KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Program Offices

November 25, 2013

Department of Health and Human Services
Office of the National Coordinator for Health Information Technology

Submitted electronically via http://jira.oncprojectracking.org/browse/PCQM

RE: Request for Comments Regarding Potential CQMs for Meaningful Use Stage 3

Dear Sir or Madam:

Kaiser Permanente offers the following comments in response to the above-captioned request for comments ("RFC").

The Kaiser Permanente Medical Care Program is the largest private integrated healthcare delivery system in the U.S., delivering health care to approximately 9.2 million members in eight states and the District of Columbia.[1]

We appreciate the opportunity to provide the following comments for your consideration.

General Comments
As providers, we understand how clinically informed quality measure can provide new insights into clinical services and operations to improve care for our patients.

We have made a significant investment in a program-wide Electronic Health Record ("EHR") system, KP HealthConnect® to securely connect our members to their health care teams, their personal health information, and the latest medical knowledge. KP HealthConnect represents a critical tool in Kaiser Permanente's integrated approach to health care.[2] Kaiser Permanente participates in the EHR Incentive Program through our MAOs and satisfies the CQM requirement through our MA reporting requirements – the Healthcare Effectiveness Data and Information Set ("HEDIS") and the Consumer Assessment of Healthcare Providers and Systems

[1] Kaiser Permanente includes Kaiser Foundation Health Plan, Inc., the nation's largest nonprofit health plan, and its health plan subsidiaries outside California and Hawaii; the nonprofit Kaiser Foundation Hospitals which operates 38 hospitals and over 600 other clinical facilities; and the Permanente Medical Groups, independent physician group practices that contract with Kaiser Foundation health plans to meet the health needs of Kaiser Permanente's members. Most pharmacy, diagnostic, and laboratory services delivered to Kaiser Permanente members are performed within Kaiser Permanente.

[2] KP HealthConnect has been implemented across our program, ensuring that our approximately 14,000 physicians and other caregivers have appropriate access to member and patient clinical information. We also have implemented inpatient billing; admission, discharge, and transfer; scheduling and pharmacy applications; and bedside documentation and computerized physician order entry ("CPOE") in each of our hospitals.

One Kaiser Plaza, 27th Floor
Oakland, CA 94612

survey ("CAHPS"). We also support sharing health care performance data as an effective way to improve performance and enhance care delivery.[3]

As a result, we understand the challenges of deriving quality metrics and seek ways to make the production of these quality metrics more efficient. Currently, the process of extracting data from the EHR to respond to increasing regulatory requirements for quality measures is very resource intensive. Given these challenges, we recommend that CMS focus on selecting measures that offer broadest possible benefits to the most patients.

A key rationale underlying the National Quality Strategy is alignment among the many government agencies that support and regulate healthcare. Therefore, it is important for CMS to promote the National Quality Strategy; we believe it is difficult to make a strong case for e-measurement of DXA and Headache, given the greater potential benefit and impact of measures that will address leading causes of mortality and morbidity, as outlined under the Strategy.

Notwithstanding our overarching concerns about establishing e-measurement priorities, we offer some measure-specific comments:

Appropriate Use of Dual-energy X-ray Absorptionmetry (DXA) Scans in Women under 65 Not Meeting Risk Factor Profile

DXA Data Elements Table:

Our EHR captures most of the elements using the identified code sets (SNOMED, LOINC, ICD-10). Some elements may not be captured consistently, if at all, and may be less accurate and reliable, for example: *Average Number of Drinks per Drinking Day*; *History of Fracture in Parent*; *Ten Year Probability of Fracture*. Some of the codes expected to be used are ICD-9 (not ICD-10). ICD-9 codes may be problematic, requiring cross-mapping (e.g., through the use of an addition tool, such as the publicly available Convergent Medical Terminology ("CMT") tool from the NLM).

Supplemental Value Set Table:

Most of these data elements are generally captured in the EHR or supplemental systems with reasonable degree of validity and reliability. However, the *Source of Payment Typology* code set (identifies the Type of Payer) is not a code set we typically use within our integrated system.

Overuse of Diagnostic Imaging for Uncomplicated Headache

[3] In addition to mandatory reporting, we participate in many voluntary initiatives sponsored by regulatory, accreditation, and professional agencies. We have extensive experience with collaborative public reporting through the California Cooperative Healthcare Reporting Initiative ("CCHRI"), Integrated Healthcare Association ("IHA"), the Pay for Performance ("P4P") initiative, the State of California Quality Report Card, California Hospital Assessment & Reporting Taskforce ("CHART"), and the National Committee for Quality Assurance ("NCQA"). We continue to be engaged with all major public reporting groups, including AQA, HQA, the National Quality Forum ("NQF") and The Joint Commission ("TJC").

Diagnostic Imaging Data Elements Table:

Because of our integrated care delivery/capitated payment model, we do not code internal encounters at a granular level (lines 720 through 742) using CPT codes. This is not an issue for external encounters or for organizations that rely on fee-for-service billing.

Supplemental Value Set Table:

Most of these data elements are generally captured in the EHR or supplemental systems with reasonable degree of validity and reliability. However, the *Source of Payment Typology* code set (identifies the Type of Payer) is not a code set we typically use within our integrated system.

Recommendation

The two proposed measures (DXA and Headache) are both population-specific, narrowly focused measures. Many other clinical areas/measures should be given priority. Therefore, we recommend that ONC focus initially on measures that are consistent with the six priorities outlined in the National Quality Strategy.[4] From the standpoint of prioritizing e-measures, the emphasis should be on cardiovascular disease/treatment, the leading cause of mortality in the US, followed by metrics related to cancer, diabetes, obesity, and mental health.

Conclusion

We appreciate your willingness to consider our comments on these potential CQMs for Stage 3 Meaningful Use. Please feel free to contact me at 510-271-6432 (email: jed.weissberg@kp.org) with any questions or concerns.

Sincerely,

Jed Weissberg, MD
SVP, Hospitals, Quality and Care Delivery Excellence
Kaiser Foundation Health Plan and Hospitals

[4] The National Quality Strategy will focus initially on six priorities:

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family is engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.