

Quality Measures Workgroup
Draft Transcript
July 30, 2012

Presentation

MacKenzie Robertson – Office of the National Coordinator

Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup. This is a public call, and there will be time for public comment at the end, and the call is also being transcribed, so please make sure you identify yourself before speaking.

I'll now take roll. David Lansky?

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Yes. Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. Tripp Bradd? Russ Branzell?

Russ Branzell – Poudre Valley Critical Access Hospital, CO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Russ. Helen Burstin?

Heidi Bossley – National Quality Forum – Vice President of Performance Measures

Heidi Bossley for her.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Heidi. Neil Calman? Timothy Ferris? Patrick Gordon? David Kendrick? Charles Kennedy? Karen Kmetik? Robert Kocher? Norma Lang?

Darryl Roberts – American Nurses Association

Darryl Roberts is standing in for Norma Lang.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Darryl. Mark Overhage? Laura Petersen? Eva Powell?

Eva Powell – National Partnership for Women & Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Eva. Sarah Scholle?

Sarah Scholle – National Committee for Quality Assurance

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Sarah. Casey Sennett? Cary Sennett? Excuse me. Jesse Singer? Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. Kalahn Taylor-Clark? Jim Walker?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jim. Paul Wallace? Mark Weiner? Kate Goodrich? Daniel Green? Ahmed Calvo?

Ahmed Calvo – U.S. Department of Health and Human Services / Health Resources and Services Administration – Senior Medical Officer

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Ahmed. Steven Solomon? Peter Lee? Marsha Lillie-Blanton? Jon White?

Jon White – U.S. Department of Health and Human Services – Direct Chief Technology Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, John. Westley Clark?

H. Westley Clark – Substance Abuse and Mental Health Services Administration – Direct Chief Technology Officer, Center for Substance Abuse Treatment

Clark's here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Wes. Carolyn Clancy? Niall Brennan? Tony Trenkle? And Michael Rapp? Are there any staff on the line?

Kevin Larsen – Office of the National Coordinator

This is Kevin Larsen from ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Kevin.

Jesse James – Office of the National Coordinator

And Jesse James from ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jesse.

Maureen Boyle – Substance Abuse and Mental Health Services Administration

And Maureen Boyle from SAMHSA.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Maureen. Okay, David, I'll turn it over to you.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Thank you, MacKenzie. And again, thanks everybody for making time. We're now on a, on a march toward November 1st as our next major time goal—outcome, which is to work with the Policy Committee and the other workgroups around a request for comment that will go out to the large community and the public as a whole to help shape the meaningful use program for Stage 3. I know Paul and the Meaningful Use Workgroup have been very hard at work this summer to get the shape of that put together.

Our—the proposal we have is to basically use the next eight weeks or so within this workgroup to try to sort out where we think the quality measurement program should go for Stage 3 and get as much of an approach as we can—we're able to agree upon among ourselves, and then put that together with a set of comment, questions for public comment, essentially by October first. In other words, eight weeks from now, um, we would've pretty well thought through our approach on the questions we'd like comment on and give that to the Policy Committee as our input to that larger request for comment that would go out November 1st. So essentially, we're going to be a month ahead of the curve to try to get our work mostly done by October 1st and then fold it into the work of the rest of the other workgroups by November 1st. So that's the basic contention.

Um, the way we blocked it out is to use the next three or four calls of this group to work our way toward as much resolution as we can muster among ourselves and then flag for public input things we can't necessarily resolve or want more input on. So that's our intention. Today, our—we really have two major goals today. One, which we'll come to in a few minutes, is to get some additional input from other agencies working on a quality measurement to make sure we understand the alignment activities that are going on and the lessons learned and the open questions that the other federal programs have been identifying. And of course, they are partly thinking about how can electronic health records support their programmatic activities, and so we want to hear from them what we can do to be of greatest value to them.

But then the first topic we thought we'd deal with today is to just try to get a, a shared understanding of what our fundamental purpose is with Stage 3—so in effect to set the boundary conditions for the work we're going to do. So we'll come to that in just a moment, but before we jump into it, let me ask if anyone has questions about the calendar of the next couple months or what our primary tasks are for the next couple months.

And I should ask Paul if you want to just make a comment from the meaningful use work in terms of how you all are thinking about the request for comment, and maybe the same question to Kevin, so we understand what we're trying to produce by November 1st.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Sure. This is Paul, and this is the same pattern we used with Stage 1 and 2, which is to give a more formal chance for the public to react to some of our thinking as we prepare for Stage 3 recommendations to ONC and CMS. We wanted to get the results back in time that they can be summarized, and then for us to react to those by our May 2013 deadline to give our reccom—final recommendations to HHS.

This is intended to be as broad about meaningful use as possible, i.e. we would love to include the quality measure thoughts as it exists by that time and, get feedback, 'cause, 'cause that tends to be very well thought out and gives us a way of testing some of our grounds before we go out with our final recommendations.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Thanks, Paul. Kevin, anything else you want to say about the RFC from ONC's point of view?

Kevin Larsen – Office of the National Coordinator

Certainly. The key thing I would say is that we're looking really for how the standards and certification rule needs to think about quality measures. And by that I mean, how should we be explaining the, um, the certification program that we have around quality measurement, how should we be thinking about the meaningful use program, setting up an infrastructure and, for quality measurement. And we'll talk about a little bit later, how that may or may not be also part of a larger quality agenda that we could use for the infrastructure that we're building.

The specifics, we think we should measure this particular measure or that particular measure, um, we, we've—that's typically a programmatic decision for groups like CMS, so we don't think we'll be getting into the details of this measure or that measure, but my understanding is that a similar kind of strategy position that this group had been working under for both Meaningful Use 1 and Meaningful Use 2.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

... if I could add. This is Paul. While the, we're certainly not supposed to set the quality agenda for the country, um, we would love—we would like to exercise the EHRs by using exemplars that are consistent with national priorities to, to stress some of the system in terms of what data, what kinds of data, can we collect as part of, um, reporting about quality, and how can they be—the systems be designed, um, flexibly to, um, improve the outcomes that are reported and the burdens of which we do that.

Kevin Larsen – Office of the National Coordinator

Yeah. This is Kevin. I totally agree. It's clear to us from our vantage point at ONC that, um, the quality measures become the first, um, innovation out of the gate for a number of the things that we hope that EHRs can do in the short-term future and in the long-term future. So inasmuch as, um, the country is focused on the clinical quality measures now, the how they are formulated and the kinds of things they focus on gives us the early building blocks for lots of other things that people want to do with EHRs in the future.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

That's really helpful. I appreciate—both those comments are very helpful. Other, other comments or questions about just the RFC and the work plan between now and then before we—because I think both Kevin and Paul have teed up some substantive questions we'll talk about in a minute.

Ahmed Calvo – U.S. Department of Health and Human Services / Health Resources and Services Administration – Senior Medical Officer

Yeah. This is Ahmed Calvo. One other comment. It seems to me that it's critical that we address the deep-in-the-weeds details around the measures also, but that we need to make sure that we also think a bit about messaging to the public up front in this. In other words my big worry is that we're running the risk of getting only NQS input, that our entities are really interested in quality metrics, or only EHR vendors, or only the components of HHS that are really engaged in doing this. And we have to be really clear that we have to avoid only speaking to the kind of, um, you know, the techy side or the, the geeky side of all this only, so that we don't, you know, find something that's really good, but fail at communicating it well. To the extent we can factor in the communication to the public at large, that, that would be helpful because even though we open up for public comments, I worry about the lack of public comment in many cases on the calls, and so they may catch people by surprise later. And so to the extent we can factor this in, I think it would be healthy.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

That's a great comment and for this part of our conversation, I'll interpret that to mean we should make sure that the RFC and the outreach mechanism in support of the RFC really does solicit broad public comment, not only the op—the important stakeholders.

Eva Powell – National Partnership for Women & Families

Um, and, David, this is Eva. Kind of, springboarding off of on that comment, um, I think part of that will need to be making sure that every stakeholder group sees themselves in the, in the measures of the future, or at least the capacity that we're building in EHRs for measures of the future, because frankly, at least from the consumer's perspective, our current quality measures, as well as—or at least most of the current quality measures, um, and really the whole process for gleaning quality measures from work that people are doing, um, isn't really yielding much of use to consumers, and that's a huge problem when you think about what's coming down the pike in terms of reform and the need to pay based on quality. And as we found out back in the '90s, if you don't have consumers on board, there will be failure.

And so I think part of Ahmed's—part of making sure that we pay attention to what Ahmed was talking about, um, we need to make sure that every stakeholder group can see themselves in the world of quality measurement being, , supported by the health IT infrastructure being developed as part of meaningful use. And that, of course, includes consumers, um, and, and that really requires thinking about quality measurement in a very, very different way that frankly isn't possible without EHRs.

And so if we, if we don't succeed in building that capacity through meaningful use, I really, really worry about whether or not our quality-measurement system is going to support the future as we've set it up so well in health, in health reform.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Well, let me, let me turn to our first major agenda item, 'cause I think you've all teed it up and this—you've all introduced a perspective on this problem. And this may certainly be part of our—see if you get some more public input on this fundamental directional question for the program.

But if you've got a copy of the detailed agenda I think Jessie sent out, um, you'll see under number two, "Purpose of quality measurement within meaningful use; re-address goal for Stage 3." We need a crystal-clear mission statement that includes attributes of quality measures program and what it's meant to achieve, which several of you just talked about.

And let me just summarize where I think the challenge is based on a number of conversations in the last two months going back to our hearing. We've heard from a number of very active and important stakeholders—the vendors, many of the users, delivery systems—a concern about the existing, um, toolkit for quality measurement, the burden from this of implementation, the granularity of the measures, issues around exclusions, around the value set. So some of the points Kevin made earlier about the standards and certification requirements are certainly on the table, and we want to be assessing that. We've had a strategic objective of having kind of a plug-and-play approach for more flexibility of quality measures. So that's one tranche of work.

And we've heard a number of people advocating, as you see on the notes just below the bullet, the bolder text, that we move toward real-time point-of-care quality measurement availability that is really woven into the process of care as a means of quality improvement. So there's, I'll say—I'll oversimplify—one school of thought saying let's really build out the quality measurement strategy to support real-time process improvement and quality improvement, um, in the—at the site where the data is being captured and used by the hands-on clinicians.

The—another school of thought—and hopefully we can harmonize there, but they're a little bit in tension—is this—, our charge from Congress and from CMS and other important users is to build a quality measurement capability which supports what the federal government is doing with payment and recognition programs, physician compare, CQRS, value-based payment, ACOs, on and on and on. Um, and we're going to hear quite a bit more about that shortly this morning—, this afternoon—from CMS, um, what those programs are.

But there's a set of requirements, which are meant to drive performance in the delivery system and to increase transparency to the public about performance, and that's the priority from the federal investment in HIT and that vendors and users will find lots of ways to improve quality to achieve those goals but that our job is to apply the priorities of the National Quality Strategy and the public programs through this infrastructure, and then, as Paul hinted, using exemplars to make sure that the technology can produce the kinds of quality measures that people will be paid on, and so on and so forth.

So those are not antagonistic ideas, but there is some tension, I think. And as we get to the question of standards and certification requirements, value sets, um, drilldown tools for quality improvement, there's a little bit of a disconnect between the emphasis of a process-improvement capability and the emphasis of a patient outcome for value capability, which might cut across multiple settings and processes and providers and timeframes.

So that's oversimplified a little bit, I understand, but you see in the text before you in today's agenda, um, we really have had over the last two weeks two versions of a mission statement. One was broad that said, "To demonstrate, promote, and advance the capabilities of EHRs to capture relevant data, and to calculate and report quality measures as efficiently and reliably as possible." And the other was, "To calculate and report measures used by public payment programs (and we can broaden that to say public payment or recognition programs) as efficiently and reliably as possible."

So let me pause there for some general discussion. I think the, the burden on us is to either decide on one or the other course, or to harmonize them in some way. But the implications, I think, really go to the question of what's the infrastructure? What are the interoperability requirements? What are the data intermediary requirements? Where does computation and production of measures happen? I think there are a number of implications of the emphasis we choose for this little bit artificial dichotomy that I pose.

Let me open that up. I think our goal in the next few minutes is to see if we have agreement about how to either select or harmonize between those high-level objectives.

Jon White – U.S. Department of Health and Human Services – Direct Chief Technology Officer

David, it's Jon White. I just want to offer, not an opinion, but a brief comment to the folks that a-as you—you know, as you weigh course A versus course B versus harmonizing, um, I just encourage you to think about what you're asking for if you ask to harmonize and not to ask for both at the exact same time. That's tempting because you want both, but, um, it's, it's ultimately fairly impractical. Thanks.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Thanks, Jon. Do you have—, do you want to drill down a little bit on that and—what do you think about the implications for staging?

Jon White – U.S. Department of Health and Human Services – Direct Chief Technology Officer

Well, just, I, in the course of being here for a couple of years, um, I have, I have seen, um, initiatives where you ask people to both go faster with what they're doing, um, and accelerate it and, you know, elaborate on it and stuff like that, and at the same time kind of blow everything else up at the same time, right, and have those things going on in parallel. And, while admirable, um, it's not, it doesn't necessarily lead you to a better place. It can lead you to more, um, kind of, confusion. Does that make sense?

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Yeah.

Jon White – U.S. Department of Health and Human Services – Direct Chief Technology Officer

Okay. And, it, it—I'm happy to have longer conversations offline. I think that the general principle—the, the high-level principle is the important thing to say here.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Okay, thanks. Other thoughts about the emphasis on process improvement and real-time quality improvement support versus ..., um, outcomes-oriented payments and recognition-program oriented quality measurement?

Darryl Roberts – American Nurses Association

Yeah. This is Darryl Roberts calling for Norma Lang. I just want to add that the process focus and the performance focus can be harmonized, but we have to realize that not all processes map—can map directly in a significant way to an outcome, but sometimes the processes are still valuable in and unto themselves.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. I think to dichotomize between process measures and outcome measures of process performance and, and outcomes performance is deeply, um, mistaken, and will, will lead us into a mess. Um, we need to see process—you know, process measures that have been validated to be connected with outcomes, obviously, but validated process measures and outcomes measures are on a, are on a spectrum, and there'll be very few outcomes measures that are meaningful in a population of 300 patients. Um, and even in much larger populations, there will be outcome measures that have no statistical validity.

And, and so I think it's—I think we need to be much more thoughtful and more clear about the need to say, "Look, we need a, an ecology of measures," or whatever you want to call it, "and we need to know which ones are, are leading indicators, which ones are lagging indicators, which ones you should be able to see a change within six months if you're talking about 1,000 patients, and which ones will take you five years if you are talking about half a million patients.

And if we don't do that, we'll end up, what, with outcomes measures that by definition almost will be disappointing and have no integrated, logical way to say, okay, what would we do to make them better, which is what one of the things process measures are, are critical for.

So I, I think it's just the wrong question. It's a category error that will keep us from asking the right questions, which is, you know, in this setting for this set of patient needs, how do we measure—how do we best measure—whether they're getting optimal care or not, and sometimes the answer to that won't be an outcome measure.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

So, Jim, let me ask you your perspective on the role as a FACA, as our—what our job as the public input to the government, um, what do you think, where, where should be emphasis be in Stage 3, um, the federal role through high-tech and meaningful use in—obviously creating incentives is really all we do—um, and what, what does that imply for the scope of the quality measurement program that we're responsible for advising?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Well, one of the things that we probably won't do, but, but could recommend the commissioning of is say let's have—commission someone to identify outcomes measures that would be the most relevant to the largest population, and measure—and the most sensitive to change as possible, so that as we're creating a set of measures that stress all the appropriate systems, we're also recommending at least that we do it in a way that the first outcomes measures don't lead to a set of articles two years after their implementation that ridicules them for being useless, and at the same time, say—and, and we need to, you know, urge whoever it is to do the research that would be necessary to identify the best validated-process measures that's validated to lead to the outcomes we're looking for, so that over time, our development of those measures—it starts with again, the most impactful.

And, and it maybe, prob—almost certainly doesn't dictate to anyone what the measures are, but gives, um, either a, a specialty society, or a measure assessment group a way of saying, you know, making one dimension of a measure's quality readiness for use of reliable measure of its predicable usefulness to actually improve care.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Okay. Let's hear other people's comments about the overall question we're discussing.

H. Westley Clark – Substance Abuse and Mental Health Services Administration – Direct Chief Technology Officer, Center for Substance Abuse Treatment

Hi, this is Westley. I agree that we do want to make sure that we have measures that are of use to both providers and consumers, um, because the—we continue to hear, apprehension about unnecessary measures and unnecessary burden on, on the system. So if, if we can, you know, be as efficient as possible, I think that's preferred.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

This is Paul. I think the purpose of this program is to make we can put into people's hands, an organization's hands, a tool that can help them improve their care a do a better job with the population. Probably today's current state of the EHRs is that they don't that very well and in a lot of cases do it perhaps very low. Um, so I'd think we'd like to, to put in the exemplars that would help, um, the providers get this information out of their EHRs. That's probably one of the biggest complaints people have about the current systems

It's, um, and I think that, that's why I think our, some of our work in the what we had previously termed platform, the ability of, to give providers the flexibility to get re-reports that are meaningful to them out of the system. But to Eva's point, we also, we have a public responsibility to get information that's useful to consumers and patients and make the decisions on behalf of—to them and their families. So that, that may be one of our biggest gaps, and I don't care what anybody says and it, it really gives the entire quality measure, um This is why we had that, that one of the reasons we had that ...

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim. Just to follow that really quickly, that's precisely my point. If, if, if you had a, a rating of hospitals on, what their performance and doing something like giving people an aspirin in acute MI, that, um, that would be something that a patient or an advocacy group or whomever could look at and, and understand pretty quickly how they did at least on that.

If you published mortality rates for MI it's been shown it would take a half million patients to show a difference between two hospitals, and, and, that's the, that's the point of which we need to think about what would actually most inform people rather than getting caught in a rubric thing about, well, that's not a, that's not an outcomes measure, so it's not what matters to patients.

Eva Powell – National Partnership for Women & Families

Yeah. This is Eva. I want to spring board off of both Paul and the last comment in the sense that, I, I think part of our problem is that the kinds of measures that are meaningful to patients and their families and making decisions, um, by and large don't exist because in a paper world they are impossible. They aren't feasible. And when I look back at the notes from our previous meeting, I think a lot of what was discussed was we need to make sure that what we're, what we're recommending is feasible.

Well, to me that is the point is to make feasible what we need to be measuring. And while EHRs are not the be all end all, and health IT is not the be all, end all—and the, the one key change that will fix all of this, it is a critical component to, to make measurement of what really is meaningful and useful regardless of whether it's a process or an outcome, um, it, it—and make it possible. And what I really fear is that if we continue on the path that we seem to be on, um, we're only going to be perpetuating the, the measures that are currently feasible. And, and I don't—honestly, I think what's currently feasible is only relevant, um, to the degree that it indicates where the gaps are and where we need to go.

And so, um, so I guess this is the upshot of what I'm trying to say is to Jim's point that it, it really isn't meaningful to a patient and their family whether or not people got aspirins. What do we care? , we care whether or not people got better, whether they died, whether they lived. And while I appreciate your, your, um, your point that you want that—whatever information they get to be valid and reliable, um, if it's valid and reliable, but completely not useful, I, I don't know that we've—I think we've wasted everyone's time.

So I guess what I would like to see, um, so what Jon advised, is to identify, as Jim said, those measures, , that may be process measures but have very clear and strong links to outcomes, and to make those relatively few so that we aren't piling a ton of burden, because we need really the bigger focus and the bigger effort to having people figure out how in the world do we get these systems to communicate in such a way that we can use data from multiple data sources, because honestly, information that's most useful to patients requires that.

And, and information that's going to be supportive of health reform requires something larger than an EHR. It requires a community-based or, um, cross-setting kind of, of input of data. And, and to me, if we fail to really advance things in that direction of being able to collect data across data sources, I-I'm not sure why we would have done quality measurement at all in the meaningful use.

Kevin Larsen – Office of the National Coordinator

David, this is Kevin. I know you had some thoughts as well, and I'm happy to broker the conversation if you want to just give your thoughts from your perspective.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Oh. Thanks, Kevin. Yeah. I don't want—I want to be, you know, judicious in my ro—I'll take off my chair hat for a minute. Um, you know, what I'm worried about, I think, consistent with Eva's comments, is that the farther we go down the process of measurement and model in real-time continuous feedback model and have a—now we have 129 measures or so and could be more than that for Stage 3 if we aren't very prudent and parsimonious—that we just can't possibly through this particular program try to develop measures of value to everybody across all settings and provider types and so on and so forth. And the more we do so, we begin to have the federal requirements specifying quite detailed parameters: code sets, value sets, algorithms, computational requirements for the products, um, across a vast landscape. And I think that's beyond our resources, and I think it's beyond our role.

To me, um, we have a fairly narrow role as an enabler of a technology which allows vendors and users to be very creative in solving all the problems of process improvement and workflow redesign and quality measurement and feedback at a local level to address local needs, and I would advocate that our focus is more on the platform issue than on the measure issues. And in fact, I think someone said at the beginning of the call it's really not our job at all to talk about the measures. That's something that CMS and health plans and professional societies and others will be doing. Um, our job is to make sure that the technology environment—the ecosystem Jim described—is capable of supporting the requirements that different types of stakeholders might come up with in the next three or four or five years.

That's very hard, and that goes back to the exemplar approach that we try to guess what those requirements will be, and we then try to make sure the technology is flexibly capable of meeting those unknown future needs. Um, and that would include the quality-improvement, process-improvement need, but it would also include the pay-for-performance need and other needs that we can so far anticipate and we'll hear about here in a few minutes.

So I think Eva's made a really important point, which I don't know that we've wrestled with intellectually yet, and, and to oversimplify it, it's: Do we build out the site-of-care EHR platforms capabilities and all the data infrastructure to support that, or do we build out interoperability capabilities to support plug-and-play specifications to, um, to support multi-site data quality-measurement integration to support longitudinal outcomes, patient-oriented data collection.

Um, and if we had to choose one path or the other, my tilt—I would tilt towards the biggest unsolved problem we have as policy advocates is the interoperability side more so than the detailed process drilldown side.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

This is Paul. Let me react to that, which, which I think is very wise, and try to harmonize in a way, try to do—amongst the various comments, ‘cause I think there’s, there’s a bit of a—if I were to in, in listening to the comments that were raised, I’d put them in three buckets. One is a flexible platform so that we can get stuff out of this EHR that’s worth our quality efforts. That’s something we don’t have and probably could be delivered yesterday. The second one is, um, we need to incorporate information from the patient. We had a hearing on patient-generated data. And the third was the interoperability—in other words, across the many participants and in, in an individual’s care, um, and health.

So in Jon White’s—look, let’s, let’s start where—with where we are, and let’s go the destination, but in a way that people—the, the world can adapt to and, and adopt. I think the flexible platform may be the one that we would love to get in even—well, love to get in by Stage 3, would love to have something happen in Stage 2, but that may be beyond our control at this point. The second thing we are working on is the patient-generated data, and that’s something, that is part of the Meaningful Use Workgroup proposal for Stage 3.

The interoperability as, as, um, important as that is, does seem it may be beyond Stage 3. So if I ordered those just as a straw man, that’s, those are the three buckets I’m hearing, and, and that’s just approximately the order just to throw out.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

So, Paul, let me just a-ask you to go a little deeper into the—your comment—‘cause you didn’t drill much into the challenge around real-time quality improvement, you know, census-based process measures that gives a clinician detailed view into their full panel of patients and all those processes Jim described. Is that the drilling deeper in within the setting—where does that fit? Is that part of the flexible platform model?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think it is part of the flexible platform, and in fact, it’s going to be one of the things we put forth—this is from the Meaningful Use Workgroup—put forth, um, on Wednesday is the notion of going from patient lists, which is a sort of a retrospective report to a real-time dashboard which is for your patient—for your panel. You can call up a—at any point in time, “How am I doing with my panel on X?” So it is making that, that switch from, um, retrospective reporting to a real-time tool. Now this is for Stage 3 of course.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

And this is Jim. Just for clarity, I believe that that dashboard will be obsolete before it is completed, and, and it is already obsolete in many organizations, so that, so that I’m not, I’m not at all proposing that we do is give clinicians of any sort a process dashboard, that if that isn’t embedded in business process management or workflow engines, um, the organization will be dead..

Peggy Honoré – Office of Healthcare Quality, Office of the Assistant Secretary for Health – Direct Chief Technology Officer, Public Health System, Finance, and Quality Program

This is Peggy. If I could just build off of what Jim said ‘cause part of what I’ve been thinking, and, and I’ve talked about this with Tom as well, is some of this the, the needs of the consumers will drive, and I think, as Jim said, those—real-time quality improvement is something they’re going to expect, and the vendors and everyone else will have to, in essence, just have available. So I do wonder if looking more at the patient reported outcomes and interoperability is a better way to go because the other pieces will follow, kind of follow naturally.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So why, why are people thinking of it as either or? Um, so, do people think that the—all the vendors have real-time dashboards currently? Remember, this is a floor we’re trying to raise all the EHR platforms to reach.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

No, Paul. This is Jim. What I'm saying is that those dashboards are already obsolete.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

What, what does that mean?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

We certainly don't want these doctors or nurses or case managers looking at dashboards. We want them to get, you know, past lists or order sets or something actionable that comes to them in their flow of work but not have something separate that they go look at. And, and so that's the issue is that fundamentally at least, I think there's strong reason to think that—what we want to do is make that invisible to, to the whole healthcare team and. And, and so the—for the patient and the caregivers (lay-caregivers also) what they get is something they may want to act on, not go look for something.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

... Peggy must have a different definition.

Kevin Larsen – Office of the National Coordinator

This, this is Kevin.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

But this isn't something someone goes looks at.

Tripp Bradd – Skyline Family Practice, VA

This is Tripp, I'm-a chime in on that a little bit. I think from a practicing physician's perspective, it's nice to have the—

M

Hello?

Tripp Bradd – Skyline Family Practice, VA

Yeah, this is Tripp. Can you hear me?

M

Yes, we can hear you.

Tripp Bradd – Skyline Family Practice, VA

Okay. It's nice to have that capability. I don't understand the obsolete comment really, except you know, not in real time care. I totally agree with you, Jim, as far delivering care to patients. But, you know, it'd be nice to have a patient see how you're doing and then be able to refer to something, you know, hemoglobin A1c's in your panel, etc., not, not moment to moment, but day to day be able to, see what kind of process changes you've made in your practice, , using an EHR. Again, we're trying to make it HIT sensitive to make a difference. So, you know, the dashboard I think, again as Paul mentioned, is something that I'd like to see personally in my EHR, , and those of others that I've seen.

Sarah Scholle – National Committee for Quality Assurance

This is Sarah. So that's essentially a population management function, right? To be able to open it up and see how you're doing? And, and, um, I agree with this, this focus on, you know, a flexible platform that allows you to look at that, that allows you to incorporate patient-reported information. And I, I want to second Jim's concerns about the—how outcome measures, um, can be used for accountability as opposed to quality improvement.

I think having information that that would allow you to look at how a patient is doing over time and how your population is doing over time is really helpful. But it may not be a stable enough piece of information that would allow you to make comparisons from one practice to another or from one organization to another.

So, um, what I'd like to see is the logic that shows you how all these pieces fit together. So in that exemplar group, it might be helpful to show here's the information that comes out of the EHR that you could use, um, to track a patient's, um, you know, um—specific kind of patients, here's the information that you could use in your dashboard. Here's the information that comes from the patient that you're using to check functioning or to check, um, experiences of care or whatever it is that's going to help you to understand, um, the patient's perspective on care.

And then the information that you'd like to get from, from outside that's critical—so for asthma it would be, whether they're having ED visits, and, you know, getting functioning for asthma, too. But it'd be nice to try to tie that together to show the different kinds of capabilities that are needed within the EHR, um, that's getting information from patients into a reporting function, and then information that's coming from outside that's critical for managing, care for that population of patients as well as, you know, for an individual patient.

Russ Branzell – Poudre Valley Critical Access Hospital, CO

This is Russ. If I could add on to this, I think we keep trying to treat these things as all separate items within a functionality of a system when the reality is they're all additive to each other. Whether it's down to an individual patient ensuring that that person's outcomes are good or ensuring that that data rolls up to the level of the physician or to a larger lever even to a group being managed of physicians and their related population, it all has to map back to that original data being put in relative to the metrics we're defining, and it has to map back to that data being accurate to be worked across the entire spectrum.

And I think that's what we're missing today is we try to treat each thing as separate and then give this to the EHR vendors, and they create different modules and different functionalities, and we drive our physicians crazy, because they're adding data everywhere rather than a single point of data entry that can serve all the functions.

Kevin Larsen – Office of the National Coordinator

This, this is Kevin Larsen. A comment about interoperability, um, as we are in the middle of the—building measures for these programs, what we're building is a real-time data collection and that real-time data collection is currently limited by what is input into an EHR. So therefore a number of the, um, outcome measures that people want really are outside of the scope of the current ability.

So for example, if you wanted to know patients that died of a certain condition, that's a great ... it's a great thing to know. Our EHR systems right now don't know how to find out who died. They're not connected to some system that knows that somebody died and so the nature of the measures actually, at least in the current way, is automating real-time capture, whereas the historic measure world has been a retrospective analysis. And there is some, I think, fundamental discussion we should have about how that change in architecture and that change in moving to real time collection changes how the measures work and, and what we expect out of it.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

That's a great point, Kevin. You know, this makes me think, too, back to—several people have made the comment. I think a-an example of that is when indeed there's a, um, adherence to a medication that's using Surescripts or other interfaces, um, readmission. All those kinds of outcome measures, so, so to speak, would be more accessible if we had solved that interface issue and had an expectation that an EHR is able to capture that external data to—whether it's from the patient or from clients or from Surescripts—in order to compute—have a working outcomes measure.

I love the—someone made the comment about having all the data you need to help manage the patient. That's a much more open state of mind capability than strictly saying, "Here's my EHR in my clinic; what does it know, um, and what processes does it influence?" But that's a—I'd like to get back to this question of whether we have a dichotomy or not, with a focus on linking information resources to help manage the patient versus managing local processes without access to external knowledge, which is the current state for the most part

Sarah Scholle – National Committee for Quality Assurance

This is Sarah. The other point here is that, um, Kevin talked about the difference between creating measures out of what's available now versus what the future state would be. And it's really design the future state of how we want it to be, then demonstrate that it's feasible to put this information together in a, in a way that's useful. But it's, um, really, um, fundamentally changes our approach to validating measures, you know, creating and validating measures.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

So I—any further comments? This is, this may be something we find a way to present to the public for comment, although I don't quite know how we'll do that yet. Or maybe we'll follow Paul's lead and find a harmonized solution.

Eva Powell – National Partnership for Women & Families

Yeah. This is Eva. One, one other, um, comment that's not really a solution, but I—it's something that I think we should keep in mind that is a real opportunity through meaningful use, um, is the fact that, that while recording is required, um, that's all that's required. There is no actual performance, um, um, requirement, and so I think that presents a great opportunity to leverage this program, um, because what, what we're talking about—particularly if we, if we go the route of really focusing a-a lot of effort on the platform.

Um, I don't think it has to be either or, but I do think that if we end up focusing a good bit of effort on the platform and being able to do these new kinds of things with, with data from different sources, um, that, that that's a huge undertaking that, um, I'm not sure we're going to have a solution that, that then makes, um, that, you know, a perfectly working system by Stage 3, but we certainly, because there is no performance requirement, could use meaningful use as a way—as a real bolster to the system of figuring that out.

Um, and, and as Paul mentioned before, providing flexibility to providers trying to meet meaningful use, that if we come up with a very small list of process measures that, that have good evidence to link to outcomes that we could collect, and they could use that for their improvement if it's relative—relevant to them, then that's fine. But if, if they, if none of those are relevant to their practice, then they could contribute to the, to the learning and development of this new system that we, we all feel would be better, but it's such a huge undertaking that we don't know exactly how to head in that direction.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

So There was some discussion earlier in the spring about allowing the meaningful use program to be a place for testing rather than simply implementation of approved measures, and whether we could allow, for example, professional societies or delivery systems to say, "I've got four measures that meet a set of criteria that have been reviewed by NQF or others, and I think I want to implement them through the meaningful use program." And if we could set what those criteria are, perhaps we could use this program for more developmental and innovative work, um, along the lines of the, the challenges we've been discussing today.

Alright, I think we'll wrap up the conversation. Um, but what I think what we should try to do, you know, Kevin and Jessie, maybe we can put together what we heard today in the form of a—at least a summary of, of points of view, if not an answer, and circulate that in written form for people to take to the next iteration.

Kevin Larsen – Office of the National Coordinator

We certainly will do that, David. I don't know if there are any particular summary comments that you or Paul want to add to, to kind of, get us thinking, so we can make a decision about this pretty early on so we can drive our scope.

Jesse James – Office of the National Coordinator

Right. Summary comments would be really helpful since when we think about we have eight weeks. That means four meetings to move from discussions to draft to something that we're comfortable finalizing before the Health IT Policy Committee. So some comments, um, both from Paul and David would be great, or even just a few summary comments from the contributors who've spoken so far could help us along that way.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

And that was Jesse James?

Jesse James – Office of the National Coordinator

I'm sorry. Jesse.

Kevin Larsen – Office of the National Coordinator

Why don't you start, David?

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Well, I'm scanning my notes, and I think, um, we have several points of view. I don't think it's—they're all aligned yet. Um, and so the things we've heard are there's a value in giving providers close to real-time pro—improvement on the processes they can manage that are associated with better outcomes. Um, we've also heard some interest in capturing data that is of value to consumers and attributable by consumers, and a view that often that data will across settings and across time be outcomes oriented. Um, so I think we have the, the broad questions of supporting local process improvement and capturing data across the continuum, and then the third layer is to fold the, the data from multiple sources back into the EHR to create this full perspective on information to managed care.

Let me pause there to see if, Paul, you want to add a couple more elements?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So I think, I think based on what you're—the way you characterize it, there may be a two-dimensional map. So one are, um, so one perspective are the drivers of what, what would drive you to want information about patients, and that's sort of to—from a patient point of view to give me information that I can use to help choose, whether it's providers or treatments.

The other, um, mentioned is what's the capabilities that we need to have in HIT systems to help supply the needs of the drivers. Um, if we cluster them—so on the latter, the EHR, the HIT capabilities we talked about flexible platforms for, for reporting. Um, we talked about patient-generated data. We talked about interoperability to support care across the continuum of sites, um, the drivers of which were, um, measures that are meaningful to consumers and patients, and, um, measures that are, are useful for people in the health care organizations to improve their, their work, their processes.

Does that sum—is that some of the two dimensions, and maybe we can, um, come up with strategies in each of these?

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Well, let's—the next part of our agenda today might help with that, the drivers question, because I think part of what we want to understand is what the range of users—in this case mostly the federal agencies—what their drivers are. They may have other requirements that we haven't yet listed.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

But I like, I like the two-dimensional framework, and as we may—I hope we might elaborate on both of those lists and let the committee react to that.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Um-hmm.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Other summary comments before we move on? Anything big that we haven't at least noted in the last few minutes?

Kevin Larsen – Office of the National Coordinator

The, the only thing that I'll mention is something that, um, Jacob and I have talked about—and this is Kevin at ONC—which is if clinical decision support doesn't fall in the domain of the Clinical Quality Workgroup, we do know that it's part of the need from ONC to think about clinical decision support. So if it's not here, then we will work with Paul and others to find a place for it. Um, and, and, that-that's sort of an open topic that clinical decision support needs a thoughtful workgroup to help guide it along ,and it may or may—it may or may not be in scope for this group.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, I mean, let me just mention an approach that we're taking right now and see if that works for you. Um, Meaningful Use Workgroup has that as an objective. Um, the way it's currently worded for Stage 3 is fifteen, um, clinical decision support interventions linked to five quality measures. I mean, that's the way, that's, um, the linking functions. Is that, is that where you're—what this looks like?

Kevin Larsen – Office of the National Coordinator

What I'm thinking about is that, um, to the point made by many people on the call, that the—we have to be in harmony with how we, um, incentivize and certify the software so that it is pretty straightforward that those decision support tools are linked to the measures. That doesn't mean we need to build the decision support tools, but it means we need to be—while we're thinking about a flexible platform for measurement, we have to be thinking about a flexible platform for decision support. And if we're signaling some kind of emphasis on certain kinds of improvement or certain kinds of measurement, to my mind we would ideally incentivize a, an alignment around decision support platforms and flexibility.

So it's a similar discussion, not about the details of we need to fire an alert if you forgot an aspirin, but we want—we're focusing on patient-reported outcomes, for example, and therefore we want decision support that also focuses on some way to do patient-reported outcome and decision support. That's my point.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, so unless David disagrees, I think that is out scope for the Quality Measure Workgroup.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, so we'll work offline and help find a place for it.

Kevin Larsen – Office of the National Coordinator

Okay.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Yeah, yeah. Alright. Well, thank you all. We've taken—, had a good discussion, and we'll try to formula— formalize it in the way that Paul described and with other notes you've all suggested, and, , we'll come back to it, in written form at least, for the next meeting.

So, next thing we wanted to do today was get some input from some of the other agencies that are depending upon us to solve all these problems. , and I'll—let me see if I can turn it over to Kevin, perhaps, to kind of tee up the sequence of events and the, the materials we received via email.

Kevin Larsen – Office of the National Coordinator

Certainly. So we have a combination of feedback from agencies, as well as some analysis that we've done on the meaningful use measures. So, um, the first person that we have is Kate Goodrich—who's actually sitting in a room with me now—who is a physician that works at CMS in a leadership role in the quality and measurement space, who's really driving a lot of the coordination around, um, quality strategy within CMS. And so she's going to give us a policy overview and a kind of direction for how CMS and across HHS were thinking of measurement and quality.

We also have, um, as, as part of trying to improve on the measures that we released from Meaningful Use 1, we've been doing some systematic analysis under a number of different forums for measures for Meaningful Use 2. Then we have some high level kind of lessons learned to bring to you really as a kind of framing question, again thinking about what would we want from a, a certification system.

So we're going to hear from the National Library of Medicine around how they have been looking at the code systems utilized in the measures and how we're looking at the new value set—um, authoritative center at the National Library of Medicine. And then we have two different contractors, MITRE and App that will talk a little bit about the analysis that they've done really on how measures work and function. It's, it's not really an analysis of this is a good measure or a bad measure; it says from a technical standpoint what are the things we need to be thinking about technically how these measures work within EHRs.

So we'll start with Kate.

Kate Goodrich – Centers for Medicare and Medicaid Services

Um—

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Do we—we'll have this on the webinar's feed, as well as most of you probably received it as, as an email attachment too.

Kate Goodrich – Centers for Medicare and Medicaid Services

Hi, everybody. This is Kate Goodrich. It's a pleasure to be talking to you all today. Um, some of these slides may look a little familiar. I, um, this is essentially the same presentation I give—gave to the NQS e-Measure Learning Collaborative with a few tweaks, um, a few weeks ago. I think my job today, um, is to give you a high-level overview of our, sort of, vision and, um, high level principles for quality measurement, um, and also to highlight for you some of the activities that are ongoing across CMS, but also across HHS. And I'll talk about one activity very briefly that we've just taken, undertaken as Kevin alluded to, which is the development of a CMS quality strategy. I don't have a slide on that, but I'll speak to it quickly.

So going to the second slide, this is a three-part aim. It should be very familiar to everybody. This is really our guiding star for all that we do in quality improvement and not just in measurements. Um, going down to the next slide—you know, the National Quality Strategy, um, is, is, —so you see here, the three aims and six priorities, which should be very familiar to everybody on this call, so I'm not going to go over them. I just wanted to highlight that the National Quality Strategy really afforded us the ability to sort of take a step back, look at our measures, look at our measurement policies, look at our high level principles, and sort of reboot, um, for, you know, for all of our programs going forward, and, and really provides the framework for us to really be able to operationally align our measures across programs, understanding that that's going to be a multi-year process. But, but obviously a very important one.

Moving to the next slide, um, this is just a way that we sort of in—, have always sort of conceptualized all of our quality measurement programs. You can see they're essentially defined by setting and population here. We have a lot of programs, so there is a lot of work to do to align not just the measures, but also the implementation and policies across our programs, um, so—and many of these were significantly expanded or even started anew because of the Affordable Care Act.

And also this slide, looking especially under the payment model reporting, um, should highlight that the Affordable Care Act really begins that critical shift from pay for reporting to value-based purchasing. And so as we are thinking about the measures that we want to develop and how we want to use the measures that we have, we really need to be thinking forward in more of a value-based purchasing-type construct.

So moving to the next slide, this is, um, this—I wanted to tell you a little bit about, um, a, a taskforce that we've had in operation for about the last year within CMS. Um, and this taskforce was started last summer so that we could really, um, again, take a broader look at all of our programs. And I don't just mean the Medicare programs here. I mean Medicare Advantage. I mean Medicaid. I also mean demonstrations and projects that are led out of the dual eligibles office and out of CMMI, and to really think about, um, how we can be more consistent, um, and standardize our measure reporting.

So the charge here is to develop recommendations for leadership for CMS measure implementation. Our main goals are for aligning and prioritizing measures across programs in order to avoid duplications or conflicts among developing and implemented—implemented measures. Um, so not only do we want to align and prioritize measures across programs where that's appropriate, understanding that it's not always appropriate to perfectly align measures, but we also need to be very—we need to be a lot smarter about how we coordinate the development of new measures across CMS, and as I'll get to a little bit later, across HHS as well.

And, no—this does not just go to the individual measures, but we really need to do a better job of coordinating the implementation of our measures, um, and our measurement policies internally and with our sister agencies at HHS.

So the Quality Measures Task Force consists of senior representatives from across CMS. Um, starting about in January, we looked at, on a measure-by-measure basis every single measure in our programs, um, for the 2012 rulemaking cycle, um, and, and really evaluated them for whether or not they should stay in the program, and certainly whether or not they align across other programs. Very importantly, one of the, um, one of the items that we looked very closely at for every single measure was what the map had to say about the measure. This is the measures application partnership. So these were explicitly reviewed for all of our measures.

Um, we thought that—um, we were hoping that alignment of measures would be a force function. I think we actually got a significant—made significant progress on being able to align measures across our programs. That should be seen, for example, with IPPS rule that came out for the physician fee-schedule rule that's out now for public comment. Um, where we're going to have more challenges is gonna be in aligning with, say, the adult Medicaid programs in great part because there's such different statutory requirements and timelines. But we're making very explicit efforts towards doing that.

And we also looked at measures for non-rule-based programs as you see here—so for Medicaid CHIP Parts C and D, the insurance exchanges. They're starting to think about what measures they want to use for the exchanges, CMMI demonstrations and projects, and of course, MMCO. That's the dual eligibles office.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

So excuse me, you might—somebody might need to change the slides.

Kate Goodrich – Centers for Medicare and Medicaid Services

Oh, um, okay.

M

You're not advancing there—so, so there you go.

Kate Goodrich – Centers for Medicare and Medicaid Services

Okay, um, this should be the sixth slide. Um, so example, accomplishments—um, one of the first things that we did that, that we undertook was to think about what our dimensions of quality were and to ensure that we had broad CMS consensus on what those dimensions were so that we could be more consistent in how we measure quality across all of the programs across CMS. Um, we also developed measure selection, removal, and retirement criteria that, again, can be used across all programs.

Um, we have been collaborating with our sister agencies, including, of course, with ONC on our Meaningful Use Stage 2 tool. Um, and we fin—we also think it's really important to prioritize and align measures with our signature programs, such as Partnership for patients and a Million Hearts. And one of the accomplishments that I didn't put here but that should be noted is that through this sort of, you know, measure-by-measure intensive review, we actually reduced for the first time the number of measures in a program by reducing the number of proposed measures in our inpatient quality reporting program, which of course aligns with HVBP, as well as the meaningful use program.

Moving on to the next slide, many of you have probably seen this slide. This is our bubble slide of the CMS measure domain. Um, this is what we came to consensus on across the agency. Um, and beneath each domain you see sample types of measures that would be included in here. , we are currently, um, undertaking an exercise to identify the different sub-domains of measures, and the idea there is really, again, not so that we can just shoehorn every measure into a different sub-domain, um, but in order to be able to be aligned on where we are driving towards and what our goals are as an agency, and also to better identify specific gaps in measures.

So we think that overall measures should be patient centered and outcome oriented whenever possible, understanding there is still a role for structural measures and process measures as well, and we also think that measure concepts in each of the six domains that are common across providers, um, and settings can form a core set of measures. So the idea would be over time that we have a core set of measures that crosses all six domains that could be measured at multiple levels.

And if you go to the next slide, that's demonstrated, um, in another conceptual model, um, identifying the different levels of measurement—so the individual physician or provider, the practice setting, which could be a pract—a group practice or a hospital, and a community setting. And, and our goal, I think, is over time to be able to measure at multiple levels and, and I—we think that that's really critical to being able to ultimately realize the three aims of the National Quality Strategy. And as many of you know, NQF is doing some work that we're funding to identify these families of measures that can be measured at multiple levels. As of right now they're working on cardiovascular disease and diabetes care, as well as safety in patient—and, and care coordination.

So moving on to the next slides, these next two just identify CMS' high level vision for performance measurement. We certainly welcome any feedback that you all have on this. Just let us know if you think we're going in the right direction. Most importantly, we really want to align measures to the National Quality Strategy and the fixed measure domains, and then implement measures that fill the critical gaps within the six domains. And we know that there are tremendous gaps within these six domains. In fact, in, in at least five of them, there's very, very broad gaps, so we have a lot of work to do to try to fill those and to identify, you know, who's responsible for developing the measures to fill those gaps. That's something that we've been working with our, you know, private sector partners to think through as well.

Obviously we want alignment measures across programs, and importantly, we really feel strongly that we need to leverage opportunities to align with the private sector. Right now we primarily use the, um, NQF-convened MAPs as an opportunity to do that, and I think the work for the coming year that we've identified for the MAP, um, is to really think hard at a much more tactical level how we can align our measures for the private sector. And I think that starts with having the private sector at the table as we identify measures that we want to use in our program, and of course focusing on patient-centered measures is critical for us. Kevin and I are both patient-reported outcomes meeting at NQF, and it's something we're very interested in.

Moving on to the next slide, you know, over time we really want to get to core sets of measures and measure concepts. We, we, um—I hesitate a little to use the word parsimonious because I've gotten a little backlash for that. I think what we're really trying to get at here is that we want to get to sets of the measures that matter. As I've heard Farzad describe it before, those bottom line measures that are really going to be important for driving improvement.

We know that for some of our programs, CQS being the main one, we need to maintain an optional menu of measures that can apply to multiple specialists and understanding that there's going to be some measures that we hope will apply actually to all specialists that are those more cross-cutting measures, you know, related to patient and family engagement, care coordination, etc.

And also, importantly, we feel very strongly about removing measures that are no longer appropriate, whether they're, you know, "topped out" or for some other reason they're not appropriate to be used in our program. And our overall goal, of course, is to maximize quality improvement and to minimize provider burden. So we hope that if we stay true to these high level principles, that we will achieve that last goal.

Um, I'm actually, if it's okay with everybody, going to skip through these next three slides even though I know they're on e-measures and that's what we're about. Um, but just to get to slide 13, which is the HHS Measurement Policy Council. Um, this is a corollary council to the QMTF, the Quality Measures Task Force at CMS that I described a minute ago. This is a cross agency council, um, led by—at least for now, led by—co-led by CMS and our—Nancy Wilson and myself co-chair it. Kevin is a member of this as well. And the idea behind this group is really twofold. Our near-term goal is to try to develop consensus on core sets of measures within six measure topics as have been identified to us by the deputy secretary. Um, so hypertension is one, smoking cessation, depression, hospital-acquired conditions, patient experience, and care coordination are the six that we're tasked with undertaking right now.

However, we also feel that it's as, if not more important, to align across HHS on, um, on based—on measure policies and measure development and implementation. Again, I think the development piece is really important here so that we can be sure that we're not developing measures in conflict with one another across the department. Um, so that's, that's going to be, um, a core duty for this, for this group going forward.

And then finally what—, you can go to the last slide if you like, which is just my contact information if anybody would like to contact me about any of these ideas or issues. I think the last thing just to say (I don't have a slide on this) is to let everybody know that right now, um, we are undertaking at CMS—, we're undertaking about a four- or five-month project to, um, to develop a CMS quality improvement strategy. This is not just about measurement. This is about our quality strategy overall. And, um, we have, again, broad representation from across all of CMS to do this.

And just, just to give you a couple of, um, insights into how we're thinking, two ways we're framing this. Number one is we are framing our quality strategy around the National Quality Strategy. That should not come as a surprise to anyone. So we are identifying, um, underneath of those six goals a number of very clear objectives. Our goal is to over time to be identified—identify specific targets underneath each of those objectives. Right now, we have only a few, um, that are same targets as the National Quality Strategy related to the partnership location. So for example, reducing readmissions by 20% with a Million Hearts producing, you know—um, preventing a million heart attacks and strokes within—I think it's five years or whatever it is. Um, so we have those in place.

But we're really challenging ourselves to try to identify aspirational targets for each of our other goals and objectives, which is something that'll happen I think over time. And that's actually a, a challenge for the National Quality Strategy as well that's highlighted in the press report that was sent to Congress in April—the need to be able to identify specific targets. So not only through the strategy are we going to identify what we think the drivers are, the CMS drivers to achieve each of those, each of the objectives that we've identified under each one of those six priorities, um, but we also are, are, looking at this, um, trying to look at this from the point of view that—you know, with the passage of the Affordable Care Act (but not just because of the Affordable Care Act) there's really been a shift for who's responsible for driving quality improvement.

So historically because of, um, you know, claims-level data that's payers had, um, payers were able to identify metrics, um, that providers were required to report on and payers really took the responsibility for driving quality improvement, but that is a shift that's changing now because of delivery system reform, um, and because of the need for driving, —the recognition I should say—of the need for driving quality improvement at the local level. And we feel pretty strongly about that as well, and so we're trying to think hard about, um, what can we embed into our own quality strategy that will create the environment or, or, or foster the environment or sort of create the capacity for providers to really be able to have access to their own data that they have generated to be able to drive improvement at the point of care.

So we're thinking hard about how to embed those types of drivers also within our quality strategy, so more to come on that. We don't have anything publicly available on that. That's just sort of a glimpse into how we're thinking right now, um, so I will stop here and see if there's any questions or I can wait till the end of all of the HHS presentations and, and a—and answer questions then.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Why don't we do questions now because the other presentations are really sort of a different flavor? They're more of the details of the e-Measures and cases of strategy discussions.

Ahmed Calvo – U.S. Department of Health and Human Services / Health Resources and Services Administration – Senior Medical Officer

This is Ahmed. Not a question, but an add-on comment, and that is that, um—well, thanks, Kate, for the, for the summary. Just so the committee is also aware, a, a parallel committee is in—exists at HRSA now that is tied into all of this work as well, so that's important from my point of view of, of the idea of addressing the needs of vulnerable populations and our experiences on all of the measures in HIT and HIE activities.

The bottom line is that, that HRSA process linked to the CMS process, it's really a, a, a key strategic link for me and, um—that we're very happy to see the evolution of this at the HHS level, as well as all, all these other pieces interconnecting. Thanks.

Heidi Bossley – National Quality Forum – Vice President of Performance Measures

This is Heidi from NQF. Again, it's not really a question, but just a vote of support for the work that you all are doing, um, in part because we do see it from the other side where, um, the alignment is absolutely critical, and to have it first start from the federal side and then hopefully move to the private we support 100% and thrilled to see.

Kevin Larsen – Office of the National Coordinator

This is Kevin. As the Quality Measure Workgroup for the Health It Policy Committee, we're thinking through what, what are the right things that we should try to deliver, um, as this workgroup? From CMS' standpoint what would be, um, a successful delivery from the Quality Measures in the meaningful use program?

Kate Goodrich – Centers for Medicare and Medicaid Services

Um, I think, um, specificity as much as possible of the, types of measure concepts that would be feasible and most meaningful within the—particularly within the National Quality Strategy domain, where they are most needed. One of the things that we have found is we get a lot of great input from a lot of different groups on, um, you know, what the gaps are, for example. But one of the things we find lacking sometimes, um, and that, you know, we think about a lot, but we, we need, we definitely need most assistance with is, again, that level of specificity of what exactly the clini—the metrics should be. And, and, with, with the meaningful use program, the feasibility has to be, obviously, incorporated into that as well, because I think we can pick of a lot of interesting and meaningful clinical concepts—or not just clinical, but patient-centered concepts for measurement—um, that we all could agree are very important.

Um, but you all know best also what's coming down the pike for capabilities of EHRs to collect and report information and what's going to be required, so incorporating that into the clinical—you know identifying some of the quality concepts that can leverage those types of capabilities to their maximal extent would be really helpful for us.

Um, and I know we'll be working with you on that to the extent that we can continue to provide sort of what, you know, direction on how we're thinking, but we're also interested in feedback from you as to the direction that you think we should be taking. If we're missing something, if we're missing a nuance, you know, we very much welcome that feedback.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Thanks, Kate. This definitely sounds like the, the path we need to pursue. Um, Kevin, should we go on to the other presentation?

Kevin Larsen – Office of the National Coordinator

Yeah, that'd be great. Jesse, do you want to introduce them?

Jesse James – Office of the National Coordinator

Yes, absolutely. I'd be happy to. Um, the next three presentations will be, um, closer to the details on measurement and testing and what we found as lessons learned after we looked back at the measure set that was created for, um, Meaningful Use Stage 2. We start with Saul Kravitz from MITRE, who will talk about their efforts to standardize value sets for the behavioral health message. But ... behavior health measures, but also more broadly about their thoughts on measurement going forward.

Saul?

Saul Kravitz – MITRE – Principal Health Information Technology Engineer, Center for Transforming Health

Alright, thanks, Jesse. Can you hear me okay?

Jesse James – Office of the National Coordinator

Yes.

Saul Kravitz – MITRE – Principal Health Information Technology Engineer, Center for Transforming Health

Okay. Um, so it's a pleasure to be able to, to talk to the Quality Measures Workgroup. Today, um, as Jesse said, I'm going to be trying to relay, some of the lessons that we learned from a project called the Behavioral Health eMeasure Project. Now if we move to the next slide, there's a little bit of background on that. So the, the project was sponsored by ONC and SAMHSA with the goal of developing a portfolio of behavior health e-measures for Meaningful Use Stage 2 and, and beyond.

And the output of the project so far has included ten e-specified clinical quality measures, two of which are included in the, in the NPRM. And perhaps the most interesting aspect of the, the, the project was the way the project was, was organized and the approach that we took to, to developing the, the e-measures and the associated value sets. Typically, a measure developer is assigned a measure to e-specify, and they're responsible for developing both the logic and the associated value sets.

What we did was we split those two functions apart, essentially modeling a world where value sets are shared and clinical quality measures leveraged shared value sets. So the measure developers were primarily responsible for, for determining—for, for contributing to the decision as to what the clinical concept upon which this portfolio of measures included and reviewing the output of the value-set developer to make sure that the value set in fact represented their, their intent when they, when they specified that that concept. So the output of the project is both the clinical quality measures and this collection of, of value sets that hopefully can be, can be re-reused.

The way the project was organized was MITRE was the lead organization, and both measure stewards and a value-set developer were contracted to, to do e-specification. So we, we worked with NCQA and the Joint Commission, as well as several measure developers, two measure developers who didn't have the capability of doing e-specification. So MITRE—in, in this case me— did the e-specification for those measures, and ... Incorporated was our value-set developer.

So in terms of my qualifications, I think I'm one of the few people who have both e-specified measures and implemented quality measures within our quality measure calculation engine. So I both produced and consumed the e-specifications. Next slide, please.

So, so we reported on a whole bunch of, lessons learned to ONC and SAMHSA and Jesse asked me to pick some of the salient ones to tell you about in my ten minutes. So this is the entire kind of list of areas where we learned lessons. I'm going to focus on four areas from this set and pick out a, a couple lessons from, from each one. Um, so the, the four are, are essentially how you represent measures in terms of intent and how they're, how they're represented for subsequent reuse, how to manage a, a project like ours where we had a shared value set together with the logic development by the measure developers, and then talk about review and testing, which are two of my favorite topics. Okay, next slide, please.

So, so when you go to, to pick a measure for e-specification and then go to implement it, if you, if you look at the collection of NQF-endorsed measures as your, as your library, what's really in there are three, three things for each measure. There's, there's some intent with a scientific basis for that intent, so for example, we should be examining the feet of diabetics. Um, there's a particular implementation or data source—the measure will be endorsed based on claims data or some other specific type of data. And then there's the logic, which says how I take that, that data from that data source and use it to implement the intent. And when we start with a measure, when we start with retooling a measure, we're essentially saying we want to preserve the intent. We're going to use a different data source, and we have to adjust the logic to make it, to make it work.

And it's really important to, to note that some measures just will simply not work in the context beyond their originally specified data source, and those that do work in other, with other data sources, you, you really have to be flexible in your, in your thinking about what the measure should do if you want to end up with a feasible measure.

So the, the lesson here is that you, you really should consider different implementations of a clinical quality measure as closely related siblings, rather than the original endorsed measure being the truth and everything else—all other implementations having to stick very closely to the original, to the original implementation. So next slide, please.

So this is just a quick example of what I'm trying to get across. One of those measures we worked on was this measure about, about bipolar manic agents. The original NQF-endorsed measure was based on claims data. The version that we worked on was based on provider EHR data, and I imagine in the future there could be a, a version that will be targeting care under, under an ACO. So, so all three of these measures, they share the same intent that the patients should be on their, on their meds. The data sources are different, and thus the logic will be different in each case. And the sensitivity and specificity of the, of the measure will be different in each context that it's, that that is applied.

And if you, if you're unwilling to, to tolerate that last bullet, that the sensitivity and specificity will, will differ, then you shouldn't try and retool... You should just start over and, and not call it the same thing, because there's really no way to achieve the same specificity and sensitivity working with EHR data from an individual provider as you get from claims data when you can see all providers that the patient saw and all, um, medication-dispense events and so on. Next slide, please.

So the next topic—kind of changing to, to the next kind of area of lessons learned—relates to this process of building value sets, shared value sets and measures concurrently. Um, so our, our approach was that the value-set developer contributed to telling us which concepts they needed value sets for, the value-set developer went off and built the value sets. Both MITRE and the measure developer who owned the measure reviewed the value sets, and we talked to each other and iterated on this process until we reached a happy, a happy ending. And sometimes this involved coordinating across multiple measure developers 'til everyone was, was happy with the, with the result.

And one aspect of this which is, which is key is communication and the traditional way of communicating value sets is essentially enumerating them in a list—so called extensional value set. And this is one of the reasons why people are very reluctant to share value sets because they don't really understand they can look at the list of specific codes, and that tells them where the value set is today, but it's very difficult to check against what you think the right value set is, and it's, and it's even more difficult to understand the intent of the value set in terms of how it will be maintained moving forward. So what we did to facilitate this communication was we used intentional expression of value sets, (what we called recipes) and we distributed those together with the, with a list of codes.

And, um, if we go to the next slide, we'll see this is, this is what a extensional value set looks like—a very long list of numbers with descriptors. And next slide, please.

This is, this is what a—the intentional value set description using the tools that ... used to, to, to develop the, the value sets. And here you can see there's at the top, there's some general information about what, what the vocabulary this is from, um, that the codes are in active use, that it's from human. And then when you get down to where it says all bipolar disorder, disorder, that's basically saying take everything in SNOMED that's underneath the bipolar disorder in the tree except for those three disorders that are that are named there: the schizoaffective disorders, cyclothymia, and history of manic depressive disorder. Exclude those, and this is a much clearer statement of what the purpose of the value set is and how it can be maintained moving forward since essentially we could snapshot SNOMED at any future time using the same rule and get an updated list of codes that apply.

So the, the lesson here, we think, is that that the communication here is, is essential to get people comfortable that they can rely on a, on a value set that's developed by somebody else and that the right way to really specify these to communicate is this intentional approach. Next slide, please.

Um, so again, moving to the next topic, which is, which is review, um, one of the things that, that surprised me on this project was how much review by a third party—in this case, myself and my— others at MITRE contributed to changing the, the measures that the measure developers put together. And the, the kind of changes and improvements that, that happened were with significant simplification of, of the measures, um, identification of just normal errors and issues with the data and the logic, significant reduction in the number of data elements that were needed, and improved, um, feasibility.

And one of the reasons why the impartial review helps is that the, the measure developer—the person doing the e-specification is typically trying to, to keep the, um, the person who developed the original measure, which has an original implementation based on another data source, happy. And sometimes that's really not the right thing to do when you, when you take a measure and, and retool it. And having another set of eyes look at the measure and say, "You know, that doesn't really make sense in this, in this setting. You really need to—well, we really need to back off of that and, and lose some specificity really, really helps to improve the, the, the quality of the, of the measures.

The same is true of the value sets. I think everyone who participated in our project agrees that the value sets that were produced were better than would have been produced if everyone (every measure developer) built their own, um, value sets. And another aspect of our review process was we reviewed test cases for all the measures, And having the measure developers produce test cases and having a third party review them significantly improved the, the quality of the, of the results. So our, our lesson that we hope can be adopted will be, would be that, um, if we're going to develop measures and value sets for inclusion in national quality programs, that incorporating a third-party review into the development process that focuses on, on feasibility, correctness, and computability would be a big would be a big help and we hope that that can happen. Um, next slide, please.

So the last, the last area I wanted to touch on (and I've hinted at it already) is that, um, we, we think that the testing is absolutely essential to measure development. A measure is essentially a software artifact, and until the measure developers can actually execute their, their measures, we're never really—we'll never really be sure that they, that they work as intended. Um, so our process included deliver-delivery of test data and outcomes in a common format that was developed by the joint commission, and in this format, the data elements are specified at the concept level not at the code level. So the, a concept would, could be something like an outpatient encounter or a vaccination administration.

And by having this test data, it's enabled us to identify logical errors in the e-measures and to identify scenarios that hadn't really been considered by the folks doing the e-specifications and to enable testing as we implement the measures within, quality measure executions environment. So again, our, our lesson here that we hope could be incorporated into future development process is that, is that one of the artifacts that would come out of a measure development process would be test data and outcomes that would, that would illuminate how the measure is supposed to work, and that automated testing for conformance with the test data should be the way things are done. That should be the rule as opposed to the exception.

And that's all I had prepared for today. Um, I'm happy to, to entertain any, any questions. The, the full—a much longer version of this report is available from ONC.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Thank you. That's great. For the sake of time, why don't we move on? Um, Olivier, do you want to go next?

Jesse James – Office of the National Coordinator

This is Jesse. I'm not sure that Olivier is on the call. We do have, um, J.D. Lee and Ryan is there from ... who are going to talk about the hospital end of the measures.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Thank you.

Ryan Fair – Health Services Advisory Group

Alright, tha—I, I don't—I know we sent out a presentation. I don't know if that was able to be incorporated into this Web presentation, so we'll just move on without it, and I'm sure that can be made available, um, at a different time.

MacKenzie Robertson – Office of the National Coordinator

Sorry, this is MacKenzie. It might be already uploaded into the webinar. Do you know the title of it? Was it the version four that got sent around?

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Well, the version four I think was, was mine...

Ryan Fair – Health Services Advisory Group

Yeah. Yeah. I don't know if it made it in time.

MacKenzie Robertson – Office of the National Coordinator

Okay.

Ryan Fair – Health Services Advisory Group

So again, um, I'll just give some pro—, a brief project background. Um, first, my name—again, my name is Ryan Barrett with Health Services Advisory Group, and then also we have J.D. from Lantana who will be also assisting me with the presentation. So we'll just talk about the project background, talk about some of the testing objectives and, and the purposes of all of the testing design and then we'll move into some of the, the lessons learned from implementing those tests.

Um, so for, for our hospital quality measures ... was the prime contractor, and, and there were several partners that are involved in this, including Health Services Advisory Group, Lantana, um, ... and ... While we've been tasked with developing new—new and reforming existing measures, um, the primary focus of today, um, surrounds, um, retooling existing hos-hospital clinical quality measures and the testing objectives and the lessons learned associated with that.

Um, so in retooling existing measures, um, we kind of developed the following test objectives, and then I'll talk about the associated activities that were performed to, to really address those testing objectives. First was validity. Um, so validity, does the e-measure conform to the intent of its original paper-based equivalent? And to ad-address that, we, we looked at measures ... review. We had to measure ... it, um, and they performs subjective assessment, um, of the re-tooled measure to ensure that the retooled e-measure reflected the paper-based measure as specified.

Um, we also asked that the e-measure correctly include and ex-exclude cases in the numerator and denominator included in the, —exclusions and accepted. And for here we used simulated case records, simulated patient records. So that was an objective evaluation of the e-measures, individual data element performance to the standardized formats established by the QDM—so similar to what's Saul was talking about in his, um, in his, his presentation.

Um, we also—one of the objectives was reliability. Using e-measure data elements conform to the national quality data map, quality data, um, model patterns. Um, for this we looked at Schematron testing, and that modeled the validation of the e-measure data criteria to ensure it conformed to the constraints and content rules as part—as required by the QDM.

Um, and we also looked at one part of reliability was reliability of the e-measure implementation across hospital systems. So here we, we looked at—we did a IT or hospital IT quality expert survey. Again, we're looking at it as a subjective assessment about whether the rendered e-measure or the human-readable format was clear and understandable for the purpose of writing or running reports or extracting data from the various hospitals or EHRs to captivate the quality measure.

And then finally, we looked at feasibility, um. And feasibility was performed via the EHR vendor survey. Um, so again, this was another subjective assessment by, by EHR experts working for vendors about the reasonableness of expecting the data elements to be collected in the course of common practices and documented in an EHR system. So we'll talk a little bit just about the—a little bit more detail about validity testing. J.D., do you want to talk about that?

Jing Dong Lee – Lantana Consulting Group

Sure. Thank you, Ryan. The objective of validity testing is to identify and validate, um, measure criteria logic differences between people measure and the retooled e-measure. Um, so the test and design involves two groups of test analysts. This is about the people measure criteria has analyst one they'll create a list of simulated patient records. For each patient record, analyst one develops paper measure population criteria based ... to indicate whether the patient record belongs to denominator, denominated exposure or numerator, etc.

Then the test analyst two analyzes the same list of the simulated patient records. Then based upon e-measure criteria and developed the e-measure population criteria based advocates for the, for each patient record. So by comparing the two sets of ... case, we can identify and validate the, measure criteria logic differences between paper measure and the retooled e-measures.

Um, so that's, that's basically the validity measure level— validity testing. Another test, another testing, um, we conducted is the, um, ... measure reliability testing. That testing the purpose is to ensure e-measures quality data elements conform to that you have quality data model QDM specifications. So Schematron is a rule-based, validation programming language. During the past QDM definition are transformed into Schematron code, and then a test engine runs QDM-based Schematron code against the e-measures quality data elements to ensure that the QDM

Um, okay, back to Ryan.

Ryan Barrett – Health Services Advisory Group

Sure, and in addition to the Schematron, that was one of the objectives of reliability testing, we also, um, performed a hospital or quality expert survey. Um, so for each e-measure, a minimum of three reviewers were asked to assess the comprehensibility of the e-measure for the purpose of writing or running a report. Um, so each IT expert was asked, "Was the e-measure easily understood after reading through it the first time, or was it understood or after rereading it multiple times? Or if it was not clear—or, or, or was it not clearly understood even after reading it multiple times—so does the e-measure require clarification?" Um, and respondents were also asked to provide comments for those items that they found confusing, um, in the e-measure.

And then feasibility testing—so for feasibility testing, we developed an EHR vendor survey, um, and that was administered to nine EHR vendors that represented about 84% of the hospital EHR market, and the survey included all the data elements addressed in the NQS QDN. So here for this survey respondents were asked to, assess the feasibility of capturing, um, certain items or all those items in a structured format. Um, the vendors were also able to provide comment for any items which they were not already included in the EHR or could not be easily added.

So for the testing methods we looked at both quantitative and qualitative analysis of the survey response so that the quantitative analysis really is that the, —that level of feasibility for each data item, and the qualitative analysis of the comments, those were used to supplement the findings of the quantitative analysis and discern patterns and relationships among those data items identified as, as, as potentially difficult to capture, um, in a structured format.

So oftentimes the results of the qualitative analysis, they often corroborated what we saw in the qualitative analysis. So those are what—um, so those are the testing objectives that we developed for retooling hospital, e-measures and through that process obviously there were some lessons learned.

Um, so, J.D., if you want to discuss some of the lessons learned from validity and reliability testing.

Jing Dong Lee – Lantana Consulting Group

Sure, sure. So, for the validity and the reliability testing, some, um, competitive findings include QDM, the NQF of QDM data and the semantics representation are not, completely standardized. So for a single QDM category, different measure developers may come up different information representation that cause a certain level for the inconsistency across measures.

Another finding is that most testing issues are related to vocabulary, such as the proper value set content or proper usage of coded systems for a group ... some missing ... value sets, or the same value side shared across multiple measures with slightly different code list content.

There's some lessons learned from the testing including early testing engagement with ... developers are necessary, so you know that you find and fix issues at earlier stage and to shorten measure testing and measure updating cycle. We also feel that we need to do more value set and vocabulary testing. Um, the third, the third lesson is, we need to have a comprehensive tool suite to support measure retooling, vocabulary and value set management automation testing, issue tracking, and relief management—all these processes.

Back to you Ryan.

Ryan Barrett – Health Services Advisory Group

Sure. And again, for feasibility testing and I think this, kind of, um—what you saw, saw presented, also what we find as well, is, is collaborating with partners, um, really makes a huge difference, , and, and retooling measures as well as it will help in developing new measures. Um, collaborating with hospitals and EHR vendors early in the process really will help eliminate a lot of the issues that we'll see in the back end in terms of whether a measure is feasible, whether it's reliable.

Um, and then oftentimes what we've seen so far is that, um, the hospitals on their own will, you know—if we go to a hospital and ask them questions, they'll of-often just go on their own an-and start collaborating with their, with their EHR vendor as well. So there's a lot of dialog that happens and a lot of things that can be addressed and fixed during the process if you get the EHR vendors and hospitals involved earlier. Um, I think it just makes the process much smoother and, um, a-and probably a little bit less work on the back end as well.

So I think those, you know, are really the main lessons that we learned, um, from, from our testing approach.

Kevin Larsen – Office of the National Coordinator

So this is Kevin again. Thank you to the ... team and to Saul from MITRE. Are there any questions from the committee to those groups? The framing for this I guess I could have said a little bit more in the beginning, some of this is for you to understand that there was significant work done in testing that was different for MU 2 than there was for MU 1. We've heard that feedback and CMS funded it.

But the other is that there are potentially some, um, technical issues that the Quality Measures Workgroup could be—, take into consideration, like how did you validate a value set, um, and, and wh—specifications around measured testing processes, not just that the vendors can do it, but that the measure is actually technically capable of doing what we want it to do not that it's fully aligned with the program.

So those were the—just some framing, but I'm curious if anyone has questions for either of the presenters.

Jesse James – Office of the National Coordinator

This is Jesse from ONC. I have a question that's based on Eva's comment earlier about how our interests in pushing measures, um, pushing innovation, but also pushing measures that leverage the technical capabilities that vendors are adding. Um, the work that was—that Ryan described on feasibility testing from a vendor's point of view, I'm curious to know: One, did the vendors often overlap in their assessment of what was feasible. and two, were vendors in particular asked what was feasible now as opposed to what will be feasible, um, with upgrades of software?

Ryan Barrett – Health Services Advisory Group

Yeah. So this is Ryan. I didn't catch the first question, so maybe repeat that again. But for the second question, um, they were asked, yeah, what's feasible now. What's feasible, um, within 18 months. And within those 18 months, is it easy, easily feasible or is it very difficult, or is it not feasible at all. So, so each of the QDM elements and data capture, they were, they were asked what's feasible now, what's feasible in the future.

Jesse James – Office of the National Coordinator

Okay, thanks. And the other question was to what extent did vendors tend to overlap in their assessments of feasibility?

Ryan Barrett – Health Services Advisory Group

I think it's pretty close in terms of what each vendor thinks is feasible. You see a lot of congruence in what is feasible.

Jesse James – Office of the National Coordinator

Alright. Thanks.

Sarah Scholle – National Committee for Quality Assurance

This is Sarah. I have a question about the, the testing, I think from Saul. In the testing that you're doing, was—is, is it simulated data? And, um, and what do you—how do you think that relates to what's actually populated? And, um, we've done some testing on our pediatric, um, measures, and we're finding that things are, are really possible in EHR. It's just that the, that the field structure within ...field aren't being used.

Saul Kravitz – Principal Health IT Engineer, Center for Transforming Health at MITRE

Hi. So I apologize if the sound quality is not as good; I'm on my cell phone now. Um, so, so the testing we did was not real data; it was simulated data. There were very thin patient, —you know, a series of patients with very thin data that the data is just enough to exercise the logic in the measure. And the purpose isn't really to demonstrate feasibility in the field. It's just to demonstrate logical coherence and correctness of the measure itself. So before you would even try to, to deploy it to the, to the field for a feasibility test, just to make sure that the measure itself covers the cases that you're interested in and, and gets the right answer.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Um, this is Paul Tang. Um, and it's sort of a, reflection on what Saul said, so I, com—I, I think I completely agree with the first lesson learned, which is, you know, when we, um, retool things thinking that it would be just like an electronic version of the former intent, that's just not the right conclusion, , for the reasons that Saul mentioned. When you use different data sources, you, you get different results. You may get better results, but let's not, let's not confuse it with the original—what the original was measuring, which actually goes to a point where I think we're, we're all sort of honing in on the conclusion that we really actually can't retool measures that ca—were built under different paradigms, built with a different set of data sources.

Why don't we go after measures that matter to—as Eva was saying—measures that matter to the consumers and patients and to the, um, providers, and actually the old measures didn't even do a great job of that. It seems like we really need to re-build measures that are far more meaningful than the ones we had, um, in the past, only 'cause we had those limitations that we no longer have.

The second point is agree wholeheartedly with the need to—for other folks to be involved, what Saul called the impartial review and the testing. We just learned so much. So that's leading up to my question of how can we redesign the quality measurement development process in the entire ecosystem so everyone can benefit from the-these lessons? And the lessons sort of point out that we just need to colab—we need to have broader folks involved from the stakeholders to the—from the data suppliers and the measure developers all at the same time when you're actually creating these new measures.

Is there any recommendation of how we get that supply chain, um, to, to organize and align and produce better measures for the future? I know it's a big question, but.

Sarah Scholle – National Committee for Quality Assurance

This is Sarah. I just want to say something. I agree with you completely, and it's a very different paradigm from the way we develop measures and claims or, or, or claims plus chart reviews when you're thinking retrospectively. It's just—you, you're building a capacity. It's really more of a demonstration than a retrospective review of data, right? Because you're building—first you have to build the capacity to say, “Well, there's a—can we build the capacity.” Then you have to say, “Can we actually calculate the right thing?” And then you have to go out and do the work with, um, practices to say, “Okay, can you fill it out, and is it filling out?”

And, you know, ideally you'd be doing some of this in parallel, rather than, you know, so that you're, you're getting that input on the workflow as you're going along. But, um, the reality is that it's, it's not—you, you can't go and demonstrate the measures and have the reliability and validity data about the measure at the same time that you're demonstrating that it's feasible. So if it's not feasible, you don't have this data ...

Saul Kravitz – Principal Health IT Engineer, Center for Transforming Health at MITRE

So the, the consequence, though, of not doing it with it all—with all this together is we get—we don't get a useful result, and, and then we lose the game anyway.

Sarah Scholle – National Committee for Quality Assurance

I agree. I mean, I'm not saying that it's—that the way we do it is, is right. I'm saying it's completely different, and, and one of the things that we're, we're facing is how to, um, how, how to reorient that because, because we're, you know, the current w-way of evaluating measures is to say, “Are they feasible reliable and valid.” Well, the, there's different phases along the way, but that, that last piece that demonstrates something about the reliability of the measure in multiple settings and giving the information that you can use to evaluate performance in different organizations or practices, you need—that needs to be a—an implementation piece., and we used to be able to do that by looking at retrospective data. But if we're building a new system, demonstrating the capability, and providing ... we have to build it and demonstrate the capability before we get the data about what's the performance level in different populations.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

What's interesting, we do have a lot of organizations with EHRs which have millions of patients. So in some sense, we can test it against that database. The other thing is I think what we're saying is you have to—my analogy in the software field is you have to look at the user interface in the design phase, not just at the end as a testing. So maybe, let me propose a, a—I mean this is a bold statement, but David, this is—you know we were talking about our two dimensions. I wonder if we, we talked about flexible reporting platforms, I wonder if the bold statement, um, but it's the one that gets us out of this mess is, we really actually have to—we collectively, HHS and ONC and the developer community—um, have to look at redesigning the QM development process for this very new tool and this very new, um, um, payment system.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Thanks, Paul, and let me thank everybody for that discussion. I do think that's a, a lesson we're beginning to learn, um, but I know today we're already out of time and we haven't done our public comment yet, so we do need to wrap up. Um, let me just summarize where I think we're at, and then first let me thank all of our guests for presenting material to us today that'll be extremely helpful as we take on Paul's challenge and the other issues that, er, surfaced today.

I think where we're at, just—and, and one quick announcement before the public comment. The ONC has developed two new Tiger Teams, one with the vendors to meet fairly frequently to give us input and expertise from their experience, and so we can feed them issues of the kind we've talked about today, including this last discussion. And secondly they're forming one on data intermediaries to think about some of the sharing of data across layers in the system. So, um, that's just so you know that.

I think we will for the next meeting, I think—let me ask Jessie and Kevin—focus on the architecture and platform issues, and, so we'll get out some material, to you on that. We may have some presentations also to guide our awareness of that discussion. I don't have a date for that in front of me, but I think it's in about two weeks.

Kevin Larsen – Office of the National Coordinator

Yes.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

And, um, I will say what we'll try to do is get out a summary of the earlier discussion today about the directional choices for the program. We will, um, get out some material on the architecture and platform issues and, um, obviously the date for that next meeting. And again, well, so we'll try to make some progress on the architecture issues for that—the next meeting as we dra—start driving toward this request for comment, and then in a written form get your feedback on these broad directional issues we talked about earlier today.

And with that, I think unless there's any last words, we should turn to public comment and see if anyone has additional input for us. We thank you all for your time today and, and, guests for giving us great presentations.

MacKenzie Robertson – Office of the National Coordinator

Okay. Operator can you please open the lines for public comment?

Public Comment

Operator

Yes. If you would like to make a public comment and you are listening via you computer speakers please dial 877-705-2976 and press *1 or if you're listening via you telephone you may press *1 at this time to be entered into the queue. We do not have any comment at this time.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Thanks MacKenzie, thank you all for your time today. We'll talk to you again in about two weeks and we'll keep moving forward. Thanks.

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Thanks, David.

MacKenzie Robertson – Office of the National Coordinator

Thanks, everyone.

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Bye now.