

**HIT Policy Committee
Quality Measures Workgroup
Transcript
March 11, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup. This is a public call and there is time for public comment built into the agenda. The call is also being recorded transcribed, so please make sure you identify yourself when speaking. I'll now go through roll call. So, our new Chair, Helen Burstin?

Helen Burstin, MD, MPH – National Quality Forum

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Helen. David Lansky?

David Lansky, PhD – Pacific Business Group on Health – President and CEO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks David. Is Terry Cullen on the line? Christopher Boone? Is that you Chris?

Christopher Boone, FACHE, CPHIMS, PMP – American Heart Association – Director of Outpatient Quality and Health IT

Yes.

MacKenzie Robertson – Office of the National Coordinator

Thanks. Tripp Bradd?

Tripp Bradd, MD, FAAFP – Skyline Family Practice, VA

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Tripp. Russ Branzell?

Russell P. Branzell, FCHIME, FACHE, FHIMSS, CHCIO – Poudre Valley Medical Group – CEO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Russ. Helen Burstin, we already have. Cheryl Damberg?

Cheryl Damberg, MPH, PhD – RAND Corporation – Senior Policy Researcher

Yes, here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Cheryl. Timothy Ferris? David Kendrick? Charles Kennedy? Karen Kmetik? Saul Kravitz?

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

Yes.

MacKenzie Robertson – Office of the National Coordinator

Thanks Saul. Norma Lang?

Norma Lang, RN – University of Wisconsin

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Norma. Mark Overhage? Eva Powell?

Eva Powell – National Partnership for Women and Families

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Eva. Sarah Scholle?

Sarah Scholle – National Committee for Quality Assurance

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Sarah. Cary Sennett? Jesse Singer? Paul Tang?

Paul Tang, MD – Palo Alto Medical Foundation – Vice President, Chief Information Technology Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Paul. Kalahn Taylor-Clark? Jim Walker? Paul Wallace? Mark Weiner? Niall Brennan? Ahmed Calvo?

Ahmed Calvo, MD, MPH – Human Resources and Services Administration – Senior Medical Officer, Office of Health IT and Quality

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Ahmed. Carolyn Clancy? Westley Clark?

H. Westley Clark, MD, JD, MPH, CAS, FASAM – Substance Abuse & Mental Health Services Administration – Director, CSAT

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Wes. Kate Goodrich?

Minet Javellana, RN – Centers for Medicare & Medicaid Services

Kate's at an offsite meeting; this is Minet Javellana in her place.

MacKenzie Robertson – Office of the National Coordinator

Great. Thanks Minet. Daniel Green? Peter Lee? Marsha Lillie-Blanton? Michael Rapp? Steven Solomon? Tony Trenkle? Jon White?

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Jon. And any ONC staff members, if you're on the line, please identify yourself.

Jesse C. James, MD, MBA – Office of the National Coordinator

Jesse James.

Kevin Larsen, MD – Office of the National Coordinator

Kevin Larsen.

Lauren Richie – National Quality Forum

Lauren Richie.

Michelle Consolazio Nelson – Office of the National Coordinator

Oh, I'm sorry. Michelle Consolazio Nelson.

MacKenzie Robertson – Office of the National Coordinator

Thanks everybody. And with that, I'll turn the agenda back over to you, Helen.

Helen Burstin, MD, MPH – National Quality Forum

Great. Thanks everybody. Quite a nice workgroup call today. Today is our transition meeting; David Lansky is going to be transitioning from his role as Chair and handing the hat off to me. Fortunately for us, he will stay on our workgroup and we'll get the benefits of his wisdom. Terry Cullen from VA will be chairing the group with me, she's not available today. But again, we look forward to having her input. So, I think what we're going to do today is go through some of the responses to the RFC, see if there are specific areas we think we need further discussion on, a deeper dive on, before we offer any recommendations back to the Policy Committee. We'll hear about the Data Intermediary Tiger Team and have public comment. So with that, I'll turn it over to you, Jesse.

Jesse C. James, MD, MBA – Office of the National Coordinator

Thanks Helen. So the main goal for today is to walk through our summary of the RFC and to get input from the group on any questions or any segment of the RFC that we should spend more time going into more detail on the comments that we received. Is there any direction from Paul, in particular, on what the Health IT Policy Committee might be looking for?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

No, I think you got it right, thank you.

Jesse C. James, MD, MBA – Office of the National Coordinator

Okay. So if you'll pull up the slide deck that's named Stage 3 RFC responses, thanks. And, next slide. So these are the slide that was presented to the Health IT Policy Committee in February and it's a summary of some 700 comments that we received that responded to the RFC that the Quality Measures Workgroup worked on late last year. And just to remind us, remind the group of our work, for Stage 2 the Workgroup focused their RFC on individual concepts and measures and for Stage 3, we decided to take a broader look at the environment in which the eCQMs both are made and are used, and the extent to which they can drive quality improvement. Next slide.

And we roughly split up our RFC into four sections. The first describing the purpose, the purpose of the Quality Measures Workgroup and the measures, the next describing how measures are built, the pipeline describing which measures we choose to move through the pipeline. And then finally, the last section had questions about how we can better use measures or better make measures that are useful for quality improvement. Next slide. And in this talk, I'll focus on the questions that are in bold. There were thirty questions in the RFC and it would take far more time than we have to go through each question and to separate the responses. But the goal for this talk is to go through the major questions and then get an idea of how we should point our resources going forward, and our attention.

So some of the major issues that we wanted to look at are one, what's our purpose and what problems in particular are we trying to solve, and how we get input from a broad variety of stakeholders on this purpose, or to meet this purpose. The next for the E-measures we asked, how could we make better measures and whether we should continue focusing on – should we shift to being entirely outcomes focused and move attention away processes or should we balance the two or find a way to balance the two. And then we addressed, or had questions about de novo versus legacy measures. For the pipeline in particular we described what might be an innovation pathway for meaningful use and asked for comments on how to apply that to the program. And then for the QI platform, we've gotten both from previous RFCs and the NPRM and from public comment; we've heard a lot about interest in the marketplace and providers for dashboards that can be used for population management. And we wanted to have a section where we have questions in particular that ask both provider groups and vendors on what was the feasibility and usefulness for these types of tools.

Next section or next slide. So here's a rough breakdown of the number of responses per segment of questions. In general we received roughly thirty to fifty responses per question. Next slide. So we started – our first section was on – we described our purpose and received some feedback on that. And then asked how we could get better feedback to be sure that our measures are focused in the direction that the public believes they can be and to what extent we could pull in comments from a variety of stakeholders or a greater variety of stakeholders. And these were, remember when we went through these questions earlier, Dr. Calvo especially pointed us in the direction of trying to remain patient-focused and patient-centered, both in our measures and in our RFC.

Next slide. So this actually was the segment with the greatest number of individual comments and nearly all the commenters agreed that there was more that both the Policy Committee and the Quality Measures Workgroup could do to seek input from a wide variety of stakeholders. Next slide. And some of the suggestions were making use of social media, using more webinars, having open forums for each measure. And the measures are of course built in different ways by each developer, but some work inside of ONC we've been thinking recently about how to post our measures prior to the proposed rule, to post them online, so that we can receive comments that way and other developers have done the same. There's asked for greater outreach to the professional societies and perhaps establishing for each measure some steering committee where either societies or the public could have input...direct input, on the direction that the development goes. The majority of responders agreed that there should be increased...there was a need for increased input from the public and increased input from patients into quality measurement and development.

Next slide. So our next set of questions was focused on process measures and outcomes measures and by all means, anyone can feel free to interrupt and ask questions. And these basic questions were should we put our effort into process measures or outcomes measures. Often the professional societies remind the group that process measures are also important at the point of care. And we asked, or what might be a compromise is that we work, as we work on outcomes measures, we think about the process measures that have similar structures and might be associated with improvements in those outcomes and we build both at the same time. Next slide. So as you can see there was, of course, strong support for outcomes measures, but also strong support for combining development of outcomes and process measures. Next slide. There was only a small amount of support for us not making measures at all. The next question we ask should be build suites of measures where we have both the process measures that are associated with outcomes and we had strong support for bundles or suites of measures as well.

Next slide. And here are some of the comments that were typical or some of the lessons that we learned. Commenters felt that our outcomes should remain the focus of the program and there was support throughout the documenter, or throughout the comments, the common theme was giving providers the freedom to choose the path they wanted to take inside of meaningful use or giving providers the freedom to make it more meaningful to them. Different specialty societies pointed in the direction of their clinicians, in particular, of course, there was some recognition that creating suites would be challenging, but it would also be valuable at the same time to the extent that suites or bundles of measures could use similar components such as denominators or value sets. And also that the suites are an opportunity to further demonstrate or investigate the relationship between processes and outcomes.

Next slide. For our question of using de novo measures or legacy measures, we asked should we consider shifting away from retooling paper abstract or administrative claims measures and work more with measures that were intentionally designed for use in EHRs. Next slide. And there were a number of both vendors and provider organizations answered this question and there was strong support for de novo measures. Next slide. One medical center in particular made the point that they found that legacy measures that they had worked with were not as easy to complete or not as easy to design as de novo measures that were designed for the EHR. Another provider noted that there were not enough de novo measures in use to make a comparison since so many of the measures, the majority of measures that are used are still the paper and claims abstracted measures.

Next slide. On to the innovation track. So we, in the RFC proposed that clinicians might be able to design their own measures for the program, perhaps within some reasonable constraints, and asked if this might be a desirable path for meaningful use or the EHR Incentive program. Next slide. And there was strong support for an innovation pathway for locally designed quality measures. And we also described, in the RFC, perhaps two approaches. One being a more conservative approach where maybe large, integrated delivery networks or commercial payers could certify themselves or be certified as measure development organizations and design measures that conform to the QDM and use a measure-authoring tool to create HQMF for them, so to create them to the standards that we currently use. And another more radical approach would be to entirely open up the process to any provider who was so willing to create measures for his or her practice. Then we asked what constraints might we put in place with either scenario. Next slide. There was I think enthusiastic support for finding an innovation pathway and adding that to the EHR Incentive Program.

Next slide. The support was often seen from large networks and medical centers to either as we said, they were building their own CQMs already and were using them for care, and also we wanted to use them as part of the Program. There was some support with reservation also from provider organizations and from professional societies, who thought it would either be challenging and resource intensive, but also who were concerned about comparability from measure to measure if a great number of clinicians or a great number of provider organizations were creating their own measures. There were a few commenters who also felt that the program should not engage of any development of new measures at the provider or at the large provider organization level. CHIME in particular recommended that MU3 not develop new measures. Some of the comments that were in this section, or to these questions, were not so much focused on the innovation track or to the point that some organizations felt that no additional measures should be added to the program and that Stage 3 should be used to repair and refine the measures that are in place.

Next slide. When we asked whether we should be more conservative or more radical in our approach, there was, actually you'll have to forgive me, these slides should be switched. The alternative slide had greater support than the conservative approach. Next slide. And the conservative approach, it was often supported by the professional societies and very large organizations. They said they...this was a typical statement, that they encourage adoption, but to be sure that the CQMs that were used were relevant and feasible, they felt larger organizations would be more capable of delivering on that. The alternative approach, number of also hospitals and even individual providers supported this idea. They especially like the idea of flexibility and the opportunity for, to deliver on the idea that meaningful use eCQMs should be meaningful to the clinician that is participating. Next slide. So we also asked how should we or should we constrain and there was strong support for constraining the measure development with the standards that are in place such as HQMF and the QDM, the quality data model that's currently used for CQMs that are developed for EHRs. Next slide. And we really, when we described the question, we did not recommend any constraints, but we consistently saw HQMF, the measure authoring tool, the use of value sets that were consistent with those found in the NLMs value set authority center, that the tools and the standards are in place were supported by the responses to this question.

Next slide. And finally we had a segment of questions where we asked for support or interest or feasibility for population management tools or EHR generated population management tools or population dashboards. They have a number of names or business intelligence tools or clinical intelligence tools. But essentially software that allows clinicians to both view population to refine the populations and either flip or adjust the criteria for entrance into the populations and then to order tests or activity on patients in the population. Next slide. So we asked if they were valuable, if there was an evidence basis and whether there was also a business case and we also asked what technological challenges might be in place and whether the Health IT Policy Committee should or might have activity in this area.

Next slide. And again for population management tools there was strong support and we've also heard this both on the Health IT Policy Committee, but also from the community. There's strong support for the capability, regardless of what it's called, its ability to create a list of patients, which is similar to the functional objective for patient lists, but also to create ad hoc queries or lists, a limited number of ad hoc queries, to answer questions about those patients. Next slide. So really the majority of commenters felt that there was a role for increased standards in this space and the need for population health management tools. There's been demonstrated evidence and value and a number of the commenters provided specific, cited specific investigations that had found value for these tools. A few commenters, especially some software companies and some larger organizations, worried that the standards to this space are immature and were concerned that over-prescriptive activity from the Policy Committee might lead to decreased innovation in this space.

Next slide. These are quotes from a few of the typical responses that the Health IT Policy Committee might set baseline functionality for such a system that would provide the functionality that the Committee desires. From AHIMA, "We feel that there will be a role for this type of information from population management, especially for ACOs." In this section in particular, many of the commenters mentioned that this is the type of functionality that's required by HMOs, for PCMHs and for transformative population based care. And CHIME also, pardon the pun, but chimed in, "Given the immaturity of the market, CHIME believes that it's better to let the market evolve," and this was a sentiment that was expressed by a number of similar stakeholders.

Next slide. So if there were recurrent themes that I might add in closing, it was to, that the Committee and the Workgroups should listen more and engage with the Societies and with patients. That we should create measures that are tailored to the technology and that we should liberate the data and especially liberate the providers. Finally, that care coordination, patient engagement and patient safety should be high priority domains for development going forward. Next slide. So to the group, thanks for the hard work in putting together questions and the discussion up to this point. And we look forward to the discussion now on how we might point our attention going forward. Thanks.

Helen Burstin, MD, MPH – National Quality Forum

Great. Thanks Jesse. So it looks like we've got about twenty minutes for this discussion, is that right Jesse?

Jesse C. James, MD, MBA – Office of the National Coordinator

Yes.

Helen Burstin, MD, MPH – National Quality Forum

Okay. Great. So any comments from any members of the workgroup on what Jesse just presented or specific areas you think in particular we should hone in on for further discussion today or on subsequent calls?

Tripp Bradd, MD, FAAFP – Skyline Family Practice, VA, VA

This is Tripp. I like the concept of the suites, although I can't wrap my head totally around how that would be implemented down to the provider, but, it's a great idea to attach process with outcome.

Jesse C. James, MD, MBA – Office of the National Coordinator

So one example of where we headed in that direction in Meaningful Use 2 was or are the CQMs that were built for HIV and there is an HIV viral load suppression measure, but there's also HIV visit measure and HIV PCP prophylaxis measure and there's been no small amount of work on an HIV highly active retroviral therapy measure. So, it's – ideally you'd have an outcomes measure with its, the value set, the logic, the components, but especially the denominators as similar as possible, so that if you're performing well or...if you're performing well in the outcome, you may be not as much interested in the process. But, we got some support for these type measures from the VA who found, for their suites of measures, when clinicians weren't performing as well, they could point to processes that were helpful, that often with improvement could lead to improvement in their outcomes measures. But they're most useful when the measure components are as similar as possible.

Helen Burstin, MD, MPH – National Quality Forum

And just to add to that, this is Helen, they're also most useful when those process measures are really proximal to the outcome. So it does lead you away from many of the process measures we currently have that are pretty distal. For example, central line associated blood stream infections associated with use of the bundle, etcetera, those are pretty tight. There are lots of examples of process measures we have that wouldn't really work in that suite concept at all.

Cheryl Damberg, MPH, PhD – RAND Corporation – Senior Policy Researcher

This is Cheryl Damberg. Helen, following up on your comment, I'm not sure that it makes sense for us to only look at proximal outcomes, because I mean as you note, a number of the measures that are in place that are really focused on longer term outcomes are still, I think, a high priority.

Helen Burstin, MD, MPH – National Quality Forum

Yes.

Cheryl Damberg, MPH, PhD – RAND Corporation – Senior Policy Researcher

Okay.

Helen Burstin, MD, MPH – National Quality Forum

Yeah, I was focusing more on process measures that are proximal to the outcome, meaning closely related, meaning if you actually move the needle on the process measure, you would hopefully move the needle on the outcome, not an issue about proximal or distal outcomes, sorry.

Cheryl Damberg, MPH, PhD – RAND Corporation – Senior Policy Researcher

Okay. Thanks for clarifying that.

Norma Lang, RN – University of Wisconsin

This is Norma Lang. Could I ask a question about the legacy and the de novo. I guess I'm a little surprised, if the legacy measures were really based on science at that time, would they not be considered as you go forward, with the emphasis on de novo. Could someone just speak a little bit to that?

Jesse C. James, MD, MBA – Office of the National Coordinator

I can and I think Kevin will chime in as well. What we found during, and we heard from measure developers for Meaningful Use 2 was that when we, for Meaningful Use 1, there was a lot of effort to stay as faithful to the paper-based legacy measure as possible, often to the detriment of the technology. And for Meaningful Use 2, we tried to, as we retooled or re-engineered measures, we tried to both think about what would be feasible inside the EHR and sometimes we changed the, what had been the paper-based measure, but we changed it to better fit the EHR. And well, that creates a number of challenges. One, documentation that's important, but two, it creates an opportunity to compare that, the EHR-generated version or what is a de facto de novo version to the previous paper-based version of the measure.

Norma Lang, RN – University of Wisconsin

Um hmm.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator

Yeah and this is Kevin. I would say that our goal is to have measures with really good intent and insomuch as measures, legacy measures measured things effectively and have a good intent, that measurement intent could be migrated into de novo measures. But what we don't want to do is fall into the place where we feel like we have to do a one-to-one translation.

Norma Lang, RN – University of Wisconsin

Right.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator

For every component do a direct translation of that from one platform to another.

Norma Lang, RN – University of Wisconsin

But you wouldn't rule out legacy measure then.

Helen Burstin, MD, MPH – National Quality Forum

No.

Jesse C. James, MD, MBA – Office of the National Coordinator

No, it's more using the legacy measure as the inspiration and keep the intent of the legacy measure, but to reinterpret it for an EHR.

Norma Lang, RN – University of Wisconsin

Okay, that helps. Thank you.

Helen Burstin, MD, MPH – National Quality Forum

Right. So just to add to that Norma, this is Helen. You might, for example, of course want to keep some of the concepts around those really important measures, but at the same time, you want to get out of the box of truly just making the measure construction match the paper construction, when that doesn't actually make any sense.

Norma Lang, RN – University of Wisconsin

Okay. Yeah, that makes sense. Thank you.

Helen Burstin, MD, MPH – National Quality Forum

Other comments from the group?

Sarah Scholle, DPH, MPH – Vice President of Research & Analysis, National Committee for Quality Assurance

Hi, it's Sarah Scholle.

Helen Burstin, MD, MPH – National Quality Forum

Hi Sarah.

Sarah Scholle, DPH, MPH – Vice President of Research & Analysis, National Committee for Quality Assurance

Hi. So I want to second that last comment. I think it's really important especially as we have tried to move from measures that were originally designed for claims, and all of its limitations and also strengths, that they don't always exactly make sense in the electronic health record. I wanted to comment on two points. One about the development of measures, I guess the – is this the innovation set, is that it?

Jesse C. James, MD, MBA – Office of the National Coordinator

Um hmm.

Sarah Scholle, DPH, MPH – Vice President of Research & Analysis, National Committee for Quality Assurance

And so the innovation track. So one thing that's going to be really important is to try to think about how all this stuff that those of us who struggled with making measures fit into the current systems, what we've learned about how to do that, and how to make sure that we don't have a lot of folks repeating some of the same mistakes that we've made. So, there's – and all the stuff that we've learned about the challenges of this work. So, I'd like for that to be on the table and, because I do think that innovation is important, and the real struggle is how to think about the innovation, but also think about the standardization that will need to happen later on. We've certainly experienced this in our Center of Excellence in Pediatric Quality Measurement where we've been struggling with that – having one foot and trying to innovate versus also trying to deal with and follow the standardized format.

The other comment I have is about the process outcome division. Of course we really want outcome measures and that is certainly appealing, but we're – there are tremendous challenges with actually creating those outcome measures. And also thinking about what the method of developing and demonstrating the measures, and so this may be a place where some intersection of our goal of having more de novo measures, that it capture something that looks more like an outcome, could be tied to this innovation track. Because what we really need are the places that are willing to go in and build these systems for tracking information with us, with standardized tool sets and capturing information electronically, in structured fields that will allow us to make...to perform logical functions, to actually see, did a number improve. That's one piece, but what we're finding is that we're hearing a lot of concerns about well what's the right amount of improvement and based on what kind of judgment and where is that information collected. It may be collected outside of the electronic health record. So I think that's another place where there is some learning that's been happening about some of these key issues. And if there's a way to actually think about that and harnessing that opportunity for innovation and demonstration to get to those, the goals of this outcome, process outcome suite and ... or a process outcome suite that's not actually to the outcome yet because we're not actually sure what would be the way to measure outcome, how to do risk adjustments or whether and how we need to do risk adjustment and whether and how we can use multiple tools or whether it would require landing on a single tool for a specific setting.

Helen Burstin, MD, MPH – National Quality Forum

Those are really good points Sarah, thank you.

Russell P. Branzell, FCHIME, FACHE, FHIMSS, CHCIO – Poudre Valley Medical Group – CEO

This is Russ Branzell, I wanted to make a couple of comments. One on the slide relative to engagement and a great start, and I would agree with that completely. I would say that the more we can create some proactive engagement rather than reactive after things come out and trying to necessarily reshape what's already been worked on. The more we can work on this in a proactive manner, and get feedback concurrently through the development cycle, I think the better off we're going to be. In particular, the comment that's bolded there relative to outreach to the professional societies and patient advocacy groups.

I think that, going along with my next comment, which is why you saw some of the reactions that are out there to – even to the extreme of don't create any new metrics in Stage 3, was an industry that was caught behind the curve on this as far as the magnitude of work of adoption. And I think in many larger organizations, this was hard, but in smaller community-based or physician offices, the magnitude of work created such a strain on them that it has created an industry exhaustion point now, that there's just a fear of more work coming at this point, that they may not be able to keep up with. So if we create a positive momentum through a positive or a proactive engagement cycle, we may see that concern decreased in the fact that they have a greater voice or opportunity to shape on the front end.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator

This is Kevin Larsen, a quick question for you. So we know that in 2017 all providers have a value modifier applied to their claims, and that value modifier will come from some kind of quality measures. So the question is: How do we get this proactive engagement so that by the time we get to that place, they believe, trust and are willing to work with the measures that are here?

Russell P. Branzell, FCHIME, FACHE, FHIMSS, CHCIO – Poudre Valley Medical Group – CEO

I would say that the way we engage them now is through those professional societies. I have a small vested interest in this in that I'm the incoming CEO and president for CHIME effective beginning of April and more than glad to help you, Helen, in this area, to create some collaboration amongst all those. I've talked to many of the CEO and Presidents of those professional societies and I think they're all interested in working in a collaborative way, rather than providing their own siloed input, which may give us that catalyst for change that we want to in the 2017, making it a meaningful timeframe.

Helen Burstin, MD, MPH – National Quality Forum

Absolutely; that's great Russ. And one other comment on that, it just seems like it's also an opportunity and part of what I also heard from Sarah's comments and a little bit through yours is, making sure that we share the learning's along the way, mistakes, opportunities so we could do differently in the future, as we kind of go through this this next time.

Russell P. Branzell, FCHIME, FACHE, FHIMSS, CHCIO – Poudre Valley Medical Group – CEO

I think that's a very fair comment. One of the things I heard just this last week at CHIME and HIMSS in New Orleans was, the frustration with everybody doing their own work after they've been given a metric to work on, rather than creating best practice and a concept of leapfrogging with knowledge, where maybe in some isolation of best practice and piloting, we shrink that adoption curve to a much smaller factor by sharing the best practices that are out there.

Helen Burstin, MD, MPH – National Quality Forum

Yeah, agree.

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I want to say that I have one other thought. I think there's a potential to bridge the outcome process distinction with the conservative local versus standardized professional strategy and what I'm thinking about is the likelihood that the outcome measures are of interest to the external audiences, payer and recognition programs and so on, and are like the value-payment modifier for CMS, going to be relatively more likely to be standardized and uniformly required.

Helen Burstin, MD, MPH – National Quality Forum

Right.

M

But the process measures are opportunities for local providers and societies to analytically determine where there are opportunities to drive those outcomes through process identification and improvement. And those don't need to be nationally standardized or top down driven. And so there may be a hybrid in play that we could think about of saying here's the core set of outcome measures of public interest and with that, let's enable the software, let's look for software certification requirements and functional requirements which enable the users to use their software to diagnose and improve processes. Rather than thinking of the quality measurement enterprise as sort of this cross-sectional measurement tool; it has two different functions, one's in effect reporting and the other is in effect analytic. And part of – because my view in general philosophically has been our job at ONC and this program is to make sure that the product had various capabilities, our job is not to set the reporting requirements or define measures or develop measures or anything like that, that's up to other entities to do. But ours is to make sure the capability is there when those other entities want something, that we can support them. And maybe we can split the difference as we think about the next stage of requirements.

Helen Burstin, MD, MPH – National Quality Forum

Hmm. Interesting idea, although in some ways I think going back to Sarah's comment, the outcomes are going to be by far the more challenging, where the innovation and the good thinking and collaboration might be even more critical. So I'd hate to cut it off, but it's intriguing. Any other comments before I turn it back to Jesse? I think we're reasonably on time Jesse, yes?

Jesse C. James, MD, MBA – Office of the National Coordinator

Yes, we're pretty close to on time. Well, our task was to find areas that we might take a deeper dive on the comments, and in particular it sounds like there's interest in both the innovation pathway and in the process and outcomes measures, but there's both an interest in those areas, but also some creative ideas that were not part of the RFC. So, what does the group feel – I would ask that, what the group thinks our next step should be? Should we present some ideas that we have in this area that were inspired by the RFC responses instead of going deeper on RFC responses?

Cheryl Damberg, MPH, PhD – RAND Corporation – Senior Policy Researcher

This is Cheryl Damberg. I think the former would be helpful.

Helen Burstin, MD, MPH – National Quality Forum

Which was the former again Cheryl, I'm sorry, I just want to make sure I'm tracking.

Cheryl Damberg, MPH, PhD – RAND Corporation – Senior Policy Researcher

I'm going to get Jesse to repeat it. It was pulling together some of the ideas.

Helen Burstin, MD, MPH – National Quality Forum

Okay. So rather than necessarily sticking to the comments as they came in.

Cheryl Damberg, MPH, PhD – RAND Corporation – Senior Policy Researcher

Yeah.

Helen Burstin, MD, MPH – National Quality Forum

I agree. Okay.

Norma Lang, RN – University of Wisconsin

I agree too. This is Norma Lang.

Helen Burstin, MD, MPH – National Quality Forum

Yeah, it sounds like there are sort of two major buckets as we've really been talking about this issue of outcomes versus process or suites as one, and the second one is this innovation pathway versus need for use of standardized tools, standardization seem like the two dominant issues we've talked about. And perhaps also, getting back to Russ' comments, also perhaps thinking more about opportunities for ongoing collaboration and learning as a third.

Jesse C. James, MD, MBA – Office of the National Coordinator

And how about the population health management component, is that of interest or not?

W

Could you say some more about what that means because – and is this focused on what would be within the EHR or – because there's work outside of the EHR or Health IT systems outside of the EHR that can do this.

Jesse C. James, MD, MBA – Office of the National Coordinator

So remember in the Meaningful Use 2 certification we certify...we can certify separately capture, calculate and report. So an EHR could only do capture if it wanted, but it has to in a certified, standardized way, send that data, export that data to something else that can calculate it and report it. For right now we only certify calculation and reporting to a payer, like the CMS. We don't actually provide any guidance or certification on how a provider could view that data for quality improvement across a panel or population. And so this would be potentially exploring on top of that calculate and report part, is there not just a submission to a payer, is there also a viewing for local visibility and quality improvement. So what that might look like is a list of all the patients that meet a measure with all of their numerators and denominators shown graphically and maybe a control chart that a provider can see they've been making progress over time.

Cheryl Damberg, MPH, PhD – RAND Corporation – Senior Policy Researcher

This is Cheryl Damberg again. Having recently visited a healthcare organization where that was currently in play, it seems like that's a really valuable tool, but it almost seems like in response to these new payment models, organizations are going to be developing these tools, if they want to succeed in this game. So I guess the question is, where to prioritize, focus attention and is that the area of greatest deficit?

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

And this is Paul. I'll speak up on – as one voice on the provider side, yes, you could make additional tools, but one, it's – not every organization, especially the smaller ones, have that capability to write their own software. Two, typically when you do that, you're in reporting mode and these are not actionable reports. If it's done within the context of the EHR, typically, well, it can be designed so that the reports are actionable, that is, you click and drill down in on a subset of patients and you get actually down to the individual patients. You can either do a back action on a whole subset like let's invite these folks in to get a mammogram, let's say, or you can drill down on individuals and do an action specific for that individual. But anyway, that takes an integration with the EHR and that's, I think, the value I see in making these tools widely available.

Russell P. Branzell, FCHIME, FACHE, FHIMSS, CHCIO – Poudre Valley Medical Group – CEO

I'll support Paul on this, this is Russ again, and say that this is a pretty significant magnitude of work that's going on at all levels of care out in the provider space. And the more we keep this in our radar, I don't know if it's priority two, three, four, whatever on the list we just provided out, but I would hate to see us lose this off the radar, given where provider-based care is going out in the industry right now.

Jesse C. James, MD, MBA – Office of the National Coordinator

So maybe it's the third priority if we focus on suites and bundles and the innovation pathway, and describe the ideas in our notes back to the group that we're ... here and our third area of focus would be on population dashboards or clinical business intelligence tools.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Or you could even potentially make that third one a recommendation to the Meaningful Use Workgroup, because in the context of quality measures, it's really the first two, let's have these suites that really measure the process of improving, but also how well you're doing. And also a way to harvest all these other wonderful ideas that come out of organizations that have these specific priorities. Not that they instantly become disseminated, but they're just a really nice pipeline for CMS and NQF, etcetera. The dashboard is possibly something related to meaning. The certification of EHRs and maybe outside the purview, but it's motivated by, we can't just report on how well or how not so well you're doing, but we've got to give you a fair shake on being able to make a change in that.

Helen Burstin, MD, MPH – National Quality Forum

Sounds reasonable. But I think there are pieces of it, and actually Petra presented at our meeting last week, referred to the term vertical alignment, which I thought was kind of an interesting way to think about it as well. So as we're thinking about measures for the provider level, how do we ultimately think about how they might work at higher levels of aggregation. And that sort of fits, I think, nicely in the Quality Measures Workgroup space.

Paul Tang, MD, MS – Palo Alto Medical Foundation – VP, Chief Innovation and Technology Officer

Yeah.

Tripp Bradd, MD, FAAFP – Skyline Family Practice, VA, VA

This is Tripp. How about research-based networks that might be able to compile across larger populations? Is that a consideration for this?

Helen Burstin, MD, MPH – National Quality Forum

Um hmm. Okay, sounds like we've got our short list, Jesse.

Jesse C. James, MD, MBA – Office of the National Coordinator

Yes, I've got marching orders.

Helen Burstin, MD, MPH – National Quality Forum

Excellent. So, are we ready to do the data interm, I cannot say that word today, Data Intermediary Tiger Team charge? Will you do that Jesse?

Jesse C. James, MD, MBA – Office of the National Coordinator

Yes. If you can pull up the Data Intermediary Tiger Team Charge, that's the Word document.

Helen Burstin, MD, MPH – National Quality Forum

Yup.

Jesse C. James, MD, MBA – Office of the National Coordinator

So the background on this, we convened a hearing on data quality at the end of the year in 2012, and we plan to reconvene the group and to focus over the next year on what role there might be for data quality assurance and meaningful use or perhaps a role for data intermediary to act as certified HIT. And if they did, we wondered about how they would be certified and how their data quality would be important. And also an important event in December was in the American Taxpayer Relief Act of 2012, there were a couple of paragraphs that described a role for qualified clinical data registries. And essentially says that participating physicians, physicians who participate in qualified clinical data registry could be deemed for participation in PQRS. And since then there was an RFI published by CMS in February of this year, that's still out for comment, and CMS is also thinking about the proposed rule that will follow that RFI.

So for the data, the work for the Data Intermediary Tiger Team for the year, we see as really two major goals. The first short term goal is to provide some inside advice or recommendations to CMS on their responsibility over the next four months, to define what a qualified clinical data registry should look like and to decide what role that clinical data registry might play with other programs outside PQRS. And then the activity for the rest of the year will be to, back to that original goal of defining what entities act as that intermediary, what their needs are, what their role should be as an intermediary between a payer and a provider. And how meaningful use or the EHR Incentive Program or certification might play a role in encouraging higher quality data, and in helping the data move seamlessly from provider to intermediary, back to provider to enhance care and to stakeholders such as payers.

And we brought the charge before the Quality Measures Workgroup to ask if there was – if you'll scroll down in the charge, the activities for the year, the tasks for the year are listed and I wanted to just see from the group were there any concepts we were missing or things that you felt we should add. So the high-level tasks are one, to define the roles and functions of the intermediary. The second major task was to explore the current state and what the desired future state might be, and that will include some public comment and testimony as required. And then at the end, really make recommendations on policy or certification of data governance that would support the intermediaries in their role. And really the first line of work that is to be done is a review of CMS's qualified entities and CMS's PQRS qualified registries that may act as templates for the qualified clinical data registries. And it's sort of a big deal to deem participation in a clinical registry, depending on how you define that clinical registry, for, as an equivalent to successful participation in PQRS. So open to thoughts, suggestions or even questions.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Hey Jesse, it's Jon White. So I look forward to the work of this group. It strikes me that this is very data savvy, resource-intensive kind of capacities that are needed, I think that's appropriate. It doesn't automatically say to me that they kind of need to be experts in the kind of stuff that we're talking about, in the kind of clinical data issues that we're talking about, they need to be more good on security issues and things like that. Does that make sense?

Jesse C. James, MD, MBA – Office of the National Coordinator

Yes.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Okay.

Jesse C. James, MD, MBA – Office of the National Coordinator

We set up sort of a straw man for the attributes of clinical registry that might be qualified for it, and we started with privacy and security, they must prove that they're up to standard for that. Some concepts of data quality that the data is timely, that it's relevant, that it's within range. And then some ideas on what business rules for the registry might be, it might be they will not sell data or they will not share data. So, it's – that's the framework we set up, but we expect in the meetings of the Tiger Team that that will be more fleshed out.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

It's like the kind of thing that you could bolt-on a clinical quality expert to a large established tech company rather than the other way around. Does that sound right?

Jesse C. James, MD, MBA – Office of the National Coordinator

It's the kind of work that a large registry or a large clinical analytics company would do...

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Yeah.

Jesse C. James, MD, MBA – Office of the National Coordinator

I think the way it's defined in the act, it may be an opportunity for a clinical analytics company.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

And that's why I look forward to the discussion. Okay, good. Thanks.

Tripp Bradd, MD, FAAFP – Skyline Family Practice, VA, VA

Jesse, this is Tripp. Will there be some requirement to demonstrate from these data intermediaries that they're actually interacting with the providers. You know, we don't want to silo this out so that the providers just make reports and don't really improve from comparing their data to other populations beyond their practice. Is that going to be part of this process?

Jesse C. James, MD, MBA – Office of the National Coordinator

That's our opportunity to comment. Yeah, we haven't described that, but we can add that to the recommendation.

Tripp Bradd, MD, FAAFP – Skyline Family Practice, VA, VA

Yeah, I think demonstrating that they're actually instead of just crunching numbers and reporting to you, or to any entity, they need to sort of say, this is what we're doing to help the providers we are supporting.

Jesse C. James, MD, MBA – Office of the National Coordinator

There must be some minimal requirement for report back to a provider, which might include the data should be reported within a minimal amount of time or a reasonable amount of time, so that it's not stale.

Tripp Bradd, MD, FAAFP – Skyline Family Practice, VA, VA

Right. Just as an example, let's say we have a quality measure and there's a national benchmark, you know the population group median, and maybe even their data intermediary benchmark that they might want to have across population, then where your practice or the provider actually hits it. So over time they can actually see how they're improving with the reporting function.

Jesse C. James, MD, MBA – Office of the National Coordinator

Yeah, we'll add that as a section, as one of the attributes.

Tripp Bradd, MD, FAAFP – Skyline Family Practice, VA, VA

Does that make sense? I mean I really, it really has made a difference when I've seen it work that way.

Jesse C. James, MD, MBA – Office of the National Coordinator

Yes, absolutely. We're running up on the end of the hour, so I'll put that in my notes and we can talk about that offline.

Helen Burstin, MD, MPH – National Quality Forum

So public comment Jesse?

Jesse C. James, MD, MBA – Office of the National Coordinator

Yes.

MacKenzie Robertson – Office of the National Coordinator

Operator – are we ready for public comment?

Helen Burstin, MD, MPH – National Quality Forum

Yes please.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Please open the lines for public comment?

Caitlin Collins – Altarum Institute – Project Coordinator

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do have a public comment.

Alison Gary – Altarum Institute – Senior Web Meetings Manager

It comes from the line of Julie Thompson; you're line is live.

Julie Thompson, MBA – SAIC – Safety Analyst

Hello, my name is Julie Thompson with SAIC and I've been waiting for this for many years. I got my IT degree along with an MBA in Quality Management, twenty years ago. And the doctors asked me, why are you here, so, the – going to have from computer system and we would like it to be free of variance in order to make the process improvement ... has this group addressed, I know you've moved in, which is exciting to see, some process measurements, but what about measurement of the variants in those processes? Have we come to that place yet?

Jesse C. James, MD, MBA – Office of the National Coordinator

I think that's – if I may, I think that's the direction we're going with the Data Intermediary Tiger Team and was one of the attributes of hot data of high quality that was described in the hearing. And something we've been thinking about internally is having quality metrics around a quality measure, and a good quality measure would be one where there's limited variance or at least the variant is attributable to the clinical population, not attributed to errors in the data set.

Julie Thompson, MBA – SAIC – Safety Analyst

Okay. So there's been some discussion around that, obviously, to the place of population. And also what I'd like to see is just the team, are the Data Tiger Team that seems to go in that direction. I think if we start maybe using the word framework to represent what the data team should be measuring around, so that we kind of have a higher level for the engineers to begin to measure. Instead of going directly to a diabetic measure this and that, if they have a framework, it's going to be easier for the software developers to get to and it reduce the amount of workload and eliminate the concern over additional work, which they've already been ... as was mentioned in the conversation today. And I thank you very much. A framework will go a long way to help the engineers move forward quickly. Thank you.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Are there any more public comments?

Caitlin Collins – Altarum Institute – Project Coordinator

We have no additional comment at this time.

MacKenzie Robertson – Office of the National Coordinator

Thank you.

Helen Burstin, MD, MPH – National Quality Forum

Well thank you everybody, three o'clock. Anything else Jesse? Are we good?

Jesse C. James, MD, MBA – Office of the National Coordinator

Absolutely, we're good. Thanks so much.

MacKenzie Robertson – Office of the National Coordinator

Thanks everybody.

Helen Burstin, MD, MPH – National Quality Forum

Thanks everybody for a great discussion. Bye.