

**HIT Policy Committee
Quality Measures Workgroup
Transcript
July 1, 2013**

Presentation

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – 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 public comment on the agenda and the call is also being recorded so please identify yourself when speaking. I will now go through roll call. Helen Burstin?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Helen. Terry Cullen? Kathleen Blake? Chris Boone? Tripp Bradd? Russ Branzell? Cheryl Damberg?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Hi Cheryl.

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

Hi.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Timothy Ferris? Letha Fisher? David Kendrick? Charles Kennedy? Saul Kravitz? Norma Lang?

Norma Lang, PhD, RN, FAAN, FRCN – Professor of Health Care Quality & Informatics – University of Wisconsin

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Norma, thanks. David Lansky?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, David. Marc Overhage?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Present.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Marc. Eva Powell? Sarah Scholle? Cary Sennett? Jesse Singer? Paul Tang?

Paul Tang, MD, MS – Vice President, Chief Innovation & Technology Officer – Palo Alto Medical Foundation

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Paul. Kalahn Taylor-Clark? Aldo Tinoco?

Aldo Tinoco, MD, MPH – Physician Informaticist - National Committee for Quality Assurance

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Aldo. Jim Walker? Paul Wallace? Mark Weiner? Olivier Bodenreider?

Olivier Bodenreider, MD, PhD – Staff Scientist - National Library of Medicine

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Olivier. Niall Brennan? Ahmed Calvo? Carolyn Clancy? Westley Clark?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Westley. Kate Goodrich? Daniel Green? Peter Lee? Marsha Lillie-Blanton? Michael Rapp?

Michael T. Rapp, MD, JD, FACEP – Office of Clinical Standards and Quality – Centers for Disease and Medicare & Medicaid Services – Department of Health & Human Services

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Michael. Steven Solomon? Tony Trenkle? Jon White?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Jon. And, any ONC staff members on the line? Jesse James?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

I'm here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Jesse. Kevin Larsen?

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

Yes, I'm here, this is Kevin.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Kevin and Elise Anthony?

Elise Anthony – Senior Policy Advisor for Meaningful Use – Office of the National Coordinator for Health Information Technology

Yes, I'm here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Great, thanks, okay with that I will turn it over back to you Helen.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Great, thanks so much MacKenzie, apologies for being late. So, it looks like a small group to start with and people tend to join as the hour begins. So, we have an exciting presentation today so I don't want to delay it with much discussion other than welcoming I guess Marc is going to do the presentation for us. This is an important discussion for us since we will be reporting this out to the Health IT Policy Committee next week and it obviously has implications for the path forward for Meaningful Use Stage 3 and other initiatives as well. So, with that Jesse are you going to run the slides from AHRQ or how would you like to – should I just turn it over to Marc?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

You can turn it over to Marc and the contractor should be running the slides.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Wonderful.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Marc, I will just ask if you could say next slide so they know how to keep up with you.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Absolutely.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And Jesse, please feel free to jump in, Jesse has been incredibly helpful in supporting the group's discussions and putting things into a form that we could share with others. As you can imagine a lot of rich discussion and sometimes difficult to distill it down to something that is interpretable and operationalizable, if that's a word, and Jesse has been super about helping drive that. If you could go to the next slide?

Everybody in this group knows that we chartered this group, the Data Intermediaries Tiger Team, to look at specifically a couple of question but driven by the thinking going into the preparation for Stage 3 and asking the group specifically, as you can see here on this slide, the charge was, as you see here – and one thing I'll point out here is that as we went through our discussions it was clear that – and there are obviously many different groups and different activities looking at this question of data intermediaries not just this Tiger Team but this Tiger Team was tasked to focus on reporting and feedback and not necessarily the somewhat broader scope that often comes up in these discussions around quality improvement. Presumably people use these measures for quality improvement but the actual sort of process of doing that was not in the charge. So, if you can go to the next slide?

And just a little bit of review for some of you, but in response to the Quality Measure Workgroup portion of the Request for Comment in Stage 3 Meaningful Use there were a couple of questions that were sort of relevant and helped to inform this discussion and if you can go to the next slide.

Specifically, the question about please comment on the desirability and feasibility of such an innovation track, meaning around quality improvement, quality measurement as an optional component for Meaningful Use CQM requirement and as you can see the vast majority, 72 percent, supported and the 15 percent of the respondents to this survey had some objection to that notion of an optional component of an innovation track.

Now on the next slide the question should we pursue a conservative approach that limits development to professional societies and IDNs or an alternative that opens the process to any eligible provider or hospital within certain constraints? So, these are I think numbers as opposed to percentages, our PowerPoint skills are sometimes limited, if we had a consultant it would be perfect, you know, but you can see that a moderate majority of folks wanted to keep this fairly open and not overly constrained, at least in the survey.

And on the next slide, should we constrain development in the innovation track with standards for e-Measures that are already in place and the vast majority thought it should be constrained with 20 percent thinking minimal constraints, and this you'll see come back in our discussion in just a moment from the Tiger Team. If you can go to the next slide and I'll take a breath here in a moment if folks want to comment on these.

Just to remind folks that the – as I said there are several activities looking at this question and the CMS request for information on data registries earlier this year asked specifically about what types of entities should be eligible to submit quality measures on behalf of eligible professionals for both PQRS and the EHR Incentive Program and what qualification requirements should be applicable to such entities. There are several of these related questions sort of rustling around here.

So, specifically as we started to launch the work a couple of months ago of this Tiger Team we wanted to focus on the issues, make sure we covered the issues of privacy and security, data quality, standards alignment and measure innovation, you know, starting out anyway, we thought those would be some of the major issues.

And we launched that with the guidance from the Quality Measures Working Group of thinking about how we could encourage broad participation in this measure process, how to maximize interoperability and standards use, how to ensure data quality and how to support innovation and e-Measurement. Let me pause there and see if the group has questions, comments or anybody from the Tiger Team who might be participating in the call have things to add or clarify about that before we launch into the sort of recommendations that the Tiger Team came up with?

It's all perfect, good. Well, we'll fix that; we'll get controversial in a minute here. By the way I should acknowledge, you know, as always these groups there is a lot of folks that contribute to and in addition to Jesse, Micky Tripathi and Eva Powell who served as Co-Chairs were very, very instrumental in helping keep the process moving along and making sure we got broad input from everybody, so I just want to make sure we acknowledge in addition to just the – participation the contribution of those individuals.

So, if we go to the next slide what we basically did is came up with a framework that listed a variety of attributes or issues related to data intermediaries and then for each of those we laid out some short-term recommendations for requirements and some longer term recommendations for requirements, recognizing that as always these sorts of things have to be a transition and then we had some sort of subcategories within there, but really summarized just a couple of the key points here for you and there is some more detail behind these that we can share with folks if helpful.

So, the first, and this partly reflects Marc's anal retentive approach to the world, you know, the first thing is getting the data, right? So, accepting EHR data for clinical quality measure calculation was the first sort of topic and we're going to go through a number of the topics here.

And the Tiger Team came up with a short-term and a long-term recommendation here where the short-term was that a data intermediary would need to be certified to the 2014 certification criteria and function as a certified EHR module and that they would accept quality reporting, document architecture Category 1 data consistent with the current standards approaches and certification approaches, but that in the longer term that intermediaries would in addition to being able to accept whatever standards had evolved that would be parallel, if you will, to the QRDA Category 1, to allow other proprietary – and it says data quality reporting formats but it really means data quality or proprietary data formats for quality reporting.

So, let me – I thought we'd walk through each one of these and pause on each set of recommendations for discussion if that sounds like a reasonable approach to folks? So, let me pause here and see what discussion or feedback we might have or would you prefer Helen that we went through them all and then discussed them?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

No, I think it's fine to stop in fact I have a question, so, thank you for stopping. Can you give, now that that phrase went away I think I can wrap my arms around it, can you give examples of what would be proprietary data formats for quality reporting? Just to make sure, it's such a mix of words I want to make sure we're all on the same page.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yeah and I think the notion was how do you open the door for different kinds of data to be used in quality reporting whether that might be data that comes through some kind of registry input process, whether that would come from claims data, whether that would come from, you know, a variety of other places, in other words the assumption was that not all of the data that these intermediaries would use in quality reporting would necessarily get filtered through an electronic health record.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

I see, I think it was the word proprietary that was throwing me a bit, thank you.

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

Helen, this is Kevin Larsen, I think there was also discussion about some of the registries or other systems have been using other data formats for a long time and so those data formats maybe owned by that registry already and it maybe a different process from what we've been describing for this national standardized quality measurement.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Got it, thanks, that's helpful.

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

Marc, I have a question, this is David Lansky, I have a question Marc?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yes?

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

The question, I don't have an opinion about it, I'm just wondering if the requirement hasn't been certified to the 2014 certification standards is there any risk that it creates an unnecessary burden on this intermediary function because it's associated with any of the requirements that are attached usually to a primary function of an EHR or are the certification standards for this purpose un-burdensome enough that are competent to the computing and archiving data function can still pass?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And there was certainly discussion about what the data intermediary would have to do here and I think a part of the balance stated in the dialogue was about burden on the participants with the data intermediary and what we could expect that they would be able to deliver from their health record and in particular as would be somewhat constrained perspective that the Tiger Team was looking at this problem was focused on the Meaningful Use measures that there were already structure for representing that data and that from a testing stand-point if you were going to certify this data intermediary and you were proposing that they would be a certification EHR module they would have to be able to consume that.

So, certainly there are tradeoffs there that, but part of it was just trying to find a balance between the rest of the infrastructure, changing around them versus the data intermediary having to do work and certainly everybody acknowledged that this then would imply the data intermediary having to do some new work.

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

Is it assumed or not that identifiable data needs to pass through the intermediary?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

I don't believe there was any explicit discussion about that that I recall but others on the call from the group could help me here. I believe that given the way the QRDA is structured you would be – it does not absolutely require that type of identifiable data, but I think in most cases does. Does anybody else from the group have recollections or thoughts about that?

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

David this is Kevin, I think that the kind of discussion that the Data Intermediaries Tiger Team was having was really around Meaningful Use and how these other activities would kind of give credit for Meaningful Use. So, I think that is a question that it would be really worthwhile to discuss either at the Quality Measures Workgroup or at the Policy Committee. I don't think it was explicitly discussed at the Data Intermediaries Tiger Team unless Jesse or others remember it being discussed there.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

No, this is Jesse, I don't recall that. I do recall for this area the recommendation being surprisingly strong that the intermediaries be able to have some floor capability so to speak and that floor being set by the quality measures, perhaps not all of them, but a subset of the quality measures that are in the Meaningful Use Program and whatever future set of measures those are that intermediaries be able to play by the rules to be able to create the measures, calculate measures and certify a basic set of measures for that program.

And then the group began to discuss the additional capabilities and requirements they might fulfill to allow or enable quality improvement, but there was a surprising amount or what I thought to be a surprising amount of consensus on a basic ability for intermediaries to play by the rules in Meaningful Use.

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

Well, I would like to put forward for future discussion there is – I think it's a threshold issue and if, I think for future measures we probably do need to aggregate by person across multiple data sources so you do need identification. For the older measures that are probably not necessary, I'm just guessing, maybe I'm wrong, and if it's not necessary creating a barrier to entry for data intermediaries seems problematic. I know in the registry world this is a big issue.

So, I think we need to speak to both sides of the line, to what degree maybe it's none, but to what degree there are HIPAA compliant and non-identifiable data that's appropriate for infrastructure or is it assumed that everybody has to be qualified to all the privacy and security standards.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Hi, this is MacKenzie, I'm just going to add a reminder if you are not actively speaking to please mute your phones, there is a lot of noise in the background, thanks.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And David, I think we'll come back to this topic in a minute too when we talk about attribution logic. So, that's clearly a topic that needs further discussion whether with this group or the Tiger Team, or the Policy Committee. So, we'll certainly call that out for the discussion next week. Other discussion about that here or other topics folks would like to rise?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Let's keep going Marc.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Okay. So, the second one is a little bit more, if you'll go to the next slide, motherhood and apple pie ensure the quality of data transferred and stored wherein the short-term the data quality focus, again driven by the same sort of issues we were just talking about was around the same as the certification criteria for Meaningful Use Stage 2 and in the longer term obviously as innovation measures would come in and so on there would have to be a level of – and the only method we came up with was attestation that the data represented the process note, obviously you have to reflect some kind of agreement and relationship with the providers, which is critically important in these organizations and that there would be some kind of audit opportunity.

So, this just really reflects how we do data quality and other processes and venues, and we didn't come up with any more clever ways to do that for data intermediaries. Are there questions or suggestions about that recommendation? There are more fun ones coming up, don't worry.

If we go to the next slide then, and this bears a little bit or comes back a little bit to your point, David, about identify ability, but the notion that there is in a data intermediary some kind of patient provider attribution logic, in some cases that is as simple as provider A submitted the patient therefore that patient, we're are going to attribute to them, but it could be more complex.

Certainly as you evolve additional data or a in a variety of care paradigms, so in the short-term, again driven by the EHR Incentive Program requirements that would provide the guidance in the short-term and then the long-term that there could be proprietary attribution logic, but that should be transparent to both the providers and the federal stakeholders at least then you would hope any other commercial entities they had a relationship with but given our focus on MU2 the federal stakeholders.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Marc?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yes?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

This is Helen, can you explain the logic of making transparency long-term? I mean, it is sort of a standard we already have for example for many of these kinds of systems now, it just seems like a step back to say that's a longer-term event.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

I think the notion was the approach as outlined in the Meaningful Use Program is transparent already so it's not really stepping backwards it is saying that as we allow other attribution approaches in the future they too should be transparent.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Right.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

So, I guess the implication was it is already transparent so we don't even have to say that explicitly, but maybe that would help keep the consistency clearer that word in the first short-term recommendation.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

That would help.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Other thoughts?

Aldo Tinoco, MD, MPH – Physician Informaticist - National Committee for Quality Assurance

Hi, this is Aldo Tinoco from NCQA, I think the long-term approach appears to be flexible. I guess what is not clear to me right now is if there is a reporting program that is downstream waiting to collect information from multiple intermediaries although transparent that variation and attribution logic may create challenges to actually comparing performance across sites of data intermediaries so that we're shifting the cost a little bit.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And this is one of those fundamental pivot points that we kept wrestling back and forth on is how do you bring consistency and still at least provide a modicum of room for innovation and flexibility. The alternative approach to something like this that we discussed was, you know, that you could have sort of a developmental pathway but then you would have to have some kind of adoption of that at a much broader level in order to meet the criteria that you were just describing and I think that is where we kept coming back to this tension without a great resolution of how to provide that level or provide enough flexibility and yet provide consistency for reporting and comparison purposes.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

All right, onward. Are you still with us?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Sorry, just muted. So, obviously we can come back to these or look at some of these issues at a broader level, you know, including, you know, this is a good example of where the balance between allowing for innovation and trying to achieve a level of consistency that is useful for reporting and tracking, and measurement are definitely at odds and we didn't come up with a great resolution of that. So, that maybe a topic we want to come back to at the end.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Yeah, agreed.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

So, if we go onto the next slide. So, this gets a little bit more fun. So, the calculate meaningful quality measures from EHR data for Meaningful Use credit, so in the short-term the notion was or the recommendation is that providers would only receive credit, and again this is just for the Meaningful Use part of the program we're not commenting necessarily about PQRS or some of the other programs, that they would receive credit only for measures that are part of the program and this really reflected sort of the reality of in a year or two you just can't turn all these things on a dime and that trying to allow alternative structures and so it just didn't seem feasible in the timeframe.

So, the longer term, and as Jesse said, this actually came through quite strongly in the group and I think actually reflects the results of the survey, that we briefly mentioned earlier for the Meaningful Use Workgroup, that there would be a minimal set of standardized quality measures that approximate the core measures for the EHR Incentive Program that everybody would have to use but at the same time data intermediaries would be encouraged to develop proprietary measures and providers would receive credit for reporting on those intermediary developed measures via standard reporting mechanisms and the notion that, and this got tossed, that those innovation measures or proprietary measures would still have to meet a minimal set of criteria which are on the next slide, which why don't we go to, because that sort of gets at the heart of trying to strike the balance.

But the other thing that we touched on as we were dialoging about this in the Tiger Team too was that, and this gets back to the balance of consistency versus innovation, was that to a degree a difference here is that presumably providers would elect to participate to an intermediary. They would still have the sort of standard pathway but they could elect to participate to a data intermediary so at some level there is a degree of choice that they may be exhibiting in working with a particular data intermediary and where they may be willing and sort of are accepting by working with that data intermediary taking on some additional effort or some additional processes that they might not otherwise feel like are appropriate.

So, that's another kind of underlying principle that I think the group commented on several times in its dialog although it is not explicitly represented here in the recommendations they were sort of more an assumption that drove some of the recommendations.

So, I'll let people read through these at their leisure here while we discuss this sort of recommendation of near term, EHR Incentive Program measures only, longer term and we threw out some percentages of the mixture of core and innovation measures, but didn't really settle on anything strongly enough and thought we'd punt that to this group to come up with that, a percentage if we felt like we needed to make that level of recommendation to the Policy Committee, but there was some discussion of sort of core versus menu similar to what is in the Meaningful Use Program felt comfortable to a lot of people.

Aldo Tinoco, MD, MPH – Physician Informaticist - National Committee for Quality Assurance

This is Aldo again, just kind of being nitpicky for item A should that be ambiguous or unambiguous logic?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

I assume that's ambiguous, Aldo, but...

Aldo Tinoco, MD, MPH – Physician Informaticist - National Committee for Quality Assurance

Yeah, I'm...

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

We trying to have it be consistent with Meaningful Use.

Aldo Tinoco, MD, MPH – Physician Informaticist - National Committee for Quality Assurance

No comment, but just...

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Other comments, thoughts? I'm a little surprised – I would have thought – we spent a lot of time on the Tiger Team on this so I'm a little surprised there is not more dialog here and I think there was a real tension. I think there was a desire to sort of say "yeah, let's do all this cool stuff" and on the other hand people going "oh, man how do we make that, you know, back to the balance with consistency and so on."

So, you know, we even got in the discussions here of "okay, I'm going to become a data intermediary and I'm going to create the one stupid measure, you know, that's good enough to pass muster and doctors will love it because it will be so easy, which obviously isn't the intent here, but this was probably the most controversial topic I think that we discussed in the Tiger Team.

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

So, Marc, it's David, I had just a couple of questions or comments, one is while I generally think the approach is really good it's elegant and I overall think it is good and the details of course are important. One of the details is who blesses the innovative measures as conforming to the criteria that are here or whatever we end up with.

The second thought I had is it would be helpful, maybe delicate, but helpful to have some examples of how this might work that are somewhat familiar to people and so I'm imagining for example a slide or an illustration that takes something like the ophthalmology registries or the cardiac registries and says, how would this look for them.

So, what would be the core measure they would have to be capable of managing and what would be the innovative measures that hypothetically they are working on or interested in that would be supplemental to the core and with the ones that we're now – you know, we understand that have either gone through NQF or are pretty well understood would they be tractable to this model?

I'm thinking the ophthalmologist have been talking about a couple of functional outcomes measures for example that would be what they want to do as innovative, you know, how would that look in this framework, is that something that they could realistically achieve in the next couple of years and I don't know the answer, but it would be good to play that out a little bit.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Yeah, that's an interesting example, David, this is Helen, since we've actually endorsed their functional status measure of post cataract.

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

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

It might be an interesting one to kind of walk through this example.

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

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yes.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

I have a fairly simple question, I think, Marc, on D when it says innovative measures that use multi-source data, is there an implication that multi-source data also equals registries? It is not listed there; it just seems like an odd one to leave out of that for example.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

I don't think there was any intention to leave it out, you know, how data gets into registries can take many forms.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Okay.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And I think the intention was just to leave it open in the sense of we weren't trying to prescribe how the data got captured as long as it met the data quality measures and resulted in a meaningful measure. So, I think it was just trying to leave it as open as possible.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yeah, Helen for clarity the Tiger Team tended to be looking at the registry as the intermediary.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

That's what I thought.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Are you asking should the intermediary be the source of data?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Yeah, that's what I was trying to understand?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

That the registry, I'm sorry, be a source of data to the intermediary?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

I was trying to understand that; yes that was my question, yeah.

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

And Helen, this is Kevin Larsen, I think one of the other tensions here is that registries mean different things to different people.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Oh, yes.

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

But in one part of this discussion was for Meaningful Use that this has been EHR generated data – registries is in Part 1 about if the registry utilizes some form of chart abstraction where does that fall in as a data source.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

I see.

Aldo Tinoco, MD, MPH – Physician Informaticist - National Committee for Quality Assurance

So, I had – this is Aldo, I'm going to throw something out there just for a reaction. We developed clinical quality measures both for our programs and under contracts and grants, and I wonder would not any quality measure innovative or otherwise still need to meet those fundamental underlying endorsement criteria that are set forth and mentioned not only on a CMS blueprint but also that we see in different quality programs and if so would these criteria that I'm seeing on screen be above and beyond that fundamental set of what makes a good measure a good measure or is this replacing that?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

I think we were trying to come up with as low a bar, so I would say I think as we discussed these and that this was more of a minimal set of criteria as opposed to an additional set of criteria with the notion of how could you, again with part of the charge trying to say, how can you encourage and allow innovation in measurement. So, if it was on top of that will probably – you know it seems that would not be helping.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yes, this is Jesse, to your question Aldo, if you think of the current process as delivering measures to Meaningful Use measures that are ready to be used in other programs inside of the federal government and that require a higher bar of perhaps validity, reliability and conformity to the standards that are in place.

And then what we heard from our responses to the RFC was perhaps allowing for both measures that are innovative but also measures that are focused on clinical areas that perhaps are not as well covered in the current set of measures and to deliver on that and to deliver within an amount of time that allows perhaps the professionals societies, registries, analytic companies to be active in this space if our bar for measure development is too high then that might become itself a barrier to entry.

So, without asking the societies or asking the ACC to be as nimble and capable of measure development as perhaps an organization like NCQA is but given them the capability of using EHR data, introducing them to the process and then allowing their members to use their measures are especially meaningful to them as part of the program and as part as an innovation path, that was more the goal we were going for by having what is perhaps a lower bar for measure development for new actors to the space.

Aldo Tinoco, MD, MPH – Physician Informaticist - National Committee for Quality Assurance

Thanks, Jesse that makes a lot of sense and puts things into context. When I look at this from a – I was trained in public health and population health and when I look at this and think about some of the concepts you said, wow this is a phenomenal approach for developing population level metrics or community-level metrics.

The big question in my mind is, you know, of course, that translation of something that would directly benefit an individual provider or an individual practice. I think that there is a great amount of innovation out there for some of those community-level or population-level measures of health and quality of care that are needed that is an unfulfilled gap. So, hopefully, this will start opening the door for that type of measurement as well.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

And this is Helen again, just one question on E there, so is the expectation that the word quality reporting was intentional rather than necessarily quality performance?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yeah, this gets back a little bit to the preamble of the focus was on measurement not on improvement, whether that is correct or not that was the charge.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Well, I mean, one could make the argument these could be incredibly useful for quality improvement I totally get that. I mean, I don't see that as the distinction. I guess the question would be if you're saying they could float on multiple programs where at times you may be held accountable for the actual result of your performance measure.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Right, right.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

And particularly incentivized for that result is that what needs to be distinguished?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Gotcha. I don't think we were trying to make that distinction, you know, I think if the measure were useful to the program great.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Okay.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Let's go to the last, sort of recommendation's slide, and then we can kind of either revisit things or have broader conversation. But, again these are a little bit more motherhood and apple pie, but still perhaps raise some questions. So, in terms of reporting to the public the thought was that in the short-term, as with the Meaningful Use Program, they would not necessarily be reporting scores to the public but then as that evolves the intermediary should follow that.

We got a little more specific in terms of reporting to HHS that current reporting would be consistent as we've done in the short-term for most things with the Meaningful Use Stage 2 measures using an aggregate of QRDA Category 3 report and that would again mimic those going forward.

And lastly, and I think there is a fairly strong sentiment that feedback and interaction with the providers was key to this that while, as I said, it might be perceived as being a little more of a choice who they worked with and so on that the intermediaries might be expected to create reports that the providers have access to that they could then use either for tracking or whatever other purposes they might have including helping with data quality and things of that nature. So, these we thought were perhaps a little more straightforward.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yes and just to add to the report to providers we left off benchmarking. Benchmarking was seen as an activity that would be very important to report to providers not only their performance but their performance relative to other similar providers and that intermediaries could especially play a role in this space if we expected for them to have similar types of providers reporting to them.

And just to add some information on the report to the public, one of the – a point that came out of the Intermediary Tiger Team was that the intermediaries somewhat owed the public a greater amount of information on their – and transparency into the innovation measures going forward since the participation in the program was a boom to the intermediaries and the data would be a boom to the intermediaries but they could payback that goodwill to the public by having more transparency into their measures.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

So, those were the basic, as I said there are sort some more details in going through these, there are a few, you know, some of the group caught and I marked a few other wording sorts of things and clarification that we talked about.

Are there comments or discussions, especially at that macro-level about the balance between the innovation and the ability to use the results of these for quality improvement and monitoring, and tracking? Because I think that was the hardest thing for the group and we just kept going back and forth and spent an awful lot of time trying to come to some comfort level on that and I'm not sure we hit it right, but – maybe not too far off then.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Okay.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Great.

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

Marc, this is David, I'm just pausing on the first one. The no reporting of scores to the public for Meaningful Use, I don't really know what the original premise was behind that and now I don't know whether the Policy Committee at least, but obviously, you know, what the Intermediary Tiger Team thought, whether that is something – what does short-term mean? How long do we think that's true?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

We had sort of used throughout the discussions here sort of two to three years as short-term for the Tiger Team purposes.

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

I guess I'm wondering well – I'm wondering whether this is sort of out of scope for the intermediaries discussion unless there is a particular reason why they favor this as part of the functionality or, you know, startup process for the intermediary role, whether or not it's appropriate for CMS or others to require public transparency of these measures seems to me independent of the intermediaries function, that maybe the innovative measures you're saying should be more protected? So, I'm wondering, maybe it's a distinction between the traditional measures and the potential innovative measures and how they should be treated in terms of public capability?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Well, I think the notion here was just to mirror whatever, as you said, not to sort of take on things that weren't sort of in scope but to just mirror whatever the Meaningful Use process was and that data intermediary measures were no different than directly reported or other quality measures so just follow the process. I think that's the general notion.

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

Okay, so I guess I'm just trying to understand if this is really about the innovative measure that is we're assuming that the normal rules and processes apply to all the other stuff, but the ones that are coming through the innovation track you're making a recommendation about whether or not they should be visible to the public or when.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

I think we're saying that all measures whether innovative or the standard Meaningful Use measures would be reported to the public following the same policies and timelines as CMS would evolve for standard Meaningful Use reporting.

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

Okay.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

So, no special treatment if you will.

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

Okay.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And we perhaps said that badly so that's another place we can work on the language here.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yeah, I'll make that clearer on the next version.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Well, Helen, I'll turn it back to you, if there are any other thoughts or comments obviously we'd welcome the feedback and we'll try to clean up some of the language and things in response to this discussion. I guess the other question though is, you know, are there any significant aspects of intermediaries that we failed to touch on?

So, we tried to sort of create a framework of here are all the issues and then comment on all of them with a somewhat simplified version but not too much of that. Are there things that we missed here that we didn't say anything about that would be critical for these intermediaries? Great, well, thank you all for your feedback on this and Helen?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Yeah, thanks Marc that was really helpful. There were a couple of questions sent in on e-mail earlier and I guess Peter Basch and Tripp Bradd had sent in some thoughts, some questions and I wasn't sure if you saw any of that? So, I guess there is a question of, you know – one of the questions are is data intermediaries the only group that would be allowed to innovate eQMs and then I think a question many of us have asked, you know, what is meant by innovation?

Sort of some broad-based questions, maybe some of these are ones we can take a closer look at Jesse after the call, but I know Tripp had also sent in comments earlier, let me grab them real quick, well if anybody else has any other questions, since he said he couldn't join us today I wanted to make sure he had a chance, but he was making the point that as a practicing doctor he wanted to make sure that any data intermediary should be able to demonstrate and report on their direct interactions with EPs and EHs besides being able to report delta changes on the measures. And again, that maybe something we'll have you take a look at on paper just to be sure that we're getting that question answered.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

Yes.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

And I know Terry Cullen joined us late, Terry, I just want to make sure you have a chance to weigh in if you have any thoughts about the discussion so far?

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

No, I may have some later but right now I'm fine, thank you.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Very good, all right, any other questions for Marc? All right, well that was a lot of information, a really well done report, thank you. Jesse, so what are the next steps here just so the group can understand what's happening with these next?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

So, the next step will be for me to make changes to the language as we described and we'll send that back out to the group in 24 hours and allow everyone to review it over the next week and then there is a Health IT Policy Committee meeting on Tuesday the 9th next week and the discussion will move to the Health IT Policy Committee and in that meeting yourself, Terry, Marc will present the recommendations where we have consensus from the group.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Okay, very good, any previews from Paul or anybody else on the call about that discussion? Okay, well why don't we MacKenzie open it up for public comment then?

Public Comment

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Sure, operator can you please open the lines for public comment?

Caitlin Collins – Project Coordinator – Altarum Institute

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 comment.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Go ahead, please?

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

Oh, hello, this is Joe Francis from VA for some reason I was not unmuted during the call because they didn't have me on the list for the Workgroup. Can you hear me?

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

We can hear you Joe, go ahead.

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

Okay, great, yeah, anyway, nice job Marc, there were two things I just wanted to kind of raise as possibilities here, one it strikes me that a large ACO might want to create themselves a data intermediary for the purposes of gathering information across sites of care like hospitals and physician offices for population health and I didn't see any mention of that as a possibility for a data intermediary, is that something that the Workgroup discussed?

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

We were not trying to think about who might be able to meet these criteria but rather take a very broad approach and say, what would they have to do in order to meet the criteria. So, I don't think there is anything in here that would preclude an Accountable Care Organization for example from becoming a data intermediary if they met the criteria.

Joseph Francis, MD, MPH – Associate Director - Veterans Administration

Very good and then my other comment for the group, which I will send the link on e-mail, I was just struck this morning by a health policy newsletter from CommonWell talking about the Medicare Doctor Payment Bill and some of the rather sharply worded comments from congress and others about the proliferation of measures and the need for more outcome oriented, and also patient reported outcome oriented metrics.

So, I think, as some of these recommendations get developed by ONC some attention to what's happening elsewhere in the legislative and regulatory world is probably needed just so that we don't create even more measures on top of measures.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare

And I think that Joe speaks to this measure criteria process, you know, saying what should be the – rather than us deciding that that there should be a common approach to how measures are sort of qualified and so I think the Tiger Team would sort of talk to that criteria and I guess the question back to you would be do you think there is enough in there to reflect that need, because again, we were trying not to be too proscriptive in terms of the requirements, but sort of saying they should mirror how we think about other quality measure requirements, but maybe we weren't – maybe we should be more directed there.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Okay, great, well we'll follow-up on that. I know there is somebody else I think waiting to comment, so operator can you bring the next comment forward? I believe Peter Basch is trying to get in the queue. Hello?

Caitlin Collins – Project Coordinator – Altarum Institute

If he has he hasn't signaled to the operator.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Okay. Well, he sent us a long e-mail, I guess we'll read it instead. Other comments?

Caitlin Collins – Project Coordinator – Altarum Institute

We have no more at this time.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Great, all right, well we're just at the top of the hour. Any last comments MacKenzie or Jesse are we good?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Just, thank you so much for your time and your input.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Great, thanks everybody for a great discussion, we'll be in touch with revised slides for you to look at in the next couple of days. Thanks, everybody.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks a lot.

Woman

Thanks.

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum

Bye.