

Quality Measures Workgroup Draft Transcript August 13, 2012

Presentation

MacKenzie Robertson – Office of the National Coordinator

Hello, everyone. This is MacKenzie Robertson of 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 & CEO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. Tripp Bradd. Russ Branzell. Helen Burstin.

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

Here.

MacKenzie Robertson – Office of the National Coordinator

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

Norma Lang – University of Wisconsin/American Nurses Association

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Norma. Marc Overhage. Laura Peterson. Eva Powell. Sarah Scholle.

Aldo Tinoco – National Committee for Quality Assurance – Physician Informaticist

This is Aldo Tinoco representing Sarah Scholle.

MacKenzie Robertson – Office of the National Coordinator

Thanks. Cary Sennett. Jesse Singer. Paul Tang. Kalahn Taylor-Clark. James Walker. Paul Wallace. Mark Weiner.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

Yes, here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Mark. Kate Goodrich. Daniel Green. Ahmed Calvo.

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

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks. Steven Solomon. Peter Lee. Marcia Lillie-Blanton. Jacob Reider. Jon White. Westley Clark. Carolyn Clancy. Niall Brennan. Tony Trenkle. Michael Rapp. Are there any staff on the line?

Jesse James – Office of the National Coordinator

Jesse James from ONC is on.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jesse.

Patricia Santora – Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment

Pat Santora from SAMHSA/CSAT is on.

MacKenzie Robertson – Office of the National Coordinator

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

David Lansky – Pacific Business Group on Health – President & CEO

Great, thank you. Thanks, all, for making time in the dog days of summer for a, a chance to move our process along. Just to remind everybody, first of all, you should have gotten a packet on Thursday, um, with a number of attachments in it, including summary from our last call, agendas for this call and some working documents that we'll come back to in a minute.

The, where we are in the process is we're collaborating with the Meaningful Use Workgroup and the Policy Committee to develop the request for comments, which will go out we're thinking, uh, November and between now and then we want to do our own work in defining some issues of... and, uh, having those infused into the larger RFC that will be developed by the Policy Committee. So, to be ahead of that curve we would like by the end of September to be pretty much done with our thinking, which is now about six weeks away.

And the, so, what we're doing is working through a series of issue categories to identify, um, directions we might consider going with the Stage 3 Meaningful Use Proposals and getting public comment on those potential directions. So, essentially we're at a point here of, of formulating questions that will merit public input and will guide the further work of this group and the Policy Committee in the next year or so. And, again, just to remind you of where we are in the meta timeline, the hope is to have the draft Stage 3 NPRM about a year from now and working back from that the Policy Committee would like to be done with its preparation in May, which means we want to have draft transmittal letters to the Policy Committee with our Subcommittee guidance by April.

Um, so essentially we're working toward getting the RFC out November 1st; that gives us four or five months to then, um, get that feedback, feedback in and process whatever we want to recommend for the Stage 3 Quality Measures proposal.

So, we're on a pretty good timeline. It's, uh, deliberate, but relatively aggressive actually as the clock keeps ticking. So, uh, what we want to do today is try to get consolidation around the discussion we had last time on the request for comment items, which are all at the fairly high level of a framework for measurement and the purpose of quality measurement in the Stage 3 rule and then we want to turn our attention to the broad category of the architecture and the standards requirements to make this work.

So, we'll move from the fairly conceptual frame we were at in the last meeting and then drill into a little more, uh, specifics about the technology approach we think makes sense going forward.

Let me stop there and see if Jesse has additional clarification about where we are in our process of if anyone has questions or suggestions.

Jesse James – Office of the National Coordinator

No, I think that was dead on for what our goals should be for this meeting and the calendar, as we see it, is about the same, that we'll use these next six weeks to go issue by issue and to gather comments from the group to describe an approach to each question and then open the RFC to get capture from industry, um, inside and also additional questions or recommendations for each major issue and we've split those up into the five issues we've described on the last two or three calls and we're through, we're fairly, we're roughly through about two of them, but there are three more big ones that we need to get through.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

Uh, this is Westley Clark. Uh, the MU2 coming in October, is that still on track?

Jesse James – Office of the National Coordinator

Yes, the um, the, what's promised for October would be the detailed specs for the measures, but maybe, um, in October or September is the general timing for the final rule for MU2.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

Okay, thank you.

David Lansky – Pacific Business Group on Health – President & CEO

All right. Any other questions about the timeline and the work ahead of us? Okay, then the next, uh, body of discussion is to, um, come back through the distillation of text and question prompts that the staff did. I think they did a really nice job giving us a, turning our complicated conversation into a series of discrete issues which could benefit from public input.

So, I don't know, Jesse, we have two versions. You have the narrative and the text format and you have a spreadsheet version. I don't know which we can put on the screen for the Webinar or which, do you pre, do you care which version we work through here?

Jesse James – Office of the National Coordinator

I guess the narrative might be easier to, um, sort of read through. The, ah, the Excel spreadsheet was more for tracking purposes—

David Lansky – Pacific Business Group on Health – President & CEO

Right.

Jesse James – Office of the National Coordinator

Over the...

David Lansky – Pacific Business Group on Health – President & CEO

So, people should have, uh, from the e-mail from Thursday the QMWG draft questions for RFC Stage 3 August 6th, version five. And that's a memo to me from Jesse and if you have that or don't have that let us know. Otherwise we'll assume you have it. And I think what we can do is go through this pretty quickly, to the extent some of it has already been vetted by us and then, um, let's talk about any other issues that are not reflected here that people want to put onto the list and ask staff to take a stab at drafting.

So, uh, assuming everybody has that we began with the, we had drafted a, a purpose statement and then four or five bullet points underneath it and the comment request here is simply to ask for public to ratify or proposes differences to the draft mission and attributes characterization here at the top of the page. So, maybe take a second and re-read that and see if that's about the right prompt material to request public input on.

I'm sure we'll come, all come back to this at the end of September, but for now we want to basically call it good enough for the RFC. So, any comments or suggestions or changes or approval of this draft?

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

So, this is Ahmed. I have a question, just to make sure I understand this or maybe it's my interpretation of it. When, when I see "The measures when embedded in EHR," the word embedded might imply hard-wired and I thought from previous discussions, though, we've learned that the, um, the difficulty in reporting a new measure, um, from our ex, different tests, it turns out that some people, some entities in the saltiness certainly can report out faster not from the EHR, but from else, because they have to go through a whole programming thing in the EHR and, um, I'm a little worried about the word embedded implying to the developers some sort of hard-wiring as opposed to the notion of combining fields in an algorithm. And I, I want to make sure that I'm not either over-reading that or whether others in the Committee think differently because I think we, we have to factor in ultimately that new measures are always going to be coming up and so how things get combined and such, eh, will continue to always be evolving and so the word embedded a little bit, um, creates a little anxiety for me.

David Lansky – Pacific Business Group on Health – President & CEO

Well, we could, um, expand on that and make it more of a solicitation of comment and, and ask it as a question instead of as a statement. I agree with you that it's, uh, that, if those, if everyone agreed on that particular statement it would probably raise some difficulties going forward.

Saul Kravitz – MITRE – Principal Health IT Engineer

Hi, this is Saul Kravitz from MITRE. I kind of interpreted that statement, and I'm new to the Committee so I apologize if this is off in the wrong direction, I kind of interpreted that embedded statement the way I would like to see things, which is that there are no software engineers required to start calculating a measure once you deploy it within an EHR, so perhaps, so first of all, is that, is that what was intended and if it was maybe deployed would be a better word.

Jesse James – Office of the National Coordinator

I think that is what, what was intended. This is Jesse. This was a statement that, um, Farzad added and the reason there's... before they embedded it to add that conditional such that, uh, it's not prescriptive that it must be embedded. The CQM could be calculated in a module or by soft, software outside of your base EHR, but saying if the CQM inside of the EHR then it should calculate automatically such that you don't need a software engineer to be involved in every calculation or for every measure that's part of your CQM inside of your EHR.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

Yeah, this is Wes Clark. I, I, I think what we're going to wind up doing is having to expand on each one of these points so, um, eh, as currently written I think we'll just need to clarify it. I don't think you can come up with a perfect, brief sentence to, to, uh, explain what you want, uh, because as we've already heard, uh, people will look at each word very judiciously and come up with their own interpretation. The question is will these five points require some fleshing out for the purpose of the explanation.

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

This is Ahmed. I, that's a very smart insight, Westley.

David Lansky – Pacific Business Group on Health – President & CEO

So, I guess we can, with that discussion leave it to Jesse and Kevin to think about how to contextualize or refine that statement so that it'll be understandable in the RFC.

Jesse James – Office of the National Coordinator

Right. And what it seems we're saying is that the CQM need not be inherently a part of the EHR. In conditions that it is part of the EHR, it should calculate, scores should be calculated in a way that the user is blind to it. And we'll add more language to make that clearer. But, in general, is that sort of an idea that we all agree with?

H. Westley Clark – Substance Abuse and Mental Health Services Administration

That's, again, I think that's what we were trying to accomplish in how we said that because we didn't want to defeat the whole purpose of, uh, getting these, uh, uh, measures practiced.

David Lansky – Pacific Business Group on Health – President & CEO

All right, that's the point. You'll take another stab at it and try to reflect this discussion?

Jesse James – Office of the National Coordinator

Yeah.

David Lansky – Pacific Business Group on Health – President & CEO

Other comments about this package, the first item? All right, well that's, that's a good clarification. Let's move on to the next one. Again, we'll come back to this. Uh, broader input. This is essentially asking, well, maybe this request, comment request should just clarify that during this entire Stage 3 development process we will want to be soliciting more input.

M

Right. This was to Dr. Calvo's point on the last call that often users and patients are, um, they aren't aware of the rule-making process and want us to think about a, a broader selection of stakeholders for input.

David Lansky – Pacific Business Group on Health – President & CEO

Yes. So, I think that's a great thing to put in. And, any additional changes to this one on here?

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

David, this is Helen (audio drops).

David Lansky – Pacific Business Group on Health – President & CEO

Helen? Sorry, I lost that point. Hello?

M

I think we may have lost Helen.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. We'll come back to it.

Norma Lang – University of Wisconsin/American Nurses Association

Could I, this is Norma, could I ask a question?

David Lansky – Pacific Business Group on Health – President & CEO

Sure.

Norma Lang – University of Wisconsin/American Nurses Association

Does this now mean that, uh, we may go beyond those who are eligible providers, hospitals and physicians?

David Lansky – Pacific Business Group on Health – President & CEO

I didn't think; I think it meant to solicit input and perspective from not only those who are eligible users, but other stakeholders, especially those who may not be plugged into the rule-making process.

Norma Lang – University of Wisconsin/American Nurses Association

Well, I was thinking of, you know, long-term care, healthcare and other kinds of social networking care. Um, so you're saying they would have input, not necessarily be included.

David Lansky – Pacific Business Group on Health – President & CEO

Right. Yeah, I don't think we have the latitude to, to do that. But the Policy Committee actually has a broad mandate to think about those other groups besides those specifically called out for meaningful use.

Norma Lang – University of Wisconsin/American Nurses Association

But we could put their input in and so note it here. Is that what you're saying?

David Lansky – Pacific Business Group on Health – President & CEO

Yes.

Jesse James – Office of the National Coordinator

I think the RFC is an opportunity to grab input from different groups and in those comments we can feed to the Policy Committee.

Norma Lang – University of Wisconsin/American Nurses Association

Okay, thank you.

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

And if, this is Ahmed. I actually, my head's usually in that broader input perspective so I was deliberating whether to even have the word healthcare right in front of the word landscape. Because if we delete healthcare, you have a broad notion of the landscape; it still allows us that input without changing our authority relative to the eligible providers and such. Because that, that was really the whole concept, right, to figure out who else out there may want to say something. Otherwise we're just saying we want to hear from the hospitals and the healthcare industry.

M

That's a good point.

David Lansky – Pacific Business Group on Health – President & CEO

Yeah, that's fine. I think it's a good point. I think this statement is as much an instruction to ourselves and ONC as it is to the RFC since the RFC is part of the rule-making process. I think the question I, I heard you raise last time, Ahmed, was how do we go outside of the normal federal register world to get input from constituencies.

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

Yeah, and the, and, just to put context. I've been hearing a number of comments from Silicon Valley and from young people who are really coming out of innovative, a very different way of looking at it or entities like Patients Like Me, etc. And unless we anticipate some of those additional inputs I'm afraid we're going to be missing some really incredible opportunities if real innovations coming from elsewhere and, uh, should be factored in.

I think we have the authority to include that insight. We may not have the authority to change the eligible provider, uh, Meaningful, uh, Stage, Meaningful Use Stage 3. But that's okay. The point is we have to work with what we have. We should not be pre-limiting ourselves with regard to input by artificially putting blinders on ourselves.

David Lansky – Pacific Business Group on Health – President & CEO

Right. That's good. All right, let's go on to the measure development life cycle item, the top of the next page. Um, this was, uh, this was a, has heavy implications. Um, the notion here is that we've seen the retooling process has raised some new challenges we didn't anticipate a couple of years ago. So the sense that top Workgroup is approaching the conclusion that more de novo measures should be conceptualized, designed and all tested and released. That's a pretty strong statement. So, there's a broad request for comment on retool versus de novo measures.

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

I think that that's factual. We know that already from the National Priorities Partnership, which says that we have to evolve measures of population health and public health on which there is a relatively short number in the way that they interface with EHR. I mean, there's clinical measures, which we have a lot of them. As long as we're thinking about measures in a general sense I think that's a factual statement.

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

Uh, David, this is Helen Burstin, can you hear me now?

David Lansky – Pacific Business Group on Health – President & CEO

Yep, yep.

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

Okay. Sorry about that. I was multi-tasking unsuccessfully today. Um, just one comment on, on this specific issue. I agree, generally, that to really get at the measurement gap suite, you want to go for de novo measures. But I do think there's something to be lost in not considering the measure concepts that are, um, that are involved in some of the current measures for other data platform that just need to be really re-conceptualized for EHRs, ah, but the concepts are still very valid, particularly some of the key clinical areas.

David Lansky – Pacific Business Group on Health – President & CEO

So, middle ground, in effect, Helen, would be to, um, go back a step and capture the measure concepts within the existing measures and rather than retool them, reconstruct them from the measure concept in the new environment.

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

Exactly, really take advantage of the rich clinical data rather than try to sort of pound a square peg into a round hole, really think about some of those concepts are really important. We've just not been able to capture them as well as we'd like with claims data, for example, but not necessarily think everything just has to be de novo, even at the concept level.

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

This is Ahmed. That's a really important insight that Helen just brought up.

David Lansky – Pacific Business Group on Health – President & CEO

Well, Jesse, maybe we can add that notion to the intro text and then make sure that the comment asks people to react to the, how best to go about doing that.

Jesse James – Office of the National Coordinator

Right, absolutely. We see, well we've been thinking of de novo at ONC as, um, staying true to the concept, but changing the, um, either the, the types of data you're measuring or changing some of the exclusions that you're measuring, or looking for different parts of the EHR that weren't included in the paper version of the measure. So, in general, we need to be more specific about the fact that we can hold on to the concept and the intent, sometimes the intent of the original measure, but still create a de novo measure that does not stay as true to the paper-based measure as we [audio distorts].

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

Perfect. And, and, and it, it just may be we need a better definition so what de novo versus retools means, then, Jesse, I think that works, yes.

Jesse James – Office of the National Coordinator

Okay, got it.

David Lansky – Pacific Business Group on Health – President & CEO

So, I'm wondering, this may be a separate item or maybe it's part of this item, whether we need; the implication of Helen's suggestion in terms of the time frames for development and so on, still relatively protracted. The original idea behind the retooling I think was a quick win for Stage 2 and the notion was we had general acceptance and understanding of the validity of those measures and simply by mapping them to an EHR we could quickly gain a group of measures that could show some value of automated data capture and reporting in the EHR environment.

Then as we discovered these bumps in the road that I'm wondering whether, since we're trying to get guidance for Stage 3, in particular, is there anything in this question or a new question related to it about given the need for either reconstructing or de novo measures in the ways that Jesse just summarized, what is realistic to be done by the time of Stage 3, essentially by next summer? What does that mean for us? Maybe Stage 4 and 5 can take advantage of those, but what can we actually accomplish? Maybe we should ask the community, given what's realistic for Stage 3.

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

It sounds reasonable.

David Lansky – Pacific Business Group on Health – President & CEO

Any further thoughts on this item or any related items people want to raise?

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

This is Mark. One thing that may not be clear on as we reconstruct these measures for use with electronic data is what's the best way to implement them and, and might there be room for, at least early on, having slight variations on the definitions to see if, if certain quality rankings will change drastically, uh, for different people under different assumptions or not because every time, uh, you know, when we talk about quality measures in public there's always a concern that, well, this measure doesn't quite reflect my style of practice and my patient panel. So, is, is there an allowance for multiple definitions for a little while so we can see if some of these differences in quality measurement actually made a difference in quality ranking?

Kimberly Schwartz – Centers for Medicare and Medicaid Services

And this is Kim from CMS. I would just like to add on to that I think also in regards to the implementation would also be considering and looking into the actual number of measures that you wish to, obviously, have in Meaningful Use 3 from a burden standpoint on the provider.

David Lansky – Pacific Business Group on Health – President & CEO

Yeah. On those two points, on Kim's point, let's hold that and come back to it because I had that as a, a possible additional item to add to the list. And on Mark's point, we're going to come in a minute to this item called MU and Innovation and I'd like to see if we could fold Mark's suggestion into that next request item. Is that, Mark, if that's consistent with what you're thinking?

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

Um, yeah, [inaudible], but I wanted to get the thought out there.

Jesse James – Office of the National Coordinator

Right, it touches on multiple issues we've talked about, especially testing earlier, testing, um, via providers and using the testing in a provider's, from a provider's EHR to change a measure or to focus the measure more or even changing the measure per setting, we've talked about that, too. So, those are all good points and probably fit in with innovation.

David Lansky – Pacific Business Group on Health – President & CEO

Yeah, that innovation item may end up getting expanded into two or three sub-items, we'll see. Okay, so, uh, further on the retooling measure development item, let's go on to the domains and exemplars, which reminds us we have the six domains in the National Quality Strategy and the question is whether we should focus on certain of those for Stage 3, where the priorities are for measure concept and development, any exemplar measures we need to bring into the program and the support for those potential measure concepts or measures.

This is one I also think we may want to broaden. One of the topics we don't have explicit on here is what happens to the old core versus menu framework and what do we do about the common related problem of measures that address primary care versus measures that are specific to specialties. So this one, this, this topic here that raises priorities across the six domains sort of opens the door to how do those get operationalized for different segments of our user population? There's an awful lot in here in this one item. We may want to break it up into a couple. Are there reactions or suggestions of how to handle this? All right, well hearing none we'll leave it as is, maybe come back to it later on after we wade through some of the other innovation topics.

So, the next, uh, topic is process and outcomes and here we have the, uh, desire to both have real time point-of-care process measures and value-oriented outcomes measures and we asked for comment on whether we need to go down one path or the other or whether we can find a suite of measures that include both outcome and related process measures.

And you all think this will work for a public comment item? I take that as support. At least I don't hear any dissent.

Jesse James – Office of the National Coordinator

Right, on the previous call there was a split between whether our goals should be outcomes for the sake of value and measurement, or process for the sake of clinician QI and the insight that UNC has gotten through our measure development on Meaningful Use, um, some of the Meaningful Use 2 measures is that there may be a way to balance both when we release inside of a single disease area, such as CHF or adverse drug events or HIV, the major outcome that we want to be focused on, but also process measures that have been shown to lead or indicate or predict, uh, success for that outcome to give clinicians an idea of where they can look backwards from an outcome and look at their processes for each and watch their scores trend. They should trend over time as they improve their processes they can find a process where they're failing and improve that and expect to improve their outcomes as well. It, of course, won't be perfect, but still it gives the tool kit instead of a single outcome whether you're doing well or poorly, it gives you a tool kit to work with.

Norma Lang – University of Wisconsin/American Nurses Association

This is Norma. Is there any thought here given to the work that's going with longitudinal coordinated plans of care, which kind of mean patient-centric over a period of time and over providers? It's a little hard sometimes to know exactly when the outcome occurs.

Jesse James – Office of the National Coordinator

Right, so some of the measures, a few of the de novo measures in Meaningful Use 2 are longitudinal, but, um, to building better longitudinal measures you need to, we need to be able to, one, exchange better and assign patients to clinicians in a better way and that's something we can comment on in different parts maybe in the innovation part or in the patient-centric part of the RFC, but we see things the same way where the patients themselves should be the center of care and we should be able to track data on them no matter what setting they're in. But to do that we have to have a better structure for exchange.

Norma Lang – University of Wisconsin/American Nurses Association

Okay, I would think that would be important to comment on. Thank you.

Kate Goodrich – Centers for Medicare and Medicaid Services

So, Jesse, this is Kate from CMS. Getting back to your question there, I don't disagree with the way that this, um, articulated here and particularly like the question about this third approach, the suites of process outcome measures. I would be probably, though, a little circumspect about articulating, you know, what may, may be a link between performance on a process measure and performance on an outcome measure, um, because we don't have enough data or information to know that because a provider does well on a process measure we can assume they're going to do well on the outcome.

Even though we know in research studies the process is associated with the outcome, from a measurement perspective we don't always know. In fact, sometimes we know that they're not really associated. So, I think we need to be a little circumspect about making that link for sure.

Jesse James – Office of the National Coordinator

Right. In the script for the RFC I don't think we made that link, but if you feel we implied it too strongly we can absolutely change the language.

Kate Goodrich – Centers for Medicare and Medicaid Services

Okay.

Jesse James – Office of the National Coordinator

Yeah, I see exactly where we can change it.

Kate Goodrich – ASPE – Chief Medical Officer

Yeah, I see, I do, too. I mean like we can sort of take out the word strongly.

David Lansky – Pacific Business Group on Health – President & CEO

Yeah, right.

Jesse James – Office of the National Coordinator

Yeah, strong word.

David Lansky – Pacific Business Group on Health – President & CEO

Or you could make it may be associated with or some other looser phrase.

Kate Goodrich – Centers for Medicare and Medicaid Services

Exactly, yeah.

Jesse James – Office of the National Coordinator

Thanks.

David Lansky – Pacific Business Group on Health – President & CEO

All right. Let's go on then to the next item on the CQM dash. How we expressed some interest in developing clinical dashboards, so the question is we ran into some dissents last week on whether there is evidence that the dashboards were going to be effective. Is there a business case for it, is there a role for the policy guidance or is it really a marketplace activity? Uh, what information or features should be in a clinical, in a basic dashboard? Uh, this... again, back to our architecture and standards issue, what are the technology challenges to widespread release and adoption? And under what mechanisms can the federal agencies use to stimulate this area other than...? Comments about this whole element?

Joachim Roski – The Brookings Institution

David, this is Joachim. So, just to make sure I understand this correctly, so what this is proposing is querying about a particular HIT tool that providers could use to improve care and it's presumed that this dashboarding approach might be one such tool?

David Lansky – Pacific Business Group on Health – President & CEO

Yes. And I think it's meant to be a, a bridge between the reportable quality measures and the feedback system to the provider, which would include both the quality measures and, obviously, other data.

Joachim Roski – The Brookings Institution

So, it seems to me that, um, it would be useful to know to what extent EHRs can do this today or HIT systems can do this today, what the experience has been. Um, the question doesn't seem to imply to me that the government is requiring anything like this, but it seems more like an informational item if I understand this correctly, which seems appropriate to me.

Jesse James – Office of the National Coordinator

Yeah, I think that's a very good way to describe it. We know that they're, the capabilities exist and I know from my previous work in my previous jobs, but also there a number of vendors who've put time in developing physician qua, QI dashboards and some ACOs and some patient-centered medical homes that are propped up by commercial payers have done the same and there's a lot of variety in the quality and usefulness of it, but it's not terribly hard to inside of a measure allow a user to drill down into smaller patient populations and to see how their scores are trending or compare my own scores as a clinician to others in my geographic area in similar patient populations. It's just a matter of developer time and we don't want to be prescriptive. This isn't currently required and we don't want to be prescriptive, but we do know that it can be helpful and it's sort of the thing that a lot of clinicians have said, you know, it would be great if or, really it should be possible for me to go deeper than just my score for these, my entire group of patients, but also see for smaller groups what the score it and where maybe some of the kinks are in the system.

Joachim Roski – The Brookings Institution

I mean, this strikes me as a value-add package that a vendor might offer. Um, um, but, but it's not exactly clear to me that the government would or should require this, um, as a, as a technology.

Jesse James – Office of the National Coordinator

Right. Hence, hence the question my own, um, I have my own anxiety about being over-prescriptive in this area. So, I think it's good to say is this useful? Should we work more in the area? How far should we go? Where should the boundaries be? And allow the industry and input from users to decide the course from there.

Norma Lang – University of Wisconsin/American Nurses Association

This is Norma. I missed the call last time. I understand you spent a lot of time talking about this. Is there a reason why the dashboard is the way of reporting or displaying data? It seems to me there are numbers of ways to do this, is could we make it so that people could display it in any way that they found useful or helpful or why is it that the dashboard is the way?

Jesse James – Office of the National Coordinator

Yeah, I don't know that the dashboard is the way. It's more a catchall term for, um, uh, clinicians facing QI interface that allows ad hoc queries.

Norma Lang – University of Wisconsin/American Nurses Association

Yeah, it just seems to me there should be a little broader statement describing what you just said.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

And actually, um, this is Mark, uh, that's a good point because I had a very different mental notion of what you were talking about because at Penn anyway, the dashboards, uh, have a, a, more of a global view and they're not necessarily meant for the provider and certainly not at the point of care, but more for administrators to kind of look at the big picture.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

Well, they are described, this is Westley, um, the dashboards are described as providing information to consumers so that they can compare practitioners and institutional providers. I think the concept of a dashboard is that it's a model that allows information, uh, about performance to be communicated.

Now, um, we don't have to be rigid in our concept of how we provide feedback to providers, but the concept in the dashboard is actually fairly broadly marketed, uh, at least in the early stages of meaningful use and, uh, um, some of these quality measures.

Jesse James – Office of the National Coordinator

So, I think what we're hearing is that the term dashboard itself, um, connotes different things and we should be more explicit in what we mean by it, but at the same time I think we want to gather comments, um, around a variety of views so it may work that we describe, without using the term dashboard or use the term dashboard and define how we see it, but also ask for input on other features that would be present in the platform to be more general.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

And, and who the user, the intended users are, so, you know, I guess it is meant for patients to judge doctors, that's one thing. It's meant for doctors to view their panels, that's another thing. And if it's meant for administrators to kind of look how their, uh, you know, institution is doing that's a third thing.

Jesse James – Office of the National Coordinator

Okay, that's great.

David Lansky – Pacific Business Group on Health – President & CEO

I wonder, Jesse, if we may want to divide this into two topics, one of which we sort of hand off to the Meaningful Use Workgroup and say this is potentially a functional capability of EHRs that the Meaningful Use Workgroup may or may not want to think about for Stage 3. There's a component of it, which is the ability to provide feedback on quality measures, a population view of performance or a comparative view of performance, um, which our particular portfolio around quality measurement, we have a question as to whether we think the function of quality measure feedback to the provider is a high value function and so going beyond our, our purview of saying what are the quality measures you have to report to get your incentive money is a question of whether we think there's a feature of the tool around feedback of quality measures.

So, we probably, we generally don't want to get into all the functional requirements of the EHR to support quality improvement, for example. We may want to get input on whether there's a, how important is it to provide feedback on the quality measures to the clinician.

Jesse James – Office of the National Coordinator

Got it.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

Well, the other question is how, uh, I mean we mention providers and we mention consumers. We need to also keep in mind that payers, insurers, including CMS, will be interested in some of these things also, so how we approach that becomes very important.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. Any other questions, comments on the dashboard, formerly known as dashboard item? Then we'll go on to this innovation question and this is, uh, picking up on a theme we've talked about quite a while, whether we can use the program to stimulate new measure development and testing. So, I'll let you read a little bit of the background. And to remember Mark's suggestion also that we allow some variability of definitions that providers can provide feedback on. Suggestions to modify this element?

Saul Kravitz – MITRE – Principal Health IT Engineer

This is Saul Kravitz. Maybe adding an option there of having some of the vendor or the provider-generated measures go up into a, a new measure if they could be coded properly.

Jesse James – Office of the National Coordinator

Absolutely, that's the goal and we can be more explicit.

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

This is Ahmed. I want to introduce a concept here that we've used a lot in our breakthrough collaboratives and that is the notion of a community of practice or a community of solutions. And that historically has been a group of people who self-decide to hold themselves accountable to a set of new measures that they're going to be playing with or testing. And some of these, of course, with subject matter expert input and all that sort of stuff, but sort of outside of the traditional sort of structure reporting of the formal, at least from our point of view, like the HRSA, uh, requirement of, uh, a set of measures or whatever, uh, government agency is requiring it for program point of view for eligibility for financing or grants making or a contract.

And so I'm wondering if it's possible to include something like the phrase community of practice or community of solutions as a way of getting people to think about innovation and getting their input? The point is that if we can toss a concept that helps stimulate some innovation in terms of the kinds of ideas that might come to us as input, it would, uh, it might bring us additional insight.

There's, from our experience, a group of people that talk about communities of practice or communities of solutions that might not be seeing their input as, uh, welcome or, um, valuable if they're apart from the groups that are talking just with the EHR vendors and such, for example.

David Lansky – Pacific Business Group on Health – President & CEO

I it's very helpful. Again, where we refer to individual providers generating measures it strikes me that we could at least pose the question; it makes me a little nervous to have, you know, half a million providers each coming up with their own measures, but the idea that there would be these communities of practice so there's some sense of self-discipline and self-regulation that if a ophthalmologist want to have a couple of uh, communities of practice in ophthalmology who develop some approaches to measurement that they think would be very advantageous to EHRs that we have a little more structure on the innovation pipeline than just lots of individuals with their own ideas.

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

Exactly. What that, what forces almost is somebody has to have talked with somebody and vetted it and talked it out together instead of just somebody in the middle of the night sending an idea they just thought of the minute right before.

Joachim Roski – The Brookings Institution

David, uh, this Joachim. So, one of the, um, uh, what sort of struck me is that obviously this is a big policy issue here in terms of, you know, do you want to forego possibly comparability for ease of implementation or practicality or some such notion and so one thing that might be useful is for folks who actually identify good examples of such measures, I just want to make sure this is not a theoretical construct, but a real construct with real measures that some people believe are really valuable and maybe there have been other discussions where that has already been established.

But, um, it does strike me and I, I think similar to what you may be concerned about, David, is that to, even though this is an attestation program now, I don't know that on a go forward basis that's the vision for how you want to use data coming out of EHRs or at least you want to enable that, you, you want to enable something else.

So, are there good example of measures that, um, are being produced in this way, that are being used that, um, have no resemblance to any endorsed measures, for example?

David Lansky – Pacific Business Group on Health – President & CEO

Well, I think there are. I mentioned ophthalmologists sort of randomly, but I know they had a package of four measures they wanted to bring into the program a year ago, um, that thought were suitable to their particular areas of interest and having a little bundle like that that they thought would be high leverage for EHRs they felt--

Joachim Roski – The Brookings Institution

Mm-hmm, I understand. Okay.

David Lansky – Pacific Business Group on Health – President & CEO

Was a natural pathway to do that. So, this middle ground of having, um, somewhat organized advocates bring a package into the program, I don't know how, how we would articulate that. We could define some criteria, um, we could create some kind of a process, maybe it's an NQS ancillary process to bring in sort of, uh, vetted credible measure sets, which may include endorsed measures, but put them into a process outcome bundle, for example, like our last discussion.

Joachim Roski – The Brookings Institution

Yeah. I mean it clearly, this strikes me as particularly useful to get at measures concepts that heretofore we don't have a lot of examples of so I think somebody mentioned earlier examples of longitudinal measures or other measures, so if, if this could spark innovation in that sense to really drive the field forward as opposed to making sure we cover a clinical discipline that heretofore maybe has not been addressed very well, that I think would be a real advantage also to this program, or to this notion, I'm sorry.

David Lansky – Pacific Business Group on Health – President & CEO

So, I'm wondering, Joachim, whether, right now we have this open-ended question what constraints should be in place and it's just open-ended. Should we in this item offer up a set of preliminary criteria for reaction, the kind we're speculating about right now? So, we could say, for example, the Workgroup is interested in the opportunity to generate, uh, stimulate new measure development and test them in the field. We realize there's some concerns. Some of the criteria that might be associated with this new program would include X, Y, Z.

Joachim Roski – The Brookings Institution

Yeah, I mean if you think that it's easier for people to react to something, that would be the way to go. If you think people would be creative and could sort of come up with their own answers relative to, you know, what criteria should be laying out the sort of policy concerns, if you will, and see how people would respond to that with meaningful approaches. Either way I think would be fine.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

This is Mark again. Um, is the intention whether some meaningful use for EHRs to provide summary data where the measures are sort of pre-calculated on the EHR end or is it meant to export more raw data that can be spun in different ways to, uh, calculate quality measures?

David Lansky – Pacific Business Group on Health – President & CEO

Well, that's a very good phrasing of one of our fundamental philosophical questions right at the beginning, um, and we've had quite a bit of debate about the entire program and its tools are meant to support, in effect, local quality improvement or meant to assess the continuum of care, care coordination, longitudinal measures, patient engagement, which raise all kinds of complexities, so I don't think we're resolved on that and right now I think there is an interesting debate, which we mention early on between and I think it bears on the... question whether we want to encourage the program to provide high local value so that a clinical team wanting to do improvement on area X can use the platform to do that even though the hospital next door wants to do area Y versus saying here is a core set of nationally important priority measures that we want to use this platform to capture.

So, there's a debate over that. I think we have to use this common process as a way to explore that further.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

And I think I, I see value in both where, obviously, the institutions and the providers themselves need to know how well they're doing on some core set of measures, but I see the research value in having a nicely compiled set of data on a much larger population than ever has been assembled before.

David Lansky – Pacific Business Group on Health – President & CEO

I think our challenge in this task is how do we say all this in a set of questions to the public? Uh, Jesse, given your job as drafter here, any further thoughts on how you want to take this innovation question forward?

Jesse James – Office of the National Coordinator

Well, I see three parts, um, to the types of measures we want to pull in, one being extreme, one being conservative and one sort of moderate between the two. So, the extreme group of measures and the extreme group of contributors to innovation would be the local practices, the small, local practices and the theme behind this question was how do we capture, if measures are available at the small local practice and if a single practitioner is interested in a certain population of patients and improvement, can they, can we make meaningful use more flexible to that individual clinician? And how can we make it as flexible as possible and probably the way to make it as flexible as possible would be to allow that clinician to use some standardized platform or software, such as a constrained QDM or constrained map to create measures?

And then more moderate is the acceptance that there are organizations like VA and DoD and large medical centers like Dartmouth, UNC, Hennepin County that are, that have been creating their own measures and using them inside a practice and using them to judge practice and using them to make changes in practice and we know that that data and those measures are out there and they're being billed and they're being coded in the software, but they're not being utilized by Meaningful Use. So, it's how do we capture from the outside of the Beltway lessons learned in measurement? Well, how do we use some of those lessons in Meaningful Use? And typically we go through NQF endorsements, so maybe there might be some alternate path to endorsement or, um, an abbreviated path to endorsement to allow these measures to bubble up to the top.

Um, and the most conservative view might be, um, we could allow only the well-established professional societies to feed measures and how can we find a way to allow them to feed measures into Meaningful Use? So, with the three points of view on how to pull in innovation I think we're accepting that the moderate view, the practice centers are making measures and some large organization's payers, commercial and some parts of government, um, have been building measures and they haven't necessarily been pulled into the program. How do we capture their measures and how do we find a way to use them and how do we pull from the societies, the professional societies, their measures as well and allow their measures to influence the program?

And that's probably a very wordy way of making the point, um, that we're trying to make, but I think the moderate and sort of conservative views are where we're trending, but I'd still like to be able to capture if the community says we would love for docs, and we think it's probable that two to three docs are going to, would be interested into making their measures with software that worked for them. I'd like to be able to get that input, but I'll leave that to the group to decide.

David Lansky – Pacific Business Group on Health – President & CEO

I think those three flavors is a good thing and getting reaction to all three would be helpful and having people be pretty specific to each of those three of how they would see it going forward.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

This is Westley. I, I would agree because in, we also need to keep in mind that this is not just meaningful use in terms of the intent of structure, but these processes will probably influence third-party payers. CMS, obviously, would be interested in it, the federally facilitated exchange, the state exchanges, um, the qualified health plans, there are a host of curious parties who are interested in quality and cost consciousness, so if these measures en, enhance quality and constrain costs or rein in costs, um, I, I think you'd have a great audience.

Jesse James – Office of the National Coordinator

All right. I'll figure a way to sort of reword it and restructure it to capture those three propositions.

David Lansky – Pacific Business Group on Health – President & CEO

I think there's kind of a meta issue there that I don't know if it needs to be called out or it's just implicit, but right now we've got this list in the tables in the proposed rule for Stage 2 of 129 measures here and 50 measures there. And in a sense we've simply said here is the inventory of acceptable measures. Choose, choose some. And the model of all three that you just described, Jesse, is, uh, a different approach, which is more user controlled and the users are generating measures of interest to them in all three versions you describe and the ONC or CMS is saying that is an acceptable way to utilize the EHR technology for the purposes of the incentive program.

So, that's a pretty big paradigm shift and somehow, we could either leave it implicit in all three of them or call it out specifically as a question for public comment.

Jesse James – Office of the National Coordinator

Absolutely. Is there anyone from CMS on the call that would like to comment on that, either Kate or Kim?

Joachim Roski – The Brookings Institution

One issue you may need to call out is if there are user-defined measures and submissions, how would you avoid fraud and abuse and how would you audit against it? So, uh, there probably would need to be some requirements in terms of, um, in terms of that that you would need to think through.

Kate Goodrich – Centers for Medicare and Medicaid Services

So, this is Kate. I'll just briefly say, I mean it's definitely a concept that's intriguing to us. I don't have anything specific to say except that the implementation parameters are, obviously, something that would be complex, but, you know, I think hearing from the broader community on this is something we're interested in, definitely.

Kimberly Schwartz – Centers for Medicare and Medicaid Services

Yeah, and this is Kim. Kate, I would agree completely with your comment.

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

And this is Helen Burstin. Just one more thought on that. In some ways that is very intriguing, but I think there may need to be a distinction between meaningful use indicating that, yes, look I can report quality measures of meaning to be, but then also if those same measures are then used for accountability there's a challenge since we just don't know whether the measures actually mat up, you know, really can measure up in terms of being valid measures of quality.

Joachim Roski – The Brookings Institution

Yeah, I think, Kate, this is Joachim, Kate. I think that's a good point. As you guys are thinking through aligning measures across programs and using measures for multiple purposes, the user-defined measures may have some challenges in figuring out how to do that.

Kate Goodrich – Centers for Medicare and Medicaid Services

Yeah, this is Kate. By the way that was Helen that just spoke from NQF, but, uh, I do agree with that. I mean that is sort of my not so secret concern about this. I still think it's worth exploring because I do think the concept is intriguing, but one of the things I've been concerned about as we've had discussions about this within the department is sort of exactly that issue, that we're afraid that what we'll get are going to be, you know, measures that are less meaningful to us, um, because they don't address necessarily an important performance gap.

David Lansky – Pacific Business Group on Health – President & CEO

So, perhaps we can find a way in the narrative here to, as I said earlier, draft some criteria for discussion of the kind that Helen and Kate just identified and test public understanding that there is this gap between the accountability measures and the locally driven process improvement measures. And some measures might migrate across that line and be acceptable for public purposes, but many wouldn't.

So, it's a complex area. We won't solve it today. I know our time is getting short, so let's see if, we'll trust Jesse to come up with a new draft that we'll probably talk about the next call.

Jesse James – Office of the National Coordinator

Absolutely.

David Lansky – Pacific Business Group on Health – President & CEO

Very interesting, okay. Last item with very preliminary sketch here was the patient-directed data. And here there's nothing really fleshed out. And I, I don't know, Jesse, maybe we should just defer this one until we come back to patient-centeredness later on in our calls.

Jesse James – Office of the National Coordinator

Yeah, I think so for the sake of staying up on the agenda.

David Lansky – Pacific Business Group on Health – President & CEO

All right. So, let me just go back to something other people have mentioned. Are there other headings, other topics that deal with this level of overall framework of the program, but are not yet in here at all and people want to have us add some questions for public comment beyond what's here? So, somebody mentioned earlier on the number of measures question, and I, I don't know exactly where that would fit, but it also had occurred to me earlier we may want to solicit input on, for Stage 3 how many measures should be expected of users. Any other topics of that kind people want to have added?

As you think about Stage 1 and the draft of Stage 2 any other red flags or what we've heard from the different hearings and meetings input? I feel like we've captured most of the, most of the themes, at least that we've heard in our feedback. All right, well keep thinking about that as you read the next iteration and we'll certainly have room to add new topics as the need arises.

So, with that I think we will wrap up this review of the RFC draft as it is to date and turn to the next big category discussion for ourselves, which is the architecture and standards category and in the detailed agenda that was sent out for the meeting today, if we can get the slide change over to the, what was it called? It's in the agenda. Do we have that version available for the Webinar, Jesse, the architecture and standards detail?

Jesse James – Office of the National Coordinator

Yes, it should be, it's with, it's a Word document that was with the package that was sent out on Thursday.

Kimberly Schwartz – Centers for Medicare and Medicaid Services

Is it the ONC2 QMWG RFC Approach and Questions?

Jesse James – Office of the National Coordinator

No, it's the, the exact name I'd have to pull up.

David Lansky – Pacific Business Group on Health – President & CEO

The one that's called Detailed Agenda?

Jesse James – Office of the National Coordinator

Yeah, detailed agenda, QMWG Detailed Agenda August Meeting 1. It's the last attachment that's, um, that was in the e-mail.

David Lansky – Pacific Business Group on Health – President & CEO

I don't see it on the Webinar list of documents, so it may be; so hopefully those of you who have access to your e-mail can find that document. Does everybody have it or does anybody not have it? No one has said they don't have it, that's good. So, let's just go through this.

We have two letter headings; A is Features of a Quality Measurement Reporting Platform. And B are Attributes of the Architecture That Might Support That Platform. And I think our goal today is just to catalog these high level features and attributes, not to try to drill down into which standard sets we want to include or not include. Let's just identify the areas where there may be different standards work needed or there may be different conceptualization of the platform needed. So, we've got an initial pass here of half a dozen features that we think looking out two, three, four years what the re, desirable reporting platform might look like given the requirement of the National Quality Strategy and the other cross-setting integration we've all been talking about, including today Norma's suggestion about long-term care and so on.

So, taking that broad lens of stimulating the right platform, let's just go through these half a dozen features under A and have you react, edit, improve upon, add to this list. So, first feature we listed on this agenda was virtually no manual data collection or manipulation. That's a desirable state for the future generating of quality measures. Any objection to that element?

M

Could you explain what you mean by manual?

David Lansky – Pacific Business Group on Health – President & CEO

No. I picture a spade, a trowel and the dirt, but, uh, I think it means that the technology platform will itself generate values for the measures or the computation of the measures themselves without someone having to go into a spreadsheet or similar tool and cut and paste and type data parameters to produce the measure, but I'll see if Jesse wants to improve upon my interpretation.

Jesse James – Office of the National Coordinator

Yes, I would say the same. Um, at the physician end it would mean, or the physician administrator end, it would mean no individual is doing an abstraction of EHR charts to find, um, patients who are either in the numerator and the denominator exclusion.

Saul Kravitz – MITRE – Principal Health IT Engineer

So, how about just stating it positively as automated extraction of data from an EHR for quality computation?

Jesse James – Office of the National Coordinator

I have no objection.

David Lansky – Pacific Business Group on Health – President & CEO

Good.

Saul Kravitz – MITRE – Principal Health IT Engineer

Because the other thing I thought you might be saying was that it imposed a, didn't impose any additional data collection burden on the provider that they wouldn't do already in support of quality of care. So, just getting rid of that ambig ... those are the two meanings that came to, to my mind, so just stating it explicitly would probably clarify that.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, that's good.

Aldo Tinoco – National Committee for Quality Assurance – Physician Informaticist

So, this is Aldo, again, representing Sarah Scholle. Two things come to mind when I see this, and I definitely agree with this feature. The first one is, um, I think the cost will be potentially, um, borne by the clinicians who will have to change their workflow and their documentation to achieve this feature. Um, so that's something to consider. I don't necessarily know whether or not that needs to be captured here.

The other one is, uh, somewhere else in the document there was mention of there are certain types of EHR-enabled measures that might merit some manual or human data collection so that you can actually calculate the measure and if those can be identified if those are out there, then, um, I wonder whether or not there's a, an opportunity to mention those here.

One example of a measure that comes to mind that does, in fact, merit, uh, human, um, involvement and measurement is, uh, hospital associated infections where, uh, current definitions of those measures do involve some type of judgment by the abstractor, so I just wonder if this is an opportunity to kind of, um, lay out some of those examples. Hopefully, that wasn't too much.

Jesse James – Office of the National Coordinator

No, I don't think so at all. Um, my point of view is that this would be broad and focus more on the majority of measures than the minority, the ones that this would not apply to, but I think we're open to the group giving input on how detailed we should be inside of this section.

David Lansky – Pacific Business Group on Health – President & CEO

Well, there's a natural tension with some of the attributes coming down below on multi-source data records and, um, longitudinal records and so on that maybe this first one we need to phrase in a way that indicates that it's aspirational. Our goal is to minimize or to maximize the extraction of data from EHR, but similarly we want to also capture data from other sources for the more complex measures. At the moment that typically involves a fair amount of handwork, so the aspiration is not only for the strictly EHR source data, but also for the composite data, the same attribute would be true over time.

Having accepted the positive framing of the item, let's go on to the next item and keep working our way down the list.

Jesse James – Office of the National Coordinator

Okay. One quick point, so we're essentially saying we will allow and be comfortable with the human extraction of data to the extent that the technology does not make it otherwise capturable or the logic of the measure, either technology or logic of the measure.

David Lansky – Pacific Business Group on Health – President & CEO

I, I, the way I think about it from an architecture point of view is more this is an ask of the industry to not build dead-end interfaces or lack of interfaces, but the quality measurement extraction and calculation functions be open-ended and by design, so that as we add new data requirements or data sources to the extent possible those don't require side work by analysts.

But I'd be concerned if we go too far the other way and say that we're only going to allow measures which can be calculated entirely through this EHR product in an automated fashion because at that point we're going to really limit any de novo measurement or, or response to the new measure concept. Any other comments about this first item beyond the input we've just had? Then let's go to the next one, which is another challenging one.

So, the broad concept is that the new platform would allow specifications to be downloaded from CMS or NQF or some source and then implemented through the local EHR platforms. People in favor of that or? Again, one thing we may want to think about as we do our list here is these could all be turned into request for comment, so at the moment we're just collecting our thoughts about where we want to go. We can then turn this into more opportunities for input if we think we're stretching the envelope too wide. So, any other comments about this idea of plug and play specifications?

M

I think it's an important motion to put out there, but I think there might be a little pushback from the vendors just because that, that's something that's much easier said than done.

Jesse James – Office of the National Coordinator

And who is that commenting?

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

This is Mark Weiner.

Jesse James – Office of the National Coordinator

Thanks.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

With... problem from the NLM's psychologic module.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, the next item here is aggregating measure data to different units of analysis. So, the premise I think is that as we specify a measure we want to anticipate and encourage the platform to permit the calculation of the measure or the export of data to prevent someone else to calculate the measure at these different units of analysis, which are mostly business structures. Anybody for or against that or any other comments about it? This may be one where we want to ask for public comment on what would be, what are requirements to make this so? Does it need different data standards, different interfaces? There may be some issues around privacy and anonymization of data.

Aldo Tinoco – National Committee for Quality Assurance – Physician Informaticist

Again, this is Aldo. I mean, just explicitly we support this, uh, because we know there are certain processes out there that are, um, not very easily attributable to an individual provider, but are owned by a practice.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. Next item down was longitudinal records. Again, this may be one we want to ask for comment on what it would take to facilitate this feature. Certainly patient identification is a big one and all the issues that raises around privacy. Uh, we've heard some comment on the public input recently about localization of implementation being a problem, but the same measure concept in reality, the code sets are implemented slightly differently, the value set slightly differently and comparability becomes tough. Any other comments about this as a desirable feature? Or any other ideas of how to frame public input on it?

Okay. Next item is somewhat related, which is not only capturing data over time, but capturing data from different types of data sources and bringing them together in a measure, including claims data and patient reported data.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

Here I think, it's Mark, it would be helpful to add, um, data from non-traditional encounters and sort of Ray Seed's notion of telemedicine and, and other, you know, just telephone calls are going to be increasingly prominent in the future.

David Lansky – Pacific Business Group on Health – President & CEO

Yeah, very good. Let's do that.

Norma Lang – University of Wisconsin/American Nurses Association

You did mean to say clinical data, too, didn't you?

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

As opposed to medical or?

Norma Lang – University of Wisconsin/American Nurses Association

No, not you, Mark. I was referring back when you introduced this topic.

David Lansky – Pacific Business Group on Health – President & CEO

Oh, yeah, I guess that was sort of the default, but yes.

Jesse James – Office of the National Coordinator

Well, is it, wouldn't financial data non-clinical from a value point of view be important as well?

David Lansky – Pacific Business Group on Health – President & CEO

Sure. I thought Norma was just clarifying the multi-source data records include the exiting EHR content, the clinical content as well as these other sources. Norma, is that, is that right?

Norma Lang – University of Wisconsin/American Nurses Association

Yes, mat, and then ultimately being able to match these, yes.

David Lansky – Pacific Business Group on Health – President & CEO

Uh, one platform implication or architecture implication of this one is whether the expectation is that all – this is probably true for the last couple of elements – does every EHR product sitting in a doctor's office have the capability of doing all this? Or, do we assume those are simply nodes on a network and there is some other aggregator of data that does this and similar items of integration, data integration. And I do think we probably want to solicit some public comment on that idea, what's the expected capability of each certified EHR versus do we have to postulate some intermediary that can do these tasks we just listed here.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

I think that's the question and that should be thrown out to it because, uh, there are some vendors who, uh, would argue that they don't have the capability and especially for small and individual, uh, providers, eh, they may be acquiring EHRs, uh, that don't have that capability.

Norma Lang – University of Wisconsin/American Nurses Association

And there are some additional vendors who are moving to fill that gap as well.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

Indeed.

David Lansky – Pacific Business Group on Health – President & CEO

So, I think this whole, the word architecture that's in the title is not so much reflected here in the feature list, but this is where this conversation is now heading us. Uh, I don't know how we move our discussion forward with a couple of models, I guess, that has, I guess it's down at the very bottom of the next section on the question of data intermediaries, exchanges, registries, warehouse, etc. So, Jesse, maybe in a minute we can come back and talk about the data intermediary subgroup and how that group might give us some models to use going forward. So, for now let's keep our attention on the features and we'll come back to the question of what the platform really looks like.

Um, next feature here was the ability to accommodate new measures and conduct real world testing and validation. We talked about this a little bit earlier with the question of whether we're going to accommodate de novo measures in the pipeline. Here's it's a question of whether the platform is flexible enough to implement on a test basis proposed measures.

So, again, the current environment is most of the vendors are specifically coding each measure that appears in the rule into their product and this model suggests there'd be quite a bit more flexibility, so this is tied to the second attribute of downloadable specs. This also says that the platforms, the certified platforms would be capable of implementing test measures as well as the highly standardized uniform measures. More thoughts about that? Is that something we would think every certified EHR could do or that it's sort of a buy up, if you want to have a flexible platform versus a nationally uniform platform.

Saul Kravitz – MITRE – Principal Health IT Engineer

It seems like there's a, this is Saul, it seems like there's an authoring aspect versus.

Jesse James – Office of the National Coordinator

Sorry, Saul, I don't think we heard that.

Saul Kravitz – MITRE – Principal Health IT Engineer

Okay, I, I wasn't sure whether there was somebody else trying to speak at the same time. Um, it seems like, it seems like the second, the second item is more of a automated deployment, like I should be able to drop a quality measure into my EHR and assuming the data elements are present I should be able to, to execute it. Whereas the, the issue we're talking about now is more of a can I, can I author or modify the, the measure, uh, in the context of my, of my EHR. Um, I mean in terms of mandating the ability to author, that seems, that seems like a, a little bit of a, a high bar to include in, in an EHR. So, I, it's an interesting question to ask whether people think that should be a mandated feature or a, or a, you know, separate piece of it you could buy.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

It may be good as an optional, but not required, but, uh, the market may demand it because if your data is included in, uh, some of these experimental, um, quality measure testing, you know, it may, uh, you know, favor your style of practice, or at least accommodate it.

David Lansky – Pacific Business Group on Health – President & CEO

So, is that an implication for how to reframe this one?

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

Well, I mean if we're going for public comment we can throw it out there and let the comments dictate how we should proceed, but, uh, although I think the comments we're raising today may favor not requiring it, but let's see what everyone else has to say.

David Lansky – Pacific Business Group on Health – President & CEO

All right. Any other comments on this one? So, the next one was the ability to drill down for QI purposes upon the, whatever the reported measure is along slicing and dicing as a capability. Any comments on that? Is that something that, um, Policy Committee needs to speak to or is that just a market, uh, competitive market feature that vendors can do better or worse on providing?

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

Yeah, I think it's something that any vendor who's creating these things would want to have, the ones that I've seen already do taut this drill down behavior to some extent or another. The devil is in the details, of course.

David Lansky – Pacific Business Group on Health – President & CEO

So, do people feel this is something you want to have input on or just leave it alone, leave it out essentially and say this is something that the market will do?

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

Well, I mean, if it's generic enough where I, I think it's, we're smart for putting it in, but the, the details is something, you know, the market is going to have drill down can mean many different things to different people, different capabilities.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. Are there other features that you are all wishing that the Quality Measurement platform would have in the next couple of years that we haven't addressed here?

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

Could I raise just a, kind of a way out question? We talk a lot about process and outcome. Do we ever talk about structural data elements? In some ways we talk about it when we talk about physicians, hospitals, payments, claims data, but not really how you structure the units of, um, how we classify or codify those people. So, I guess I'm a Donabedian person and I just wanted to bring it up. Is that too far of a question, way out of a question? Because we're talking about new measures, new whatever, we're just assuming that there are physicians out there and there's the right, um, the right physician is doing whatever they need to do, but we never really have any measures for that and if we look at nurses we just assume there are nurses and they're staffed and they're doing things, but they never show up in any of our measures. Is that by design or, because it is, you know, the third leg of that stool?

David Lansky – Pacific Business Group on Health – President & CEO

I think it's a really interesting question. The first place my mind goes to with it is attribution as a construct.

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

Yes, and that would be the, kind of the second part of this how, is we want things to improve and yet somehow we just feel by, I don't know, by default or something there will be the right people to do it.

David Lansky – Pacific Business Group on Health – President & CEO

Even as a research question whether we want to know who constitutes the care team and who are the accountable providers that are producing this quality result.

Helen Burstin – National Quality Forum – Senior Vice President, Performance Measures

Yeah, and are they part of the, the strengths or the problem and, if so, how do we, might we do. Anyway, I guess I'd just like it to be put someplace there as we start to look at attribution and so.

Kate Goodrich – Centers for Medicare and Medicaid Services

David, this is Kate. Um, I stepped out for a bit and just came back in about ten minutes ago, so what I'm going to say may have already been discussed and I apologize if so, um, what about the, uh, ability for the EHR to accommodate composite measures? Is that something that's been brought up or something that we could think about asking as well?

David Lansky – Pacific Business Group on Health – President & CEO

That's a good question. We talked about sort of longitudinal and multi-source. We didn't per se talk about composites. Are you thinking about the ability to construct it and provide feedback to the users on the composite and then deconstruct the composite?

Kate Goodrich – Centers for Medicare and Medicaid Services

Yeah, I mean I say this because, you know, use of composite measures is something that we have been interested in, um, using more of, um, and so, it, it, that would be an interesting thing to just even call out specifically, um, not only just for, you know, local sort of QI purposes, but even for reporting.

Patrice Hope – Centers for Medicare and Medicaid Innovation

Kate, this is Patrice Hope from CMMI. That's a really good question because, um, we're using the composites in the accountable care organizations in some of the models in CMMI, but we're not able to use them for electronic reporting yet.

David Lansky – Pacific Business Group on Health – President & CEO

And, Patrice, can you say why, what's the barrier for the electronic method?

Patrice Hope – Centers for Medicare and Medicaid Innovation

Well, there's just no way to roll them up. Um, there's some problems with the fact that if you do aggregate data collection, to do a composite you need to be able to attribute to the same patient, um, and there's no way to do that with the aggregate right now in an EHR. Um, so the only way it could potentially work is from a patient level perspective or doing it manually once got the individual measures.

So, there's no algorithm for doing an EHR composite, both in the logic, the H2MS logic nor in the calculation of the measure.

David Lansky – Pacific Business Group on Health – President & CEO

And in this context when you say composite you mean, um, for a patient with diabetes there are these five quality services or functions and we want to see how many of the five were done for patient X?

Patrice Hope – Centers for Medicare and Medicaid Innovation

Not how many were done, but in the ACO model right now they're using composites and it's an all or nothing score, for instance. So, you wouldn't be able to, you know, look at each patient and based on those measures that the patient meets all of those denominators for.

David Lansky – Pacific Business Group on Health – President & CEO

So it's a patient-oriented calculation rather than a numerator/denominator cross-sectional calculation.

Patrice Hope – Centers for Medicare and Medicaid Innovation

Exactly, exactly.

Kate Goodrich – Centers for Medicare and Medicaid Services

But I think this does kind of, I mean what made me think of it was looking, um, at this document is the, um, the one about incorporating multiple sources because, you know, you could, you could imagine that it would, might be desirable to have composite measures that incorporate data from multiple different sources as well, but, so it is related to that one, but I, I think the patient centeredness that you just articulated is what we're thinking about.

David Lansky – Pacific Business Group on Health – President & CEO

Good. That's a great add. Any other comments on that or additional elements that we should try?

Norma Lang – University of Wisconsin/American Nurses Association

The other one, and I don't know how far we've gotten this, through with this, Jesse, so speak up if I'm wrong, but the ability to look at, um, functional status instruments and actually, uh, take in the scores on those, health status instruments.

Jesse James – Office of the National Coordinator

Right. So, of course, you know there's, uh, functional status measures for hip replacement and for patients with CHF, um, but what would be interesting going forward would be capturing it through a PHR, so capturing patient reported data on functional status and using a standardized tool, that's what we're working on and we've been thinking about and, yeah, I think this would be a good place to call it out.

David Lansky – Pacific Business Group on Health – President & CEO

I think in the item we had about multi-source records, including patient data, that one could, could merit from a subset of a sub-item along the lines you just described, Jesse. As we talked about in previous contexts and in the hearing the sort of architecture of data interoperability for that, given the world of CAP Surveys and independent promise and functional status tools, um, we haven't got a model yet for how data will pass between those platforms and whether, when it's appropriate and whether it's appropriate to send that aggregate data back to the EHR, so that would deserve public comment.

Let's go down to the next bucket here for the last couple of minutes on the attributes of the architecture, a little more technical interpretation of some of the items above. So, essentially we're asking here what are the technical requirements of the EHR or the quality measurement platform, if that's separate from the EHR that may need further work to realize the features we just listed above? So, there's a question here on the first one.

Um, should it be standardized for data collection, calculation, reporting and use in the analytic functions if we have the analyses items? And here I think we're, this really tests the, the theory of whether we have a lot of local implementation tailoring or whether we have a highly standardized platform and how do we do both? Maybe this one should be posed as, in scenario one where we continue to have a highly standardized set of measures that are pretty well pre-determined, what are the implications for these standards and that may take us down to the issue of value sets, for example, we've been talking about recently and to the what tool set is necessary for the plug and play approach? And are the existing tools sufficient to support this model? If we go to the localization model what does that imply for standards?

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

Is, is the question on this one whether the current tools support standardized data collection, calculation, reporting and use?

H. Westley Clark – Substance Abuse and Mental Health Services Administration

Or is the question that we want them to do that?

Jesse James – Office of the National Coordinator

I think the question is how we get closer to doing that, how we make the process more standardized. We understand that currently there's, um, there are ambiguities in here to the measures and that decisions are made on the provider end and on the vendor end, on the software designer and the implementer on how the measures will be collected, which data will be collected, um, what time frames are used and our goal is to make this a more standardized process such that one, the intent of the codes that are used is understood, but also that value sets that are used are used in the same way, um, across practices. And the value sets that are used are the same value sets from measure to measure.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

And this is some of the kind of challenging, you know, so for instance, as we try to do quality reporting of immunizations we realized that immunizations can be, um, uh, stored in several different parts of the medical record and unless you look in all parts you may under-report the presence of immunization, again, because not all immunizations are administered in the office. Sometimes it's just reported as a guided umbilical CVS, so, um, so there's standardization in, in how the immunization is, is named in the record and then there's standardization around how and where it's recorded. So, this is another one that's easier said than done.

David Lansky – Pacific Business Group on Health – President & CEO

Well, from the architecture point of view it seems to me that there's a layering here. If we just say, let's live in the world of the certified EHR product in a physician's office and all the functionality and data sources are contained there, there's one set of standards expectations for that and we haven't achieved that one yet. That's sort of the base case.

As we layer up and say we're going to do longitudinal or we're going to do multi-source or we're going to do patient-based data, each of those opens up a new set of requirements, both for the data standards and the value sets at each contributing source and for the standards of communication of those data between the sources, including identification of a patient and identification of the setting and the provider or data source. All of those open up standards questions.

So, maybe at some point if we ever have a drawing or something that illustrates these layers and the nodes on the network that contribute to the measure we would need to attach a set of standards questions to each of those additional nodes and the interface between those nodes. Does that seem plausible to people? I think those are, in a sense, listed in the next item, standards gap. So, I'm wondering if there's a way as we get towards the public comment issue we can take the features listed above that we just went through and turn them into a set of requirements or implied requirements as the complexity gets greater and the size of the network of data sources gets greater we have a way of soliciting public comment on how to slice through that or what the reasonable incremental task would be.

Maybe the bottom line question is what's reasonable for Stage 3 and how do we do it in a way that's not a dead end?

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

Well, maybe limiting it to certain types of, of data that'll be standardized may be reasonable starting with, you know, things like some of the diagnoses and labs. I know that a lot of EHRs are utilizing LOINC for codings of their labs, but that's something I think that a lot of institutions are migrating toward and may be reasonable for Stage 3. Um, would you customize them, well, how is that automated specification for, you know, beta blockers post-MI going to be instantiated, so that means that, um, there has to be an internal consistent specification for what a beta blocker is within all EHRs. Right now I think a lot of the EHRs use different encoding systems for medications, so.

David Lansky – Pacific Business Group on Health – President & CEO

So, I wonder if we, uh, can talk about something like a base case, which is, what, is that what you just gave, um, that is primarily an EHR-based measure. And then have another example of one that stretches with the cross settings, maybe the immunization example, the immunization information may be in multiple locations and how do we capture that?

Uh, or something like a readmission quality measure that requires a forward look at claims data. Um, take a few use cases like that and map them into this layering I was talking about and then pose the standards question for each of those use cases from the base case up to the more expansive case. I think for the (inaudible) standards gap question our challenge would be to frame this in a way that is answerable. Right now there's an awful lot of content implied by that set of bullets.

Mark Weiner – Perelman School of Medicine, University of Pennsylvania

I, I think it may help to, you know, especially when we're putting something out for public comment that we realize that this is differently complicated for different types of quality measures and maybe to enable some distinction between lab-based quality measures versus medication-based quality measures to something to, in the films-based quality measures to something that is less well defined, like immunizations and then people can comment separately and maybe we can develop a migration or a phased approach.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. All right. So, looking down the rest of this list here, up until we get to this intermediary, the last bullet, any other thoughts on how to reorganize it or present it for either our own discussion or public comment?

Saul Kravitz – MITRE – Principal Health IT Engineer

I'd like to add something to the standards gap, or suggest adding something, which is just improving the match between the way that measure developers think about measures and the representation that they have for capturing those measures. So, today there's a, there's a significant semantic mis-match between when a measure developer says I want to make sure the patient took the medication during the measurement period to what it actually takes to encode that.

And it's a real struggle and it ends up leading to a lot of instructions and guidance, which cause measures to fail our aspiration from 3A that you should be able just to pop a measure into your system and calculate it. So, I don't know how to say it more concisely than that, but just to improve the semantics of the CQM, um, measure specification tools.

David Lansky – Pacific Business Group on Health – President & CEO

Well, you know, item five down below that we won't really get to much today, expanded forum for measure pipeline, it does seem like that's a place we should do a little more thinking to this question of how do we take what we've learned from the vendors and others about the specification process and bring that back to the measure developers so they are doing their work, either using the same tools ultimately, or at least cognizant of what those tools can do so that they are framing their own thinking about measurement design in the language and tool set of the implementers.

Jesse James – Office of the National Coordinator

Saul, to your point, is it, it's not a standardized semantic approach, is it a more, um, a consistent one that's used across measure developers?

Saul Kravitz – MITRE – Principal Health IT Engineer

You mean how, how do the measure developers deal with the, the issues in the specifications? Do they, do they deal with the problem consistently? Um, there's some, there's some consistency, but the consistency is not always, um, satisfactory. Like if you, again, the measure developers will understand that a certain set of logical constructs does something whereas a literal reading of the measure might not accomplish the same things and it's not because the measure developers are not thinking or not thinking in the right ways. They're doing their best within the tools that they have to say things that are very hard to say in the, common things, that are very hard to say in the current framework.

Jesse James – Office of the National Coordinator

So, then what could change would be either the current framework or the way the say things. That's probably not likely to change since we say things in plain English and the challenge is moving from that plain English, um, into code.

Saul Kravitz – MITRE – Principal Health IT Engineer

It's, it's more just having a better match from the concept and the nouns and verbs that people use in the English to the operators that they can use in the specifications. Well, maybe if I give you a concrete example it'll make it clearer. There's, there's no way to say in the current specification that two intervals of time overlap, which is a common thing that, that people want to say, that something, you know, a diagnosis overlaps the time of some encounter in some way.

Um, there's, that's a, to do that correctly is three or four logical statements that not, that measure developers will argue about endlessly, exactly which ones are appropriate.

Jesse James – Office of the National Coordinator

Then what would help would be an authority on how logic should be expressed to do some of the, for some of the common attributes of quality measures.

Saul Kravitz – MITRE – Principal Health IT Engineer

That, plus just improving the operators, improving the lexicon that they can use in a measure to more closely match what they actually need.

Jesse James – Office of the National Coordinator

Right.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. Thanks. Um, so let me, the last bullet on this list was the intermediaries item and I'll ask Jesse to see if you could update the group about the data intermediary subgroup on the agenda, what we want to ask from that group?

Jesse James – Office of the National Coordinator

Well, what we wanted to do in this segment was to allow the word group to raise any issues that we can take to the data intermediary subgroup and the data intermediary subgroup will be composed of, um, data warehouse, EHR vendors, analytic vendors, um, registry vendors who will have an opportunity for a hearing. And in this hearing we'd really like to talk about data integrity, data quality management and the needs for, um, quality measure calculation. On the contractor end we're also asking for QIOs and HIEs to give inputs on their challenges to data management and data exchange.

And we're planning for early September for the hearing to take place. We've put in place an agenda with some basic questions about challenges to exchange in data management, but we also wanted to know if there's anything the Quality Workgroup, in particular, would like to have addressed.

David Lansky – Pacific Business Group on Health – President & CEO

You know, Jesse, just thinking on this last conversation it may be worth our coming up with two or three use cases consistent with the attributes we just talked about, the features we talked about this morning and posing those to the hearing folks to say, okay, this is what the Policy Committee wants to do. How, what are the challenges that you see in the way of getting that done and what, uh, activity do we need the federal agencies to do to make your job easier in achieving it?

Jesse James – Office of the National Coordinator

All right.

David Lansky – Pacific Business Group on Health – President & CEO

So, other suggestions for the data intermediary discussion people want to put forward? We do have a draft list of some topics we can send around for comment before the next meeting.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

I'd appreciate that.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. All right. Well, I think we've worked, worked down through our time and, uh, most of our agenda for today. I think the next steps, but Jesse tell me if you think this is right, would be to, um, we'll do a second review of the, uh, first part of today's discussion, the draft RFC questions based on today's input, we'll do a first draft of comment, request for comment pertaining to the architecture and standards issues that we just looked at. And those can be the topics for our next call to review the revisions of both. And then we'll turn our attention to this measure pipeline question and essentially that's about the innovation opportunity and some of the linkages between the measure developers and the technologists that just came up in our last conversation. Um, Jesse, anything else you want to try to get to at our next call?

Jesse James – Office of the National Coordinator

No, I, I think the, um, also the, in the end of the RFC are some of the subjects we've spoken to briefly before, but didn't really, um, expound on, so we'll move those to the agenda for next time and in the time between this meeting and the next Kevin and I will have our offline meeting with you to, um, to go over what we come up with and that'll be we'll do notes, we'll update the RFC and pass that on to the group, we'll update the agenda for the data intermediary subgroup and also the Vendor Tiger Team is meeting this month and they'll have input on what we've come up with, um, as the major issues for the RFC so far, so by the next meeting the Vendor Tiger Team will have met and will update the Workgroup on the Vendor Tiger Team's comments.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

When is the Vendor Tiger Team meeting actually?

Jesse James – Office of the National Coordinator

I think that's Friday this week.

H. Westley Clark – Substance Abuse and Mental Health Services Administration

Friday this week, all right, thank you.

David Lansky – Pacific Business Group on Health – President & CEO

All right, unless there are any last words or requests, we will ask for any public comment.

MacKenzie Robertson – Office of the National Coordinator

Okay, hearing that, 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 your 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 have no comment at this time.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. Well, let me thank everyone for making the time again to guide this discussion. We're making very good progress now and we'll get it next month or so to the point where we can get public input. So, thanks, everybody, for your time. We'll send out some more materials for review and talk to you again in a couple of weeks. Thanks.