices to pursue those opportunities. HHS should further empower professional organizations, like the AAFP, with advanced notice and tools to realize their specialties' futures through quality improvement initiatives and the requisite point-of-care systems for their members.

*8. Many EHR, HIE, and other health IT vendors are developing software code to support measures. Tools such as the Measure Authoring Tool (MAT) were created to improve efficiencies in the process of creating and implementing eMeasures. What additional approaches might be used to enable consistent, accurate, and efficient quality measurement when using health IT?*

-Standardization requires constraints, agreement on the need for those constraints, understanding of the implications of those constraints, and acceptance of the distance between the constrained model and the real world. Currently, the AAFP believes there is unfortunately too much distance between the present model for quality/performance measures and a future state with implementable technology and workflows that actually and efficiently improve quality at the point-of-care.

*9. How do you see the establishment and adoption of data standards impacting the future of health IT- enabled quality measurement? For what types of quality measures should a combination of natural language processing and structured data be considered?*

-"Data standards" or lack thereof, are a distraction from the real work that must be done to understand and improve healthcare systematically. Without a clinically understandable and defensible concept model, data (whether structured or unstructured) remains of limited analytic relevance, whether to humans or computers. "Data standards" created in a theoretical vacuum rather than in real-world application, impose a potentially haphazard and disjointed concept model that results in attempts at "harmonization". The AAFP advocates that research standards are applied to health IT hypotheses. Many standards or "data experiments" that HHS and the health IT industry have conducted thus far have seen limited success in terms of real-world, scalable interoperability and improved quality care. A non-proprietary, generalizable, and international model of the fundamental concepts of medicine should be our initial "standard" on which essential, modular, and interoperable "data standards" can be built.

*10. Much support has been voiced for the need of longitudinal data in quality measurement. What are the strengths and weaknesses of different information architectures and technologies to support health IT-enabled quality measurement across time and care settings? How can data reuse (capture once, use many times) be supported in different models? What examples might you provide of successful longitudinal health IT-enabled quality measurement (across time and/or across multiples care settings)?*

-The same issues that face individual patient versus population management can plague the evaluation of quality of individual physicians versus organizations. The care of a patient in our

current system often represents a “one to many” relationship from which responsibilities and outcomes are not easily delineated or attributed. A side effect of the current data culture (capture many, use once) is the horrendous “data quality” that has permeated health IT. Processes and tools for data validation and accuracy must be substantially improved to support longitudinal assessments which can lead to appropriate interventions.

*11. What are the most effective means by which to educate providers on the importance of health IT-enabled quality measurement and how clinical information is used to support health IT-enabled quality measurement and reporting? How can providers be better engaged in the health IT-enabled quality measurement process?*

-Family physicians are typically more concerned with “quality improvement” than with “quality measurement and reporting”. Though “measurement” is a prerequisite to “improvement”, the current healthcare quality initiatives have placed the cart squarely before the horse by overly emphasizing “reporting”. The AAFP urges HHS returns to clinically relevant, evidence-based improvement efforts fueled by data collection techniques that are a by-product of usual care. Physicians will engage in an effective and relevant “health IT-enabled quality measurement process”. Unfortunately, that is not what has been made available to them thus far.

*12. What is the best way to facilitate bi-directional communication between vendors and measure developers to facilitate collaboration in health IT-enabled measure development?*

-Vendors have shown little, if any, interest in engaging with the AAFP, or any clinical entity we are aware of, to improve or add clinical functionality to improve clinical quality measurement. This is perhaps a symptom of vendor dependence on proprietary data constructs to “lock in” users, rather than true competition within the market. Vendors that the AAFP has attempted to work with are interested in only those opportunities that increase their short-term revenues. Several start-ups have proven a commitment to improving healthcare and health outcomes for patients, but too many established vendors are not agile enough to meet the basic meaningful use requirements. Without dedicated commitment and resources to research and development, health IT will not experience a “next generation” but will remain in perpetual “catch up” mode.

*13. To what extent do you anticipate adopting payment models that use quality measurement informed by electronic clinical records (as opposed to exclusively using claims data)? What strategies are you pursuing to gain access to clinical data and test the reliability of health IT-enabled clinical outcome measures? How do you anticipate sharing quality measure results with consumers and other stakeholders?*

-The patient centered medical home (PCMH) is founded on a blended payment model that includes clinical outcomes and quality improvement efforts. Our experience with aggregated claims data reveals some basic analytic potential, but far too little to fuel an effective PCMH (or accountable care organization) model. The incorporation of data, not only from the primary care practice but from all aspects of care delivery for a given patient or population, must be a part of any attempt at coordinated care. Our current clinical data repository pilot is working toward aggregating claims and EHR data and presenting a “new view” of clinical information to AAFP members that will spark their own targeted quality improvement efforts.

*14. What tools, systems, and/or strategies has your organization been using to aggregate information from various EHRs and other health IT for use in quality measurement? What strategies is your organization pursuing to move toward greater automation in quality measurement?*

-Historically, AAFP quality improvement efforts have required focused double entry of data into a constrained registry-like application by AAFP member physicians or their staff. Attempts to interpret native Continuity of Care (CCR) or HL7 Clinical Document Architecture (CDA) templates (e.g. CCD) directly from EHRs have proven practically infeasible. Our current technology is able to tap into claims submitted by participating provider, make “educated” clinical assumptions, and present visual comparisons to AAFP members of their data characteristics versus an aggregated sample of family physicians.

*15. Please describe scalable programs, demonstrations, or solutions (domestic or internationally) that show material progress toward quality measurement enabled by health IT.*

-Quality improvement is about looking at data in new and informative ways, about opening your eyes to something that was in front of you the whole time but you could not appreciate under “business as usual”. These new ways of looking at care delivery, at patient data, at longitudinal outcomes are essential to sustained quality improvement and doing the right things for patients as opposed to pushing the right buttons or clicking the right boxes to get paid. Make analytics easy at the point-of-care for providers will innovate, identifying meaningful measures and effective interventions for themselves to their patients’ and the healthcare system’s benefit.

We appreciate the opportunity to provide these comments and make ourselves available for any questions you might have or clarifications you might need. Please contact Steven E. Waldren, MD, the AAFP’s Director of the Center for Health IT, at 913-906-6000 x4100 or [swaldren@aafp.org](mailto:swaldren@aafp.org).

Sincerely,

A handwritten signature in black ink that reads "Glen Stream MD". The signature is written in a cursive, slightly slanted style.

Glen R. Stream, MD, MBI, FAAFP  
President