

**HIT Policy Committee
Quality Measures Workgroup
Transcript
April 5, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon everyone. 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, and the call is also being recorded, so please make sure you identify yourself when speaking. I will now go through our roll call. Helen Burstin?

Helen Burstin, MD, MPH – National Quality Forum

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Helen. Terry Cullen? I know Terry's on the line; I think she might be on mute. Chris Boone?

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

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Chris. Tripp Bradd? Russ Branzell?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Russ. Cheryl Damberg? Tim Ferris? Letha Fisher? David Kendrick? Charles Kennedy? Karen Kmetik? Saul Kravitz?

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

Here.

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. David Lansky?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks David. Mark Overhage? Eva Powell? Sarah Scholle? Cary Sennett? Jesse Singer? Paul Tang? Kalahan Taylor-Clark? Aldo Tinoco? Jim Walker? Paul Wallace? Mark Weiner? Olivier Bodenreider?

Olivier Bodenreider, MD, PhD – National Library of Medicine

Hello.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Niall Brennan? Ahmed Calvo?

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

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Wes. Kate Goodrich?

Kate Goodrich, MD, MHS – Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Kate. Daniel Green? Peter Lee? Marsha Lillie-Blanton? Michael Rapp? Steven Solomon? Tony Trenkle? Jon White? And any ONC staff members on the line, if you could identify yourself please.

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

This is Jesse James from ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks Jesse.

Kevin Larsen, MD – Office of the National Coordinator

Kevin Larsen from ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks Kevin. Okay with that, I will turn the agenda back over to you Helen.

Helen Burstin, MD, MPH – National Quality Forum

Great, thanks MacKenzie. That is one very, very long roll call.

MacKenzie Robertson – Office of the National Coordinator

I know.

Helen Burstin, MD, MPH – National Quality Forum

Hi everybody. I know we only have an hour today and it's a pretty packed agenda. We're going to first go through, take another look at the guiding principles to eQuality Measurement and then after that we're going to have a discussion of how a lot of these new efforts around eCQM development really align with some of the other work that's happening out there. I was glad Kate was...I heard Kate's voice on the line today. Thinking about, for example, how some of this work relates to registries. Kevin and I had a chance to chat about that earlier today, and I think this is an important topic and hopefully we'll help move the field forward with some of these ideas and principles moving forward. So with that, I'm going to turn it over to Jesse I guess, to walk us through the principles. Yes Jesse?

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

Yeah, absolutely. So the guiding principles that's the word document that is titled "Guiding Principles of eCQM Development." And the reason we chose this document to start the meeting was to get the juices flowing on what the goals for quality measurement are, what the goals for development going forward should be. But we especially want to focus on the parts of this that are relevant for the later discussion in the call, the next item on the agenda, which is looking at the Qualified Clinical Data Registry description in the Tax Relief Act last year, which essentially said that physicians that report satisfactorily to a registry can be considered as completely...or reporting to the satisfaction of performance measuring programs. And that...and CMS's RFI earlier this year mentioned both PQRS and the Meaningful Use EHR Incentive Program. So as we later will talk about what types of registries or what types of measures might be involved with that program, but I figured it would be good to think about what our goals are in particular for measure development and then use that to decide or make recommendations to the Health IT Policy Committee about the Qualified Clinical Data Registries.

So we've discussed this document before, when it was in early draft late last year. And is it necessary to walk through the whole thing? Have folks had a chance to look at it? I can walk through it if we all have it.

Helen Burstin, MD, MPH – National Quality Forum

It's pretty brief Jesse, I mean if you just want to quickly walk through the highlights of it.

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

Okay, I'll go ahead and walk through. So we start with, one of our goals for, and this started with the measure development group inside of ONC, but we also shared it with the measure development group at CMS and we've iterated back and forth on letting the document grow. So we started with one goal for the next year would be to eliminate retooling, and that measures going forward would be de novo and retooled measures would only be done with the purpose to re-engineer it, but we'd try to keep with the principles that we describe below. Another would – high-level goal is to eliminate defects. So there was lots of work for the Meaningful Use 2 set of measures to find codes that were invalid or out of date and also to find logic that was unambiguous, and we continue this effort going forward to make better measures with better components of the measures as well.

And then the third principle is to have multidimensional criteria. And that's really getting to the desire from both the specialty societies and from PCMH as an Accountable Care Organization, to have measures that use our standardized components, either the terminologies that are part of ONC's standards for certification criteria, so SNOMED CT and RxNorm, and value sets that have been used in previous measures. So instead of exponentially expanding on the number of value sets, using value sets that previously have been used and using logic that has been found to be unambiguous, and also that has been previously described in other measures. So it's really the goal of building measures that can be more simply applied and implemented and making them more easily and more consistently implemented by using interchangeable parts.

The next principle was to build valuable measures. And there we say there's a high cost to making measures and as we align the components of the measures, we should be able to make measures in a way that's frankly cheaper, but also more efficient. And it can be more efficient by using standardized components, but also by minimizing exclusions and exceptions and appropriately choosing targets for measures. Finally, these last 4 points were one, to update frequently, and that's something we've been achieving over the last year. We just had an update of the EH measures and we'll update the outpatient measures, the EP measures, at the end of May.

Another principle was to democratize development...I think we're getting some feedback. And that was a principle we described in the RFC last year, we described an innovation pathway where perhaps clinicians or integrated delivery networks or registries or clinical societies, could design their own measures that were especially meaningful to them and could be used for partial completion of requirements for the program. Finally, we have a goal of aligning the eCQM programs and for delivering on that in 2014 and beyond. So meaningful use and the core set of PQRS are overlapping the value-based modifier. And finally, our eighth principle was to harmonize CQMs with CDS. That effort will be started on internal to ONC, but we'd like to push forward in harmonizing both the components and the data model for eCQMs and for clinical decision support.

So, if there were – if we step back from the document and thought what were the themes we'd like to get across, one would be, I imagine, having measures that are more similar and are of high quality, but also building measures in a way that's more efficient. Finally having measures be more useful, but also more innovative. And we'll open to responses and reaction.

Helen Burstin, MD, MPH – National Quality Forum

Great. Thanks Jesse.

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

Hello, this is David, can I comment?

Helen Burstin, MD, MPH – National Quality Forum

Great.

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

I mean I don't disagree with anything here, but there are a couple of things that make me a little uncomfortable, collectively I guess. I think we've been reacting and responding to concern by the user community about burden, complexity, etcetera, etcetera, which is all important to do and at some point, we can go too far in the direction and lose sight of the value to the other equal stakeholders in the process. So, I think as we go through this document and it keeps living in the future, we should think about what we mean by the word "better" and we should think about what we mean by the word "value," in number 4, and valuable.

I'm a little concerned about kind of a tension between the idea of rigorous scientific testing and then the reference to face validity to clinicians and the public, because I don't think we're doing a lot of – we could be doing rigorous scientific testing about face validity, but I don't think we are. And that's probably a fairly deep problem that's worth discussing, but I don't think we should treat it too casually, as we do in this document. And then I think the idea of alignment, as I've said in this group many times, I'm very concerned if alignment means lowest common denominator or sort of simplest path, instead of recognizing that the different programs often have different purposes and the value for those programs has to be retained. We don't want to do alignment at the expense of driving value to the health care system, which is the primary goal most of the programs we're talking about have. So, that's kind of a broad set of issues, but maybe to reconcile, either we can wordsmith some more or maybe there's some way to write a new element that addresses the idea of value to multiple stakeholders being in balance, so that we don't tip too far in the direction of, let's just make it all easy and aligned and lose sight of the important changes in health care we're trying to support.

Helen Burstin, MD, MPH – National Quality Forum

Thanks David. I had many similar reactions on a couple of those elements. Other thoughts?

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

Yeah, this is Saul Kravitz. A couple of thoughts; one is, I think there's some tension between item number 2, eliminating defects and item number 5, updating frequently. Since the updates we've done so far have really not been based on any feedback from the field, they've been kind of very localized updates. So I'd hope that whatever we do in order to speed up the cycle time here includes actual testing...I think the word testing should appear in here someplace, that we test measures before we incorporate them into programs.

Helen Burstin, MD, MPH – National Quality Forum

Great.

Terry Cullen, MD, MS – Director, Health Informatics – Veteran’s Health Administration

This is Terry. I have some comments. Just like David thinks there’s interaction between some of these, I wonder if there’s an interaction between eliminate defects and democratized development. I’m not sure how to evaluate or constrain the tension between them, but by democratizing development, while I agree with it, I’m a little worried that we may increase our defects. The other thing is that, I think the last thing eCQMs with CDS, and I don’t know how we’re using CDS. But I’m wondering if we want to just limit that to CDS or also talk about clinical reminders, some people could say that’s clinical decision support, but be really pretty clear how we’re using that term here in terms of the harmonization.

And the other thing I worry about is that we’re using kind of like eliminate, I’m wondering if there’s a more positive way to describe what we’re trying to get at, as opposed to eliminate, which sounds like, oh my gosh, we’ve had all these problems and now we’re moving forward. And I recognize there have been some problems. Finally, the whole thing about how to democratize development, I almost wonder if you need like a little SDK, a software development tool kit, somehow for what do we want to do with measures. And how do we want to accelerate the – at least the software development side of this in a way to embrace, to let more people be there, to ensure we’re doing, from the VA perspective Open Source, APIs, make sure we’re really giving some guidance in that. And perhaps we don’t want to go there, because that’s more technical, but I’m just throwing that out there.

Helen Burstin, MD, MPH – National Quality Forum

Great. Other suggestions? Well, I’m happy to build on a couple of those points. I also had several concerns, primarily to David’s earlier point, I think face validity is probably not sufficient, and I wouldn’t specifically talk about face validity. I think if you want to talk about validity to patients and clinicians and the public, that’s fine, but face validity may be too low a bar for what we’re really trying to achieve. And I agree with the points around democratization of development, we need to do it in a way that obviously brings in the innovation, but brings it in a way that is standardized and ready to be used. So I think those are all important points people made and perhaps one way to reframe eliminate defects is to try to move towards a defect-free process of development, where early iterations allow for that defect-free cycling. Jesse, do you feel like you have enough to maybe do another round of this, or do you want people to specifically give you wordsmithing?

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

I think I can – well I can do some smithing with the comments we just received and then send it out for another round.

Helen Burstin, MD, MPH – National Quality Forum

Perfect.

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

For a round to vet it.

Helen Burstin, MD, MPH – National Quality Forum

Great. I mean I think it’s close, it’s just – and I think it is useful to have as we begin sort of this next round of work for Stage 3. And it’s obviously a really important backdrop for the next conversation. If there aren’t any other comments or questions, just to keep it moving, perhaps we should move on to the next agenda item, which is really thinking about again, the comments people, Terry and others raised about this democratization of eCQM development and how that may relate to the Qualified Data Clinical Registries and the fiscal cliff legislation. So Jesse, do you want to run through those slides and then open it up for discussion?

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

Yeah, I’d be happy to. Could we post the slides, the Qualified Clinical Data Registry slides?

Helen Burstin, MD, MPH – National Quality Forum

It’s up. It’s up on my screen Jesse do you see it?

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

I don't, I've actually paused, but I can walk through them. My screen froze on the WebEx. But, the first slide is just the title, Qualified Clinical Data Registries. The next slide. The next slide describes the American Taxpayer Relief Act of 2012, which included a section, it's really only about two paragraphs, that essentially say that starting in 2014, the Secretary of Health and Human Services will treat eligible professionals as satisfactorily submitting data on quality measures in lieu of reporting measures under the subsection, which is referring to PQRS, if the eligible professional is satisfactorily participating in a qualified clinical data registry. Which essentially is saying, you can get credit for doing PQRS and/or CQM portion of meaningful use, if yourself as a clinician, you submit quality data to a registry that has been found to be qualified, and says that the Secretary will also decide how to define "satisfactorily participating," what you as a clinician must do vis-à-vis this registry and also what the registry must do to be considered qualified. And the Act lists some attributes such as data transparency or submitting multi-payer data and reports...having reports on performance back to the provider and including some types of clinical quality or quality improvement initiatives also providing that to the provider.

Next slide. And in response to the Act, CMS really – in January of this year an RFI asking for some guidance or some thoughts on some of the areas that were described vaguely in the Act. A few of those were, one, what requirements should there be to define a registry. And they ask, what types of entities should be considered as eligible to act as this type of registry for physicians who are participating or who would be deemed as participating satisfactorily with PQRS or the EHR Incentive Program. And they have some examples, might include medical board registries, specialty society registry or maybe a state registry or a state collaborative. But that could even, it might be as broadly defined as perhaps a data warehouse for quality measures or an HIE. And then what types of measures should the registries have to have or what attributes of the measures inside of the registry that physicians are reporting to and getting credit for, should CMS expect? And that might be NQF endorsement, it might be that the measures have been submitted to CMS and there is an evidence basis and they've been expressed in HQMF and they use value sets that are consistent with those used for the meaningful use value sets. So, the Act was not detailed in description of the measures for the registries, so CMS is asking for guidance in this space.

And finally, there are also a number of questions around what reporting criteria should be in place, how many measures should a physician report on, should they span all six NQF domains or should they submit three measures, in only three domains. So you can imagine that there's interest in how this program shall fit into the goals for CMS and the goals for health IT adoption and quality improvement. The next slide describes the work the Data Intermediary Tiger Team has started discussing in this space, how to maintain data quality and expect privacy and security and what business rules a registry might need to have in place to be considered a Qualified Clinical Data Registry.

Next slide. And for the Quality Measures Workgroup, we really wanted to take a step back and think about, well, what are the goals for quality measurement inside of the Meaningful Use Program, and how can we be confident that this pathway to getting credit for quality measures is still consistent and preserves those goals. And some of those principles were having measures that are valuable and, as David Lansky made the point, that are meaningful at the point of care, but also meaningful to additional stakeholders, patients and payers, and how can we be sure that the measures are valid and use valid components and interoperable components. This is a way to democratize development to a certain extent that a professional society can use their own measures and physicians who have been using them or receiving report from them can now get credit in PQRS – PQRS and meaningful use. That also, to some extent answers the question we've had around how do we get more innovative and more specialty focused measures in the program and is this – does this continue along the alignment plan for PQRS and meaningful use and the modifier, and are there opportunities for linking eQMs and CDS inside of this pathway. And on that note, open to any questions and looking forward to healthy discussion.

Helen Burstin, MD, MPH – National Quality Forum

Perfect Jesse, thank you. Anybody have any thoughts on this issue? I also should – actually, before we do that, not to put you on the spot Kate, but anything you'd like to say from the perspective of CMS as you've been hearing from folks about this issue.

Kate Goodrich, MD, MHS – Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services

So we have – we are still getting responses from our RFI. We anticipate that we'll get a number of them next week, because I think the deadline is next week. We are very, very, very interested in hearing from this group and from the respondents to the RFI on their thoughts about how we should put this together. And I will say we anticipate, like with many of our programs, that it'll start off probably with not...it'll start off in one direction and will continue to grow over time. I think what we put out there in the first year is not going to be how it ultimately ends up looking, but we'll at least show the direction that we think we want to go in. And we really want to be very responsive to input from all of sort of the usual stakeholders. Right now, of course, we're in rule writing, so there's not a lot that I can say, but I'm really looking forward to hearing what this body says.

Helen Burstin, MD, MPH – National Quality Forum

Great, thanks Kate. And certainly it sounds like having some thoughts from this group about sort of some principles around the qualities or deeming for those registries, as relates to the HIT piece could be potentially useful.

Kate Goodrich, MD, MHS – Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services

That would be particularly useful, yes

Helen Burstin, MD, MPH – National Quality Forum

Great. Okay. So, comments for Jesse or anyone else around this issue of the registries.

Russell P. Branzell, FCHIME, FACHE, FHIMSS, CHCIO – College of Healthcare Information Management Executives (CHIME)

This is Russ Branzell with CHIME now and Jesse and I have actually talked a little bit about this. But for the general group, the more we can make this blueprint oriented, or even clear standards for some of the areas where the providers and organizations that have providers are trying to input this data, I think the better off we can be to standardize this process. Having worked with many of the HIEs out there, all running at different standards, different collection rates, different ways they're aggregating the data, the more I think we can say, here are some blueprints for success, even best practice standards for them, I think the easier it's going to be in the long run, rather than trying to look at this from a broad stroke to begin with. The more we can standardize on the front end of this process, I think the easier it's going to be to aggregate the data and to be able to do some of these necessities such as standardize the PQRS and other reporting processes. It's pretty amazing the diversity of data aggregation that's occurring out there.

David Kendrick, MD - MyHealth Access Network

Yeah, this is David Kendrick. I'm with MyHealth, which is one of the Beacon HIEs and we encountered the same challenge obviously, right in the midst of Beacon when we recognized that we all had quality measures to produce and the EHR feeds or the ability to get data out of EHRs really became a rate-limiting step in producing those measures. And so we actually launched a project called the EHR eWorking Group from our perspective, which basically – in which we started down the pathway of let's choose specific variables we need to calculate specific measures. And very quickly began to realize that that would only get us those measures, instead we need to look at the standards that were already being requested of the EHR vendors and identify within that standard what we absolutely, positively had to have and generated a CCD C83 specification from that. And have successfully moved several million CCDs that meet that specification from a number of vendors, in order to be able to do just what was suggested, which is standardize our reporting. But it began with, what's already being required of these vendors, within that framework what can we measure and therefore have to both enforce that standard with the EHR vendor and set our sights on measurements that we could get.

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

This is Russ again. Just to the principle, the guiding principle that was there on the slide relative to the democratic view of this, to democratize this, the more we can involve the vendor side of this and application developers on this, I think the easier this will be as well.

David Kendrick, MD – MyHealth Access Network

Absolutely, that was the key with the project we did, was the vendors came to the table with us and sat down and did the work together.

Helen Burstin, MD, MPH – National Quality Forum

Yeah. Other comments?

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

It's David. We've been wrestling with this operationally in California with our joint replacement registry and trying to build it, as much as possible, off of direct data feeds from EHRs, both surgeon and hospital, and then departmental hospital systems that need the specialized data for that particular registry. So we've been on this for a while and I think, as everybody just said, there's plenty of opportunity to improve the standards to support registry implementation in the most inexpensive and most reliable way. And I think that's the opportunity we have is to focus the piece of feedback to CMS on the pathway of additional standards or standards adoption that's needed, both in the various systems that contribute to the registry and then I'm also interested in the interoperability over time and across settings. Because I think part of where the registries add a lot of value is the ability to integrate data beyond what the scope of any one EHR is, but to the patient course of care across time and space. So, maybe there's a project, or at least a requirement, that participating registries have adopted a set of standards now and are part of a process to adopt additional standards at both sort of interdepartmental interoperability and sub-system interoperability and inter-organizational or across setting and time interoperability, become more uniform.

The other one I'd add is the patient, we all have this patient engagement goal as one of the quality strategies and many of the registries are moving toward acquiring patient reported outcome measures and patient experience measures and patient self-report of preoperative status or pain level, symptom level and so on. And so there's an opportunity here to use the registry process as an extension of ONCs interest in patient engagement as one of our priority areas. And I think working, again, setting an expectation that registries that are operating in clinical domain where patient provided data is valued, have a mechanism for capturing data, whether it's from instrumentation or from patient reports, would be a really positive tool in driving the agenda that we have.

Two other things, what I think of as measure production. I'm a little skeptical that a lot of the registries that are out there now have kind of a sophisticated capability of producing measures that would be acceptable to the payers, like CMS. And, as someone said earlier, a flexible capability so that it isn't necessarily hard-wired production, but can respond to the emerging needs of the payment programs in particular, as the measure scope changes. So if there's a way to have the registries implement or commit to flexible measurement calculation and production that would be valuable. And the last one is the feedback loop. I think we want, like the clinical decision support argument, we want to see these intermediaries and registries doing benchmarking and feedback to providers so that while on the one hand they may be reporting up to PQRS or some external system, they are also using that data to drive quality improvement feedback now. So I hope that's a criterion that CMS uses in considering qualifying registries.

Theresa Cullen, MD, MS – Veterans Health Administration – Director, Health Informatics

This is Terry. The other thing I'd like to do, and it really follows on what David said, but it's somewhat categorized differently, is the definition of the core capabilities of registries. Because I think if we focus on that and define them, and this has been a dialog that's been had over the past 5-10 years, and I don't think we...anybody has really done it to a large extent is what does – what are the capabilities, then you can get that parsing of denominators, parsing of numerators. You know, what the Health IT Policy Committee this week was the issue of can patients get access to their immunization registry data. Can they access the registry to pull out what they need to get? So I think there's probably some important work that could be done there to help set the stage so that people that are building registries, build them from the ground up with expansive or expandable capabilities that will meet what we perceive to be the needs coming in the future.

Kevin Larsen, MD – Office of the National Coordinator

This is Kevin Larsen. A couple of other kind of questions to the group, sort of first to this idea of how do we help the registries become part of the interoperable Health IT ecosystem? What is the – what's the first step in that path, and that's I think a place that this group could really help with, is it a minimal data set of demographics, is it – what exactly is the sort of first step? And then I was at the Minnesota Community Measurement meeting on Wednesday, and had a long talk about this with one of the registry owners there, and they're very interested in how this registry data move back into EHRs. Just to the point that David mentioned, things like pain scores and patient reported outcomes, those things may actually be important for decision support at the point of care, how do we – what are the thoughts around that?

David Kendrick, MD – MyHealth Access Network

This is David Kendrick again with Beacon in Tulsa. We've had that as a core component of our project from the beginning and the standard we settled on for communicating out from our systems to decision support vendors, of which it sounds like a registry would be one. If it's reporting some unique measures in them that are helpful, and basically we generate a continuity of care document on any patient with a change in their record, and then that's what the decision support group has to digest and get back to us with. And that's been pretty useful and fairly quick to implement.

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

David, this is Jesse, well, David Kendrick. I have a question about your earlier comment, you seemed to be suggesting that it would be beneficial to societies if they built – when they build their measures for EHRs, if they start with the type of data that are available in the EHR, they start with a standard and then they built their measure back from there. To your knowledge, and to the group's knowledge, do you think that's the typical process for registry measure development. I think they haven't been as active in this space and I ask because we're trying to think about how we should...how we can be sure that they build measures and how we can guide them to build measures that are going to work well with automated data transfer from EHR. So, I'm asking what we can do to guide the societies to build measures that will work well with EHR data extraction.

David Kendrick, MD – MyHealth Access Network

Oh, I think – thanks Jesse. I think that we have a really clear historical example of that. What are most measures built on today? They're built on claims data. Why? Because that's what we had. So, if we just extrapolate to now, where we now have electronic clinical data, it's going to be the structure and type of that electronic clinical data that's frankly going to be available to us, so let's figure how to measure within it. The second piece of that, of course, is we absolutely, positively have to enforce the Meaningful Use rules and make sure these EMR vendors are producing a CCD that is standard today, and is not just the one that got certified in testing, but it is actually what comes out in a practice when somebody pushes the button, that's one.

Two, that there's a trigger to automate the sending of that CCD, so it doesn't have to be manually done every time, or you won't get the data. And then the third is, that it has to be forwards and backwards compatible, whatever that format is, because we're going through an experience now where people are upgrading their EMRs, just to the next service pack, and their CCDs completely break. So, those are 3 critical elements to ensure that just like the claims data is standard enough to have built measures on that have lasted for years, we make sure our clinical data is standard enough to build measures on that last for years.

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

So that would mean a capability for a registry, to make sure I'm understanding. If you were to make a recommendation, it might be the capability of a registry to receive from certified EHR technology, a QRDA at the patient level with the data for that – the clinical data for that patient that is relevant to the numerator and denominator, and – well, to be able to send that – to receive that from an EHR and for the registry to be able to send back some report of a measure calculation to the EHR.

David Kendrick, MD – MyHealth Access Network

Yes. The receiving end, the EHR end of it, is a little more difficult to control, but certainly the data out to the registry to do the calculation should be very standardized, well based on what they're prescribed to put out now.

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

The only – this is Saul. The only problem with making that restriction is that you'd be restricting yourself to measures that – to data elements and types of data elements that are covered by the meaningful use clinical quality measures. So for example, the example you gave before about the patient, I forget what you called it, but the patient generated data wouldn't really fit cleanly today into the QRDA framework, because it's not part of the Meaningful Use 2.

Norma Lang, RN – University of Wisconsin

This is Norma Lang. Could I ask, how – registries seem to be a very narrow approach, and I hear a couple of you speaking about the broader one. Listening to some of the most recent webinars that are going on among all the vendors and there's a large move towards the large data sets, big data and analytics and not really necessarily wanting to do only these narrow pieces. What – how does what we're trying to do here relate to building those large data sets – and who owns them and who governs them? They're more than data warehouses, they're talking about how to build this and into cloud access, etcetera. It just seems to me we're just doing a small piece here and maybe that's all we can do. Can somebody help me understand how those two developments – and I might add that I also listened to the HIMSS press conference of some of the biggest vendor presidents who said they would be making a commitment to interoperability, to move this along and I wondered if anyone else heard that and whether that will help our work here move along. So, two parts to my question, I guess.

Russell P. Branzell, FCHIME, FACHE, FHIMSS, CHCIO – College of Healthcare Information Management Executives (CHIME)

This is Russ. I'll try to give some perspective, and maybe Jesse can jump in on this, that we have started some work with that. Two of the largest of the big...analytics companies Health DataWorks and Health Catalyst have stepped up in wanting to work with Jesse and the team there in some of this proactive testing on the front end. And I think that really what that does is that gives you some testament to the complexity within the provider organizations, whether they're eligible providers or eligible hospitals, with how hard it is to aggregate this data, that most will need some large, outside data aggregator to pull all this data to make sure it's workable over a long period of time, which is one of the comments made earlier. And I think we're going to see that starting to play out more and more in the marketplace, that it may be less the primary application vendor that's doing all that data aggregation but rather a third party that wants to be involved in that and keeping that data normalized.

As to your second question, having been there as well and talked to some of those organizations, they're part of our CHIME Foundation, I think this is a great step forward. But it's probably going to take a considerable amount of time, maybe well outside of our time frame for these things to get accomplished, to see that true level of interoperability to occur. Because a lot of them are working on products too for their next updates for meaningful use, for ICD-10, for blah, blah, blah, blah, blah, and it's just going to take a considerable amount of time for them truly to be interoperable. That's just my perspective on it.

David Kendrick, MD – MyHealth Access Network

So this is David. In answer to your first question, I believe – the way I view the use of data is either at the point of care when I'm making a decision about a patient, or an aggregate for things like reporting and registries we're talking about today. And I think the health information exchanges backed up by robust analytics platform and governance, because that obviously requires community governance to put in place, is a pretty efficient way to do this, because the people supplying data to health information exchanges have a great interest in it being accurate and mapped, when they're dependent on the analytics that come out the other end of it. So, you've killed two birds with one stone if you get good data to doctors at the point of care, when they're trying to take care of patients, but you also get good analytics on the back end for them if you tie the two together. And it can be a third party working with an HIE, but however, it's structured, the governance becomes the critical element.

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

Norma, I'm glad you made that point because we did earlier discuss how to define a registry, and up to this point we often in our conversation move towards the professional societies. But to the point of having HIEs or your quality cube for a large delivery network functioning as a registry and I think they'd probably also be more likely to be comfortable, and have more experience with handling EHR data and doing analytics on EHR data, there are several actors that are ahead of the curve in this area that we can learn from. But that also reminds me of David Lansky's point on the work of California Joint Replacement Registry, that they're of course some registries that have more experience in using EHR data and they might also be good templates or comparables or exemplars for this program.

Helen Burstin, MD, MPH – National Quality Forum

Yeah. And this is Helen. Just I think building on what Jesse's saying is where I actually went up and you also attached to the invite the actual RFI from CMS and it does specifically talk about data reported to specialty boards, specialty societies, regional healthcare quality organizations and other non-federal reporting programs. So that may narrow it a bit, I think to the broader vision we were talking about. I think that's still relevant, but I think for the question at hand, I think a lot more of the discussion currently is about how we might handle data that otherwise is living in really fairly disconnected registries without much of a tether to an EHR. Kevin and I had a brief conversation with David Shahian today, who's running the National Quality Registry Network. And I think it might be appropriate for us, on a future call, to bring David and perhaps a couple of more advanced registries and just – the clinical registries, to really get more of a handle on how many of the data elements within their registries would even be something logically within a current EHR versus how many could we at least give them perhaps a core set of elements within an EHR that would add value to the registries. So, those seem like some important questions as we think more specifically about the somewhat narrow range of registries as listed as part of the RFI.

Ahmed Calvo, MD, MPH – Office of Health IT and Quality, Human Resources and Services

Administration – Senior Medical Officer

This is Ahmed. I want to add one other comment. We keep talking about big data as if what we're really trying to do is build giant data repositories, and I would like to challenge that idea a little bit, because it could be thought of as an algorithm, a query algorithm. In other words, a conceptual query into different EHRs to build kind of a functional registry for the purposes of whatever the query might be, in which case going out to the different databases, i.e. the different EHRs or the different whatevers from other sources as opposed to just the clinical record of a hospital or medical practice, is a functional way of thinking about registries that is different than the traditional way of looking into the question of registries. I, for one, am not making the assumption that big data equals a giant repository, it could actually be a really smart algorithm that functions as a registry. And so I want to just put this out there right now, because I think we may inadvertently be locking ourselves into a method approach, which I think is a leap of logic.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration

This is Terry. I'd really like to echo that because I think in the future, the registries may all be semantic web ...

Ahmed Calvo, MD, MPH – Office of Health IT and Quality, Human Resources and Services

Administration – Senior Medical Officer

Yes, exactly.

Theresa Cullen, MD, MS – Veterans Health Administration – Director, Health Informatics

... pulling data in, and so I – I'm really glad you brought that up, because what we don't want to do is constrict ourselves right now with what the current technology is, because there are going to be quantum leaps pretty fast.

Kevin Larsen, MD – Office of the National Coordinator

Yeah, this is Kevin. Terry, to your point earlier, I really like the idea of setting some parameters, some functional outcomes of what a registry is rather than...so what do we want it to do, rather than defining exactly who's in and who's out.

Helen Burstin, MD, MPH – National Quality Forum

Okay. Other thoughts from anybody?

David Kendrick, MD – MyHealth Access Network

This is David. I would just agree that the future does hold smarter equations, but let's not skip the step where we have to aggregate enough data to educate those equations.

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

And this is Westley. We want to make sure that the registries can actually benefit behavioral health consumers as well as providers in the behavioral health community, and they often don't. So, I like the way the discussion is going.

Helen Burstin, MD, MPH – National Quality Forum

Okay. Well this is Helen. It sounds like a lot of good suggestions here, it sounds like a great deal of support for thinking about how we might come up with a list of functional outcomes, perhaps more of core capabilities of registries, both now as well as in the future. And consider some of the innovative pieces, for example connections to PROs, connections to clinical decision support and begin to understand what might be those important capabilities we want to make sure we have, as David said at the outset, about flexibility, feedback loops, benchmarking. So, Jesse, what's the logical way to proceed here in terms of queuing up future conversation.

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

So, I will take from what we've said. I think we start with the large question, how should registry be defined, and we've answered. I think there's consensus around a registry is, what a registry does, so I'll set up some requirements from what we've described, interoperability, quality analytics, reporting, and send that to the group to react off. And so that would be a goal of this – as we describe the functional requirements, I think that also will answer some of the other questions about interoperability standards and receipt and sending data. So, I think the functional requirements of a registry will answer the additional questions we had. But what we may not answer would be what the policy levers should be, but that's maybe a follow up discussion.

Helen Burstin, MD, MPH – National Quality Forum

And one thought Jesse, it might be helpful to pull some of the work AHRQ's been recently doing around registries, just in terms of some definitional items, to kind of help move it along. Again, as I sort of scan through the document as well as in talking, not a lot specifically about relation to HIT, but I do think there's some really valuable definitional work in there that might be helpful.

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

Yes, excellent. That came up in the Data Intermediary call; they started with the AHRQ definition. So yes, absolutely.

Helen Burstin, MD, MPH – National Quality Forum

Okay. Okay.

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

Are there any other questions or comments from the group?

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

This is Cheryl Damberg. I'm sorry I joined part way through the call, so you may have already covered this. But I'm thinking back on my experience working with registries like the ACC or the STS and I recognize we're kind of in a transition period where a lot of the information may be captured in electronic health records. But I know from my experience using data from those two systems, that the data integrity issue is front and center, because the people in all the different facilities code things very differently and I wasn't sure where that comes up in this discussion. Because it isn't clear to me that a lot of EHRs are capturing some of the detailed clinical elements, and where those potentially would be captured in the workflow and where say a surgeon or a cardiologist would be entering that information directly versus relying on someone else to enter information from some other source?

Helen Burstin, MD, MPH – National Quality Forum

Yeah thanks Cheryl, that's a great question. I think this whole issue of, for example, the way many of the large clinical registries, like ACC and STS, have a certain portion of charts that are auditable every year as part of the process. So it's something we have to think about how that flows over into a more electronic environment.

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

Yeah. I definitely think you're going to have to have some sort of training standards and audit functions ...

Helen Burstin, MD, MPH – National Quality Forum

Yup.

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

... as part and parcel of this, because there are variables such as the New York Heart Association Classification, I think it's a scale of one – four and how different parties and different hospitals interpret that terminology and code things. And it has considerable impact in terms of running outcome measures.

Helen Burstin, MD, MPH – National Quality Forum

Yeah, it's an excellent point. Was there another comment, or it's just me echoing. Okay. All right. So I think we're just about at the time for public comment, unless there are any other questions. MacKenzie, shall we open it up for public comment.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the line for public comment?

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

Helen Burstin, MD, MPH – National Quality Forum

Great. Thank you.

MacKenzie Robertson – Office of the National Coordinator

Great. Thanks everyone. So I think, Jesse do you have the next meeting?

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

The 22nd.

Helen Burstin, MD, MPH – National Quality Forum

Great. And perhaps Kate, as you are getting the RFI responses, if there are any that are specifically relevant to this HIT piece, maybe we could try to queue them up for this group as well.

Kate Goodrich, MD, MHS – Senior Technical Advisor, Office of Clinical Standards and Quality, Centers for Medicare & Medicaid Services

Yeah, that would be good. I'm not sure if I can join on the 22nd, but I could share with Jesse what we've gotten that's relevant to this, so that it can be shared.

Helen Burstin, MD, MPH – National Quality Forum

Perfect.

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

Excellent.

Helen Burstin, MD, MPH – National Quality Forum

Okay.

MacKenzie Robertson – Office of the National Coordinator

Thanks everybody.

Jesse C. James, MD, MBA – Office of the National Coordinator
Thanks all, enjoy the spring weekend.