HIT POLICY COMMITTEE MEASURE CONCEPTS

PATIENT AND FAMILY ENGAGEMENT	
Self-Management/ Activation	
Measures of patient activation, including skills, knowledge, and self-efficacy	This measure concept relates to a patient's' ability to effectively self manage and engage in his/her care. It is geared toward measuring whether a patient is continuing to manage his/her care, measuring health outcomes, and measuring whether the patient has been led in the "right direction" by his/her healthcare provider regarding his/her plan of care.
Measures of patient self-management	This measure concept focuses on provisions of effective, personalized self-management resources and tools that are in accordance with patient preferences, and also the need to measure self-management of health risk behaviors and preventive care of both acute and chronic conditions.
Honoring Patient Preferences and Shared Decision Making	
Measures of shared decision making or decision quality that address a combination of patient knowledge and incorporation of patient preferences	This measure concept is focused on measuring whether or not shared decision-making occurred, the level of clinician awareness of patient preferences, and the level to patient engagement in the shared decision making process.
Measures of patient preferences/experiences of care	This measure concept focuses on measuring the extent to which the delivered care aligned with the patient's preferences and measuring the patient's preferred method of communicating these preferences (paper, portal, universal serial bus [USB], emails, PHR, etc).
Patient Health Outcomes	
Measures of patient health outcomes, including health risk status, functional health status, and global measures of patient health	This measure concept focuses on measuring avoidable risk of death, disease/disability status, and patient level of ability in physical, mental and social domains.
Community Resources Coordination/Connection	
Measures of patient access to community resources for improved/sustainable care coordination	Connecting patients to community resources for health promotion, complex chronic disease management and care, and social/other non-medical needs/support, including online patient/caregiver communities is important. Improving health outcomes, including functional status, often requires other non-health institution resources (e.g., support groups, transportation, etc.). This measure concept seeks to capture patient access to these non-health institution resources.

CLINICAL APPROPRIATENESS	
Appropriate/Efficient Use of Facilities	
Measures of all cause readmissions and length of stay	This measure concept was selected because frequency of visits and length of stay are indicators that care is not being administered effectively to a patient. Combining all cause readmissions and length of stay in this measure concept addresses the correlation between lowering the length of stay at the cost of more readmissions or lowering readmissions but increasing the length of stay.
Measures assessing ambulatory care-sensitive preventable admissions	This measure concept relates to admissions caused by unaddressed ambulatory conditions at the onset of symptoms due to multiple reasons such as inappropriate clinical management or inefficient systems issues.
Appropriate/Efficient Use of Diagnostic Tests	
Measures assessing the appropriate use of diagnostic imaging procedures, with measures for redundancy, cumulative exposure, and appropriateness	The measure concept focuses on the causes and impacts of unnecessary diagnostic procedures, which are a high-cost area of medical care. A potential radiology measure would assess the appropriateness of procedures as well as patient safety related to radiation exposure.
Appropriate/Efficient Treatment of Chronic Disease across Multiple Sites of Care	
Measures assessing the development of co-morbidities as a result of uncontrolled chronic disease (sequelae of uncontrolled diabetes)	This measure concept addresses the effective management of specific chronic illnesses and the prevention of subsequent sequelae
Measures assessing reconciliation of the care plan for chronic disease patients across care settings and multiple specialists (process measure)	This measure concept focuses on effective care across multiple providers, including treatments as well as other services, such as patient education. In addition to determining whether patients have defined treatment plans, it addresses concerns that as patients meet with various providers, they may receive inconsistent care.
Appropriate/Efficient Use of Medications	
Measures assessing appropriate medication treatments, including overuse and/or underuse	This measure concept evaluates the appropriate use of medications based on standards of care for applicable conditions as well as the underuse of medications warranted for effective management of the condition.
Measures of medication use linked to adherence outcomes	Evaluating adherence rates related to outcomes will allow providers and hospitals to evaluate factors associated with patient adherence in the delivery model. The measure concept seeks to address this issue.
Measures assessing usage rates for generic vs. brand name medications	Evidence suggests that there is no difference in efficacy of generic vs. brand name medications for certain conditions. This measure concept seeks to assess generic vs. brand name medication usage rates.
Measures assessing the appropriate use of cardioprotective medications (aspirin, angiotensin-converting enzyme inhibitors, and statins) in individuals at high risk of experiencing heart attacks and strokes.	Innovative risk reduction programs using health information technology demonstrate significant impact on relevant communities and populations at risk for cardiovascular events and strokes. This measure aims at assessing the use of such strategies.

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CARE COORDINATION	
Effective Care Planning	
Measures assessing adherence to a comprehensive care plan in the EHR with an up to date problem list and care plan that reflects goals of care	This measure concept seeks to address the receipt of a comprehensive care plan that is HIT sensitive. A comprehensive care plan may include the presence of a post visit summary (if applicable), self management plan, annual care plan covering all aspects of a patient's health, patient goals of care, pertinent history, problem list, medication list, and allergy list. Potential measured do not only have to be process measures, outcome measures can be created to assess adherence to the care plan.
Measures of an Advance Care Plan as a product of shared decision making	An advance care plan, which includes patient care goals, DNR status and health care proxy, is a product of shared decision making and an affirmation of patient preference. EHR enabled measures should ensure the retrieval of such plans at the point of care.
Measures of the success of a self management plan for patients with conditions where a self management plan might reasonably be considered to benefit them	Self management plans for patients with chronic conditions, such as CHF and asthma, can be delivered and measured through the use of the EHR. This measure concept relates to measures that are actionable for the provider and allow a feedback loop so that patient goals are continually incorporated into the plan.
Care Transitions	
Measures of reconciliation of all medications when receiving a patient from a different provider	Measures of successful medication reconciliation throughout all care transitions will be enabled through HIT and become a necessary element of care coordination.
Measures of patient and family experience of care coordination across a care transition (e.g. questions within HCAHP surveys)	This measure concept addresses measures that should assess the extent to which the health care team accounts for patient/family/caregiver preferences of care. The measures should also address the patient's understanding of his/her health care needs upon discharge to enable a successful and safe transition. (example: NQF #228 Care Transition Measure three-item survey and the HCAHPS survey questions)
Composite measures assessing receipt by both the care team members and the patient/caregiver of a comprehensive clinical summary after any care transition	Measures within this concept will use the EHR to determine if both the patient and the care team have received a comprehensive clinical summary after any care transition. Measures may assess patient understanding of the critical elements of the clinical summary. Composite measures may also include an assessment of care team compliance with critical elements of the care plan, including medication reconciliation, after a care transition has occurred.
Appropriate and Timely Follow-Up	
Measures assessing timeliness of provider response, and appropriate response, to clinical information, including lab and diagnostic results	Measures derived from an EHR allow the measurement of a provider's response to clinical information. Responses may be measured in two ways: through timeliness, and through appropriateness. (example: Calculation of longitudinal performance measures for hypertension that cross all settings of the care spectrum)

HIT Policy Committee Measure Concepts

PATIENT SAFETY	
Medication Safety	
Measures of adverse drug event (ADE) reporting	This measure concept addresses measures that track ADEs. Measures would include those that capture general ADE rates or those that focus on specific medications or medication errors such as drugs to avoid in the elderly.
Measures monitoring drug safety for patients who are on chronic medical therapy	This measure concept seeks to address measures that assess appropriate monitoring of patients on chronic medications such as warfarin for which regular monitoring is required.
Measures of patient reported adverse events	Adverse events refer to any medication related adverse event or medical error which are traditionally reported by physicians. This measure concept focuses on patient-reported adverse events that would allow patients to engage in their own safety while under medical care.
Hospital Associated Events	
Measures of process and outcome improvement of hospital associated infections	This measure concept encompasses measures that assess process improvement and reduction of hospital associated infections such as central line associated blood stream infections and ventilator associated pneumonia.
Measures of venous thromboembolism (VTE) prophylaxis and VTE rates	There is strong evidence to support VTE prophylaxis as effective in preventing VTE in at-risk patients. This measure concept includes measures that capture rates of VTE prophylaxis and VTEs.
Measures of falls events and screening	Falls prevention can be facilitated through EHR use. This measure concept addresses the incidence of falls as well as falls prevention through measures of screening and use of precautions for at risk patients.

POPULATION AND PUBLIC HEALTH	
Healthy Lifestyle Behaviors	
Measures of use/availability of services that promote healthy lifestyles (smoking cessation, body mass index management, patient health literacy): *A) Smoking cessation - focused specifically on quit rate for patients within a reporting period.* *B) Body Mass Index - focused specifically on tracking longitudinal change to determine patient outcome.*	A) This measure concept encompasses longitudinal delta measures of improvement (or lack of improvement) that document smoking quit rate in a given reporting period; for example, a possible numerator and denominator might be the number of patients in the denominator with a smoking status of "former smoker" as their most recent status within a reporting period divided by the number of patients with a smoking status of "current smoker" as their earliest status within the reporting period. B) This measure concept encompasses longitudinal delta measures of improvement (or lack of improvement) that document Body Mass Index in given a reporting period; for example, a possible numerator and denominator might be the number of patients in the denominator with a BMI of "overweight" or "normal weight" or ≥ 10 percent weight loss as their most recent status within a reporting period divided by the number of patients with a BMI of obese as their earliest status within the reporting period.
Measures of screening for alcohol use using a validated tool.	This measure concept encompasses longitudinal measures that document alcohol use screening (using a validated instrument) in a given reporting period; for example, a possible numerator and denominator might be the number of patients in the denominator who were screened during a reporting period for unhealthy alcohol use divided by the total number of active clinical patients, aged 18 years and older seen for a visit within the reporting period.
Effective Preventative Services	
Measures of mental health screening using a validated instrument.	This measure concept encompasses longitudinal measures that document mental health screening (using a validated instrument) in a given reporting period; for example, a possible numerator and denominator might be the number of patients in the denominator who were screened for depression at least once in a reporting period divided by the number of active clinical patients, aged 12 years and older who were seen for a visit within the reporting period.
Measures of blood pressure focused specifically on tracking longitudinal change to determine patient outcome.	This measure concept encompasses longitudinal delta measures of improvement (or lack of improvement) that document blood pressure in a given reporting period; for example, a possible numerator and denominator might be the number of patients in the denominator with a Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC7) classification of Stage 1 (140–159/90–99) or controlled (<140/90) as their most recent status within the reporting period divided by the number of patients with a JNC7 blood pressure classification of Stage 2 (≥160/≥100) and no diagnosis of diabetes mellitus or renal disease, as their earliest status within the reporting period.
Measures of glucose monitoring focused specifically on tracking longitudinal change to determine patient outcome.	This measure concept encompasses longitudinal delta measures of improvement (or lack of improvement) that document glucose levels in a given reporting period; for example, a possible numerator and denominator might be the number of patients in the denominator with a hemoglobin A1c < 9 percent as their most recent status within a reporting period divided by the number of patients with Hba1c ≥ 9 percent as their earliest status within the

	reporting period.
Health Equity	
Measures with no discrepancy when comparing health outcomes among those within priority populations to those not within the priority populations	Instead of purely measuring individual outcomes, this measure concept encompasses priority populations (as defined by AHRQ: racial and ethnic minorities, recent immigrant and limited-English-proficient populations, low-income groups, women, children (< 18), older adults (≥ 65), residents of rural areas, persons with special health care needs, those with maximum education level of less than a high school education and high school graduates, and insurance status) and documents health equity by noting the discrepancy between the health outcomes for the priority populations and the outcomes among those not in the priority populations; using glucose monitoring as an example, the denominator would be the total number of population groups serviced by a provider (for example, if the physician didn't see children, it would be excluded) and the numerator would be the number of these distinct population groups (ex. Children, African Americans, older adults ≥ 65) serviced by the provider for which there were no discrepancies in glucose monitoring outcomes, as compared to the non-priority population.

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OTHER	
Measures that assess preventable ED visits	This measure concept focuses attention on the conditions that most affect the emergency department setting, as opposed to other measures that focus more on primary care physicians and/or hospital settings.
Measures that assess adherence to clinical practice standards (appropriate cardiac/cancer treatments)	This measure concept focuses on measuring clinician adherence to appropriate clinical practice standards.
Measures that assess combined quality and cost measures at each level and site of care reflecting potential defects in care	This measure concept encompasses important missed steps in managing a patient's chronic conditions across all care settings; for example, missing patient transition information and lack of follow-up.
Measures of medication error near misses	This measure concept focuses on documenting situations where a medication-related error almost occurred but did not.
Measures of patient identification errors and near misses	EHRs can help prevent patient identification errors, for example, by using photographs to confirm patient identity. Important concepts in this category include patient identification, error reporting, and proper verification before medication administration
Measures of common EHR-related errors (mechanism to report EHR related errors and delays in care to improve EHRs)	This measure concept relates to assessing provider's safe and effective use of EHRs through measures such as alert adherence, proper patient identification, and confirmation of review of results sent electronically.

Italics indicate a measure concept that overlaps with other Federal programs/activities.