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

American Health Information Community 2007 Quality Use Case

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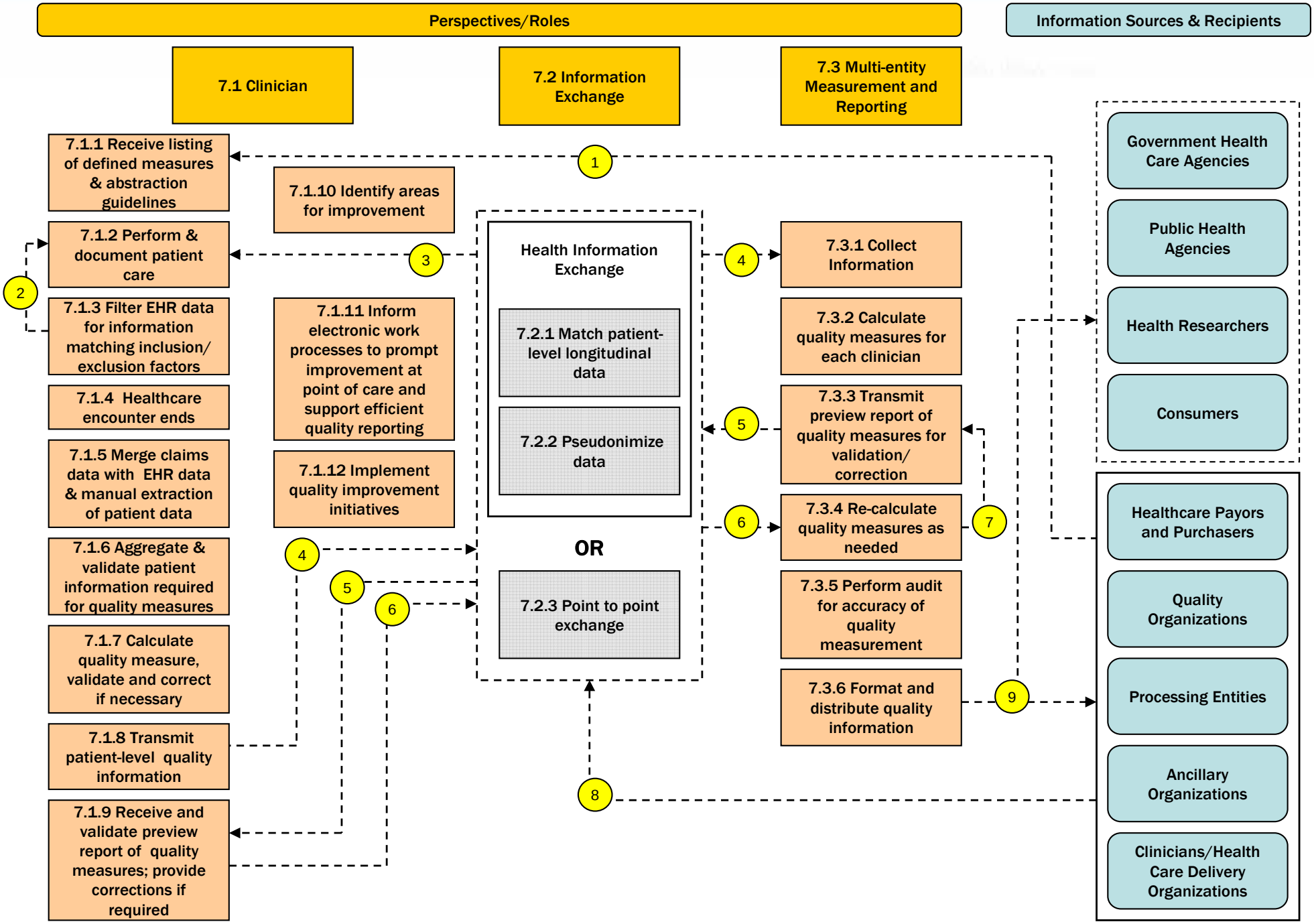
Quality Use Case

- AHIC Quality Use Case addresses key areas based on AHIC working group priorities and issues:
  - Use of EHR data to support quality measurement, feedback to clinicians, clinical decision support, and reporting
  - Support for quality measures based on non-claims-based clinical measures
  - Support for quality measures based on data from multiple entities and data sources
  - Support for quality measures based on longitudinal patient data

Quality Use Case

- Considerable “to be” expectations
- To support a core set of AQA and HQA measures
- Two scenarios:
  - Quality measurement of care provided by clinicians
  - Quality measurement of care provided in hospitals
- Multiple functional roles

Clinician Quality Information Collection and Reporting

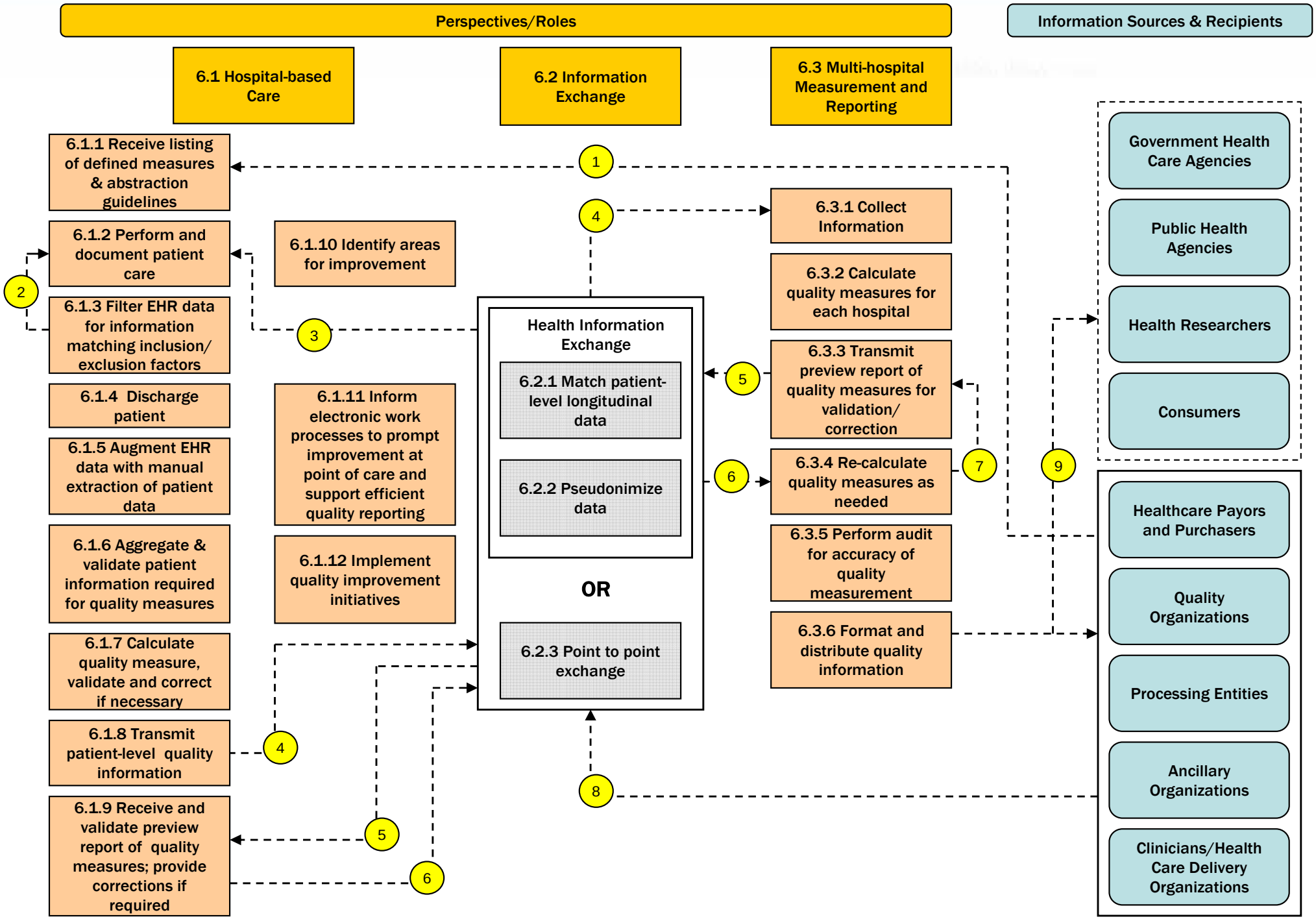


Clinician Quality Information Collection and Reporting

Scenario Flows

1. Defined quality measurement specifications to be reported are sent to clinicians.
2. Notice is given to clinicians to support clinical decisions and augment recorded data
3. Longitudinal health information held in associated repositories is forwarded by the HIE (patient-level – identifiable)
4. Clinician quality data is sent either via an intermediate entity or point-to-point for onward transmission to the Multi-entity Feedback and Reporting entity (patient-level – identifiable)
5. Preview report is sent directly for validation and/or correction (aggregated clinician-level data)
6. Corrected quality information is sent directly to the Multi-entity Feedback and Reporting Entity (patient-level – identifiable)
7. Corrected reports are sent for validation and/or correction (aggregate clinician-level data)
8. Claims data is collected from Payors (patient-level – identifiable)
9. Distributed data is available to users (aggregate clinician-level data)

Hospital-based Care Quality Information Collection and Reporting



Hospital-based Care Quality Information Collection and Reporting Flow

Scenario Flows

1. Defined quality measurement specifications to be reported are sent to hospitals.
2. Notice is given to clinicians to support clinical decisions and augment recorded data.
3. Longitudinal health information held in associated repositories is forwarded by the HIE (patient-level – identifiable).
4. Hospital quality data is sent either via an intermediate entity or point-to-point for onward transmission to the Multi-Hospital Measurement and Reporting entity (patient-level – identifiable).
5. Preview report is sent directly for validation and/or correction (aggregated hospital-level data).
6. Corrected quality information is sent directly to the Multi-hospital Feedback and Reporting Entity (patient-level – identifiable).
7. Corrected reports are sent for validation and/or correction (aggregate hospital-level data).
8. Claims data is collected from Payors (patient-level – identifiable).
9. Distributed data is available to users (aggregate hospital-level data).

Some Quality Intersection Issues

- Data stewardship, authorization and access
  - Linking of longitudinal, multi-data source data
  - Temporal stewardship - provider feedback from such data that precedes reporting
  - Needs for measure result validation
- Integration with consumer capabilities
- Levels of information
  - Longitudinal, multi-entity, multi-provider, multi-hospital
  - Relationship to linking, pseudonimization, de-identification
- Use limitations and appropriate business rules