

February 24, 2016

RE: CMS and ONC Hospital-MDM Project team's request for feedback  
*eCQM499 Access to Quality Advance Care Plans*

Virginia Commonwealth University appreciates the opportunity to comment on Advance Care Planning (ACP) policy and electronic quality measure development. VCU supports the development of electronic clinical quality measures that have been fully tested to show:

- Data needed to populate the measure can be collected as part of a normal care delivery workflow (which includes the role of patient reflected data.)
- The measure is an accurate reflection of care delivered.
- The measure is actionable for providers to leverage to improve clinical outcomes.
- The measure clearly supports the goals of the Triple Aim: Improving the patient experience of care (including quality, outcomes, and satisfaction); Improving the health of populations; Reducing the per capita cost of health care.
- CMS provides a clear business and clinical case demonstrating that the eCQM presents a clear value proposition for providers, including a cost to implement/collect versus benefit analysis of each measure.

On behalf of Virginia Commonwealth University Health System, our Palliative Care Medical Directors, Dr. Egidio DeFabbro and Dr. Danielle Noreika, and the VCU Health System's Advance Care Planning Committee Members respectfully give feedback related to eCQM499:

1. The appropriateness of the serious illness denominator value set for capturing patients who would most benefit from advance care planning during their hospitalization

Since the serious illness denominator value set was not published for review we are not able to comment on its appropriateness. However, we are concerned about one standardized code being used to identify the denominator. We believe the end of life process can have varying scenarios; from one aggressive Cancer (one standardized code) to the sum of multiple less threatening diagnoses (several standardized codes) leading collectively to an end of life prognosis. VCUHealth supports a measure that encourages a workflow where all patients, with serious illnesses or not, receive advance care planning education with the opportunity for further discussions as welcomed.

2. Whether the numerator criteria appropriately reflect and capture the features of high quality advance care planning for hospitalized, seriously ill patients

The term "high quality" for the purpose of measuring quality care is subjective and cannot provide an accurate reflection of care delivered. "High quality" is unique to each patient and each patient encounter. Factors

such as disease stage, conversations that drive behavior, ACP training of staff, population wide ACP vs palliative care, and variables found in end of life care could all be regarded as contributing to a “type of quality”, and yet these variables are difficult to measure, especially within an electronic health record.

- Numerator 1: VCU understands the intent of this numerator is to validate or initiate ACP documentation within 24 hours of admission. This supports our desire to capture eCQM data as part of our standard workflow and the data is actionable for providers to leverage for quality improvement. However, the numerator takes a step further and adds the word “current” making this numerator subjective to a specific moment in time and is no longer actionable for quality improvement. An ACP document that is validated as the most current on admission could be outdated within an hour of admission. We see no value in this requirement and believe it will support a workflow that defaults electronic documentation fields to “current” to meet the measure but does not add value to the patient or to the provider of care.
- Numerator 2: VCU understands and supports the identification of a surrogate decision-maker as stated in the Numerator 2 description. However, we do not support documentation of “legally authorized.” Our staff does not have the means to validate the legal authority of a surrogate nor do staff have the legal training to make such decisions. In most cases documentation of a surrogate decision-maker is patient or family reported information with limited resources for validation. We recommend “legally authorized” be removed from this numerator so that the numerator states, “Did hospital staff identify the current surrogate decision-maker’s name, contact information, and patient/family reported source of legal authority in the EHR or document in the EHR that the patient did not identify a surrogate decision-maker within 24 hours?”

3. The current and future feasibility of capturing the necessary data elements in an enterprise EHR (a standard EHR or an EHR with an advance care planning component)

Electronic health record technology is evolving and each year becomes increasingly sophisticated to capture unique data such as the ACP workflows and associated documentation. In the paper chart world ACP documents were usually the first pages a provider saw when opening a chart and ancillary notes concerning ACP documents were often part of that documentation. EHRs present an electronic documentation workflow that does not support ACP. Documents are organized according to provider type (Physician, Nurse, Chaplain, Social work, etc.) and each of these provider types often have documentation regarding ACP. This creates a workspace where electronic documentation has been scattered. In response, many health care providers create workarounds that often include paper and whiteboard flags. All to provide manual reminders that brings the documentation together in the EHR, while required scanned paper documents remain that do not contain essential discrete data elements. Vendors are making progress. There are now palliative care plans and documentation templates that support capture of ACP data elements and flags that can assist in identifying do not resuscitate patients.

4. Whether advance care planning documentation in the EHR are accessible to hospital staff across service lines and units

Advance care planning documentation is accessible to hospital staff across service lines and care units as scanned documents that are mixed with other scanned documentation.

5. Feasibility of data collection and submission for the purpose of public reporting under CMS's quality reporting programs
6. Usefulness of the measure to assess the quality of care for Medicare or Medicaid beneficiaries
7. Appropriateness of the measure to assess performance of hospitals.

We will address questions 5, 6 and 7 together as we believe these tie together for all eCQM's and the requirements for submission and public reporting. VCUHealth recommends that CMS and ONC implement an aggressive, and thorough, quality measures testing program to ensure that measures have been adequately specified and tested before requiring them for public reporting, Meaningful Use, IQR and MIPS e-Reporting, and use in any Medicare incentive program. All eCQMs should meet the following criteria:

- The eMeasure specifications are tested and piloted to confirm they are accurate, with the correct clinical category defined and mapped to the correct vocabulary standards (taxonomy) and codes, along with the correct attributes and state(s).
- The eMeasures are validated by the measure steward and tested for validity and reliability against the measures intent.
- Required data elements can be efficiently and accurately gathered in the healthcare provider workflow, if at all possible using data elements that are already collected as a byproduct of the care process and stored in the EHR and other business information systems.  
CQM reports based on eMeasures accurately reflect the care given by the applicable healthcare provider(s).
- This testing evaluates the output from translation of the measure to established standards in the electronic quality measure format (HQMF) and the successful transport using QRDA format to CMS.

The eMeasure testing process should include a testing site with a set of sample data, testing examples and an Implementation Guide that can be used by vendors during their implementation and testing. (This process has been launched in the form of the National Testing Collaborative, however needs to be fully funded and endorsed by CMS.) No measure should be included in any HHS payment or incentive program without fully completing this testing program, and upon submission in professional journals (as proposed in the [draft Quality Measure Development Plan](#)) or submission for NQF endorsement.

VCUHealth is committed to fostering a culture where health IT is fundamental to transforming healthcare by improving quality of care, enhancing the patient experience, containing cost, improving access to care, and optimizing effectiveness of public payment. Our ACP team of professionals support your work and appreciate this opportunity to provide comment on ACP eCQM499. Our team is available for your questions and will provide additional information as requested.

Sincerely,

A handwritten signature in black ink, appearing to read "Egidio DelFabbro". The signature is fluid and cursive, with the first name being the most prominent.

Egidio DelFabbro, MD  
Director, Palliative Care Program  
ACP Committee Chair

A handwritten signature in black ink, appearing to read "Danielle Noreika". The signature is cursive and somewhat stylized, with the last name being the most prominent.

Danielle Noreika, MD, FACP  
Medical Director, Inpatient Palliative Care Services