

**HIT Policy Committee
Quality Measures Workgroup
Transcript
December 9, 2013**

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Good afternoon everyone; this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Quality Measures Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder this meeting is being transcribed and recorded so please state your name before speaking. Also, if you are not the person who is speaking please mute your line. I will now take roll. Helen Burstin?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Terry Cullen?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Kathleen Blake? Chris Boone? Tripp Bradd? Russ Branzell? Cheryl Damberg?

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

Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Letha Fisher? David Kendrick? Saul Kravitz? Norma Lang?

Maureen Dailey – American Nurses Association

Maureen Dailey for Norma Lang.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

David Lansky? Marc Overhage?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Eva Powell? Sarah Scholle? Paul Tang? Aldo Tinoco?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Alexander Turchin? James Walker? Mark Weiner? Olivier Bodenreider? Ahmed Calvo? Westley Clark? Kate Goodrich? Daniel Green? Heather Johnson-Skrivanek?

Heather Johnson-Skrivanek, MS – Agency for Healthcare Research and Quality (AHRQ)

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Michael Rapp? Jon White? And are there any ONC staff members on the line?

Lauren Wu – Policy Analyst – Office of the National Coordinator

Lauren Wu.

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

Kevin Larsen.

Kim Wilson – Health Communications Specialist – Centers for Disease Control and Prevention

Kim Wilson.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Good morning all and I will turn it back to you Helen.

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

Wonderful, thanks so much, appreciate everybody joining us today on this oddly rainy, somewhat snowy day in D.C. We would like to get some advice from you today and give you some feedback of the survey you participated in.

One quick thing is we've actually gone ahead and noticed that we haven't refreshed this group in quite a bit so we actually went back and looked at some other folks who had indicated that they would be potentially interested in joining our Workgroup and have reached out to four additional folks and if you have thoughts about who else might be appropriate for us going forward as we talk about our future work towards the end of this call please let us know.

I think the one person who could join us today and I'm not sure if I heard any others, but Jason Colquitt from Greenway Medical, are you with us Jason?

Jason Colquitt, PhD – Executive Director of Research Services – Greenway Medical Technologies

Yes, I am.

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

Wonderful, welcome. So, we wanted to make sure we had a good mix of folks for this group going forward as we begin thinking about both the measures for measure concepts for Meaningful Use Stage 3 as well as what sort of some of the foundational work might be. So –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Helen, can I interrupt, I'm sorry Helen, we also invited the Vendor Tiger Team to today's meeting to see if we could get any representatives from that group and I forgot to ask if there was anybody on the call from that group.

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

Oh, great.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I'm sorry.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

Hi, this is Maggie Lohnes with McKesson.

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

Oh, wonderful, thanks Maggie.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

Hi.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Hi, this is also Ginny Meadows from McKesson and from EHRA.

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

Great, thanks Ginny.

Jon D. Morrow MD – Senior Medical Leader & MQIC Director – GE Healthcare

And this is Jon Morrow from GE Healthcare. I think I'm here under that rubric.

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

I think you are thank you again.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you, I'm sorry about that Helen.

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

No that's perfect, thank you, I'm really glad to know that one of the things we've been talking about is as we begin looking towards the concepts for Meaningful Use Stage 3 it became apparent to Terrie and I and others that it would be really useful to have more of the vendor voice at the table to understand some of the functional issues and infrastructure needs to kind of make some of these a reality and with that, let's go to the next slide, please.

So, the goal of today's call is we'll finalize the MU3 recommendations to the Policy Committee which we need to do on January 14th. We'd like to, with your help, choose a few major measure gaps that we think need to be filled. We want to look at the criteria we're going to put forward to you and think about whether those are the likely criteria we'd like to recommend and then have some further discussion about this innovation pathway we've been discussing.

We'd also like to begin planning for what we're going to do in 2014 as a workgroup and in particular some of the issues around infrastructure to get us to the next stage of measures. And maybe before we move forward, because there might be some confusion, Kevin I was wondering if you could perhaps just give us an update of the Meaningful Use Stage 2 and 3 the announcement on Friday just to put it in context?

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

Certainly, so the context is that Stage 2 is being extended and that means there is a delay from in which the Stage 3 rule writing and the Stage 3 rule will come out as well as a delay most importantly in when Stage 3 will start for organizations, it's essentially been pushed out about a year. So, we'll be – we have some additional time to dive in and give some deeper recommendations to the –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Actually, sorry Kevin, that's not true.

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

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

They've asked that we still have the recommendations in January so that there is still time for rule writing, that's again – CMS.

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

Okay, I stand corrected, thank you, Michelle.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Sorry.

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

My assumption, this is Helen again, if it does allow us, even if we have to make a recommendation in January gives us a significant amount of time to sort of iterate and think about the foundational issues and it also gives more time for those measures to be ready for Meaningful Use Stage 3. So, even if we need to give another presentation in January I still think we've got a bit more time on the sort of meatier issues perhaps. Any comments Terrie before we launch in?

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

No, but I do want to reiterate what you just said Helen. So, while we are constrained to this date in January of reporting I think that the fact that there is another year in between when something is really going to be implemented, not the impact on rulemaking, but the implementation may give us some – may loosen up some constraints that we thought might be there both from infrastructure and from production of the measurements so –

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

Super okay, great, so let's – next slide please. I'll walk us through this. So, just a little bit of a recap, at the November Health IT Policy Committee we did present the work we had done to date on the concept of deeming for MU3 and although they were generally supportive of the concept it was unclear how it could be operationalized and so subsequently the Meaningful Use Workgroup suggested that we not pursue that further at this time and we again pay more of our attention towards thinking about the measurement concepts that would be needed going forward so that's the work we've been doing. Next slide.

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

Helen can you, this is Terrie, can you clarify though that was what happened to us, do we have a sense what happened at deeming overall from an MU perspective?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Hey, Terrie, this is Michelle, from the Meaningful Use Workgroup perspective how we decided to leave it was that we were going to put in all of the work that was done by the Quality Measure Workgroup and the Meaningful Use Workgroup provide that as context and background and suggest that there would be additional work done by CMS, ONC to see what is feasible and that the idea of deeming was largely supported it was just really the operationalizing of it that became the difficulty. So, you know, more would have to be done but they want to make sure that the work that was done is provided as context.

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

Great, thank you.

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

Yeah that's very helpful. And so what you'll see on the next two slides will look familiar for those of you who have been around the Workgroup for a bit and these – this first slide was the recommended framework that emerged out of Accountable Care Subgroup of this Workgroup which Terrie led and just I think it gives us a helpful context of sort of if this is true north and where we all want to go ultimately being able to capture this very broad set of outcomes, patient experience, expenditures, intermediate outcomes, etcetera, while not necessarily what we're going to focus on right now, it just seemed helpful to at least have it as perhaps the sort of uber framework over our work going forward. Next slide.

And to that end we also took a look at the criteria that we had put forward with the Accountable Care Workgroup and thought about its applicability towards this path we're now on which is thinking about the measures for MU3 and in some ways they still seem like the right set of criteria and we'd love to get your input on this.

And some of these build on the criteria that go all the way back to the beginning of Meaningful Use that emerged out of the Gretzky Group and some other initiatives of, you know, really beginning to think about HIT sensitivity as we called in early on, preference for eCQMs or measures that would leverage data from HIT systems wanting to ensure moving forward that the measures would have the ability to enable a patient focused view of care longitudinally and that they would increasingly help support health risks status, assessment and outcomes.

The second column of criteria there were more applicable we understood certainly at the population or group reporting that emerged from the Subgroup specifically around accountable care, but we still thought these were potentially important criteria for us to frame the broader discussion going forward, the idea that you would have reporting once across multiple programs that aggregate data reporting, that the measures would be applicable potentially as well at the population or group level.

Ultimately we want to ensure that the benefit of those measures outweighs the burden and increasingly, and a major theme I heard at the Accountable Care Hearing that was held last week, was the idea of really ensuring that the measures also promote interoperability and in this case more broadly shared responsibility. So, one of the questions we've teed up for you is this question of are these the right criteria, are there others that we're missing just as a starting point. Next, please.

So, we asked the Workgroup to provide some input on measure concepts and potential objectives for MU3. We got about, I think about a dozen responses, and did a compilation specifically around gap areas and a couple of select questions we had asked which we'll get to towards the end as well as the innovation pathway. Next slide, please.

And this is some great work Lauren had done where she went back through all the measures currently under development at various stages of development in the major domains that had been identified in the last round as being important domains that we'd want to cover through Meaningful Use and indicated in green, yellow and red the number of concepts currently under development.

So, for example patient safety in the middle right there, there are more than three ADE monitoring and prevention measures currently under development but as you can see there is a fair amount of red as well, for example EHR safety or false prevention have no concepts under development. So, this is a very helpful way to see how far we've gone and seeing where there might still be some red areas that would need further measure development.

And frankly, as we also look toward some of what's listed inside here and we sent along the full list of measure concepts under consideration it's also possible that some of the measures being developed at this point may not go as far as they potentially could go towards Meaningful Use Stage 3 so there is also a possibility that they could ultimately be expanded and moved forward. So next slide.

So, we also asked, as part of the survey, were there any sub-domains that should be added to the ones we just listed there and a couple of suggestions were brought forward. For example in population and public health something around measures that the population or community level that would be useful at the point-of-care and around care coordination some very specific comments about wanting to ensure that it wasn't just the presence of a shared care plan but it was management to a shared care plan and that care coordination also reflected multi-provider care planning and execution.

Under patient and family engagement a couple of additional sub-domains around shared decision making, patient understanding of their condition and their treatment, experience of care and those were just a couple of the sub-domains people thought should be added. Next slide.

So, I've kind of gone over this a bit, but as you see here specifically just at a very high level the areas highlighted in red here would be the obvious gaps where we previously identified that as an important sub-domain for which there are no measures currently under development. Next slide.

So, here are a couple of the domains that you shared with us and again so those of you who are new to the call today we'd be very happy to take your input on this as well. A couple of additional areas mentioned the first two specifically around the areas of population health and disparities. A couple of comments about that what we really probably need is the ability to consistently capture variables we need for stratification to be able to look for disparities as opposed to necessarily having different measures to assess disparities. I've already mentioned the population health metrics meaningful at the point of care.

There was some thinking that we would want to make sure that we had measures that didn't reflect sort of the standard of care but actually increasingly reflect optimal management in the way we've deemed some measures really more composites or things that are more comprehensive getting towards optional management of care.

Multiple have raised appropriateness of care and in fact a comment from Kate Goodrich also made the point that appropriateness is especially important because it could also be tied back to clinical decision support functionality as being an important consideration.

A couple of people have raised issues around patient safety and the need for patient safety defect rates and a specific comment about for example having measures of ambulatory procedural safety as being an important gap currently.

More conceptually the idea of measures across patient centered episodes of care, patient centered outcome measures in particular, general as well as disease specific and then a few people raised how some of these may not be clinical per se but also for example patient reports on care coordination.

A few additional comments about cardiovascular risk including patient activation and goals and achieving treatment goals post procedural functional status, recovery times, improvement from baseline or prior year delta measures and a few specific areas were mentioned as well, but those were really the highlights of some concepts that didn't seem to be in the measures under development perhaps as fully as they could be and ones that fit some of those gap areas. Next slide.

So, these were from the ACO measure domains for example how the various domains listed here, examples of what measures those might likely be and then an example of a few types of data that would be required to capture that.

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

And Helen, I can add a little here if you want?

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

Please?

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

So, during the ACCQM Workgroup we came up with this model of domains that actually probably follows closely in the NQF framework. And then we pushed it out to example measures, now actually this Workgroup, the Sub-Workgroup of this Workgroup has a call Friday and what we recognize today in the pre-work for that is that these really aren't types of data so that column is a little wrong, it's really data sources if you look at that that's what we're looking for.

We're going to go out a little and look for what types of data do we think currently exist and/or don't exist that can help inform the HIT Standards Committee as we go forward as we elect to look at these specific measures. So, this is just another way to frame looking at measures with these different domains.

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

That's really helpful, thank you, I hadn't seen this slide before, so I was kind of winging it.

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

You did a good job.

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

Thank you, thank you and I'd also point out since we also did also ask you about this on the survey that a couple of these also get at the idea of hybrid measures of EHR plus claims and I think we'll come back to that at the end as well and this might be an area in particular we'd love to hear from our vendor colleagues about the likelihood of being able to put some of these together to get to the sort of next level of measurement at the accountable care level. Okay, next slide.

So, I guess this is where we're going to stop and ask the question I assume about just taking a look at the criteria that we listed out do these seem applicable to the gap areas? I don't have the slide deck in front of me, so, do we want to pause here or are there some examples we're going to walk through to follow/learn?

W

I think we can maybe go through the next two slides and then stop and kind of have a discussion around these three in general and just remember that what we're trying to finalize today to present to the Policy Committee are a final set of criteria for measures and measure gaps that we feel are pretty priority to address in Meaningful Use Stage 3 and then after we discuss this point we can move onto to talk about the innovation pathway.

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

Okay, great. So, we've already gone through these but as we go through the next couple of slides keep these in mind and see if you think they would be useful. So, next slide please. So, for example, these were a couple of gap areas pulled out and if you took those criteria that are listed on the prior page would this be a useful way for example of thinking about the likelihood of getting at – are these the right criteria to help us move toward the next set of measures for MU3?

So, just as an example here, interestingly, total cost of care is high here for most of the domains medium for prefer reporting once and I actually question whether that's really high or medium, but certainly presents some challenges and if you look at something like the first one there around care coordination which seems to be everybody's highest priority, a couple of them about whether it would actually help leverage HIT was low. Longitudinal care, patient health risk and outcomes improvement were high.

Reporting once potentially low although that could be something prospectively to work on very applicable obviously to the population and the hope that the benefit would outweigh the burden here and certainly very high on producing share, promoting shared responsibility.

Let's do one more slide and then we'll stop and have some discussion. So, just picking out one of these that has a rainbow of colors here, you know, for example if you looked at periodic assessment of disease activity you would see for example potentially low on whether, how it could leverage HIT, high in the next two, medium on potentially reporting once not as applicable perhaps with the population level more the individual patient, benefit might outweigh risks and certainly promote shared responsibility.

Closing the referral loop something that's already been developed might be useful especially with Aldo on the line here. Certainly high across many of these domains and thought to be medium around health risk outcomes and reporting once and the last two here.

So, with that can we just flip back two back to the criteria slide and perhaps take a pause here and let's open it up to the group and give us a sense of whether you think these are the logical criteria, are we missing any, are any of these off base in terms of how we might use them to help identify and put forward to the Policy Committee the major gaps.

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

Helen, this is Terrie, so the one thing I want to say, and David Lansky I think isn't on now, but I did listen in, for those of you who may not be aware there was an accountable care hearing, is that what it was called, about accountable care organizations.

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

Yes.

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

And one of the themes, and Helen and I have talked about this, was interoperability and how difficult that is and how while it's not necessarily a measurement gap it's clearly a "can you do it" gap and actually – David talked about and I know we're going to get to this later at this whole sense of capability and how do we ensure that the capabilities are in the system actually, one reason why we wanted the vendors on this call if we could get them.

So, I would – when we're looking at this list we may really want to think about is the framework the right framework, because are the measures themselves things we can get at with the gaps to address for instance interoperability. Is there anything else that anybody thinks is really important?

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

Great, thanks, Terrie.

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

So, this is Cheryl, to follow-up on that I just want to ask a question. So, the idea of interoperability I think is a really important one but is that something that we – because these seem like these are evaluation criteria, right?

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

Yes.

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

So, are we trying to embed say, interoperability or some other type of thing in as an evaluation criteria? I just want to get some clarification on that last point.

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

This is Terrie; I don't know that we've made that decision yet. I think I was just struck by that all day meeting how the theme that kept coming up was interoperability.

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

Right, but it's the idea, as I'm looking at the list that's on slide 11 on the framework.

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

Yes.

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

This notion of promote shared responsibility. So, interoperability seems to underlie that.

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

Yeah.

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

Exactly, yes.

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

So, you know, if they can't communicate and, you know, some of the measures such as around episodes, you know, require that interoperability. So, I don't know whether it's implied here or whether it needs to be more explicit.

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

What do folks think?

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

I personally think, you know, it's not only there it's that longitudinal care, patient focused view of longitudinal care and the only way you get longitudinal care is through interoperability. I think calling it out somehow but I don't know – I don't think it's on this slide. Somehow Helen it's in the – it's just foundational.

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

Well, is it in and of itself more of a measure that – it feels to me like it's a structural measure that says to the provider –

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

Yeah.

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

You know, can you connect, talk to, share information with other providers that your patients come in contact with. It feels almost more like a measure rather than a criteria.

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

Criteria?

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

Yeah.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Hi, this is Ginny Meadows; it's like a dependency really.

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

Yes.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Because to do this we sought to be interoperable and I was actually at the ACO hearing as well and heard a lot of the frustration from some of the providers and I think one of the things that we have to keep in mind is that for most providers Stage 2 hasn't even started yet. So, they haven't really seen how beneficial the improvements to interoperability will be for them, that's still something I think a question that we can't really answer for a while.

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

Right.

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

That's right, that's really helpful Ginny. So, in some ways maybe the actual criteria here as you think about the gap areas and the measures we would want potentially for MU3 is you would want a measure to – we would preferentially want measures that would require interoperability to get at the more comprehensive view of care so in some ways perhaps it's a combination of enable patients focus view, promote share responsibility through interoperability perhaps to Ginny's point of it being a dependency.

But I think we probably would try to push towards measures that wouldn't reflect for example just what I did in my clinic this morning by myself, but instead reflect those dependencies of what I did at the sort of intricacies between me and another provider, between me and the patient and their family. So, does that make sense?

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

This is Terrie; it makes sense to me, so in fact if you don't have that capability in your system you probably won't be able to do the measure.

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

Right exactly.

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

Or you won't be able to perform well on the measure.

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

And if part of the goal of MU3 is being able to push on some of these big broad national quality strategy kinds of areas –

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

Right.

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

Like care coordination and improved outcomes then it's going to – I mean, it seems logical you'd have to have that baked in to do well.

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

Right and that's – I mean, that's partly where it feels like it's a structural measure to me, but –

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

Okay.

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

Yeah, but, again this is Cheryl, I mean, I think these criterion really do address, you know, the gap areas that were identified on the previous slide, I think there is, you know, reasonably good alignment there and I guess what I don't see here and I can't remember if this is a criterion sort of all along is, you know, this concept of high cost or population problems, or place of variability, because I think part of what we're looking to do is to tap down on variation and things that lead to poor quality or high cost. So, I don't know whether that's present in any of these.

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

That's a good point I don't think it is actually.

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

I mean, we've got this benefit outweighs the burden and I understand that from the provider's perspective but I think we haven't really sort of tackled this notion of, we have limited resources and we have to decide where we focus.

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

Yes.

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

This is Terrie, I think we started seeing that in ACOQM Workgroup where there was a lot of attention to cause inefficiency not just fiscal but human inefficiency. So, I don't think it is right here.

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

Well, we can certainly leave that in. Also, it would be helpful to go back to some of the older criteria we had way back when Kevin and maybe resurrect those and I think we actually had something along those lines we might be able to tee up again.

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

So, this is Aldo, I don't want to try and take us in a different direction, I'm looking at the very first criterion preference for eQMs or measures that leverage data from Health IT systems and when I first came into the eQm developer role a couple of years ago there was a term of Health IT sensitivity that was floating around and it resonated with me because there really is no inherent value to Health IT or EHR systems right?

I mean, just because it's in a database and its structured data doesn't mean much. However, there is something very special and unique about EHR systems and within certain measures the ability to improve performance.

So, what I'm thinking about when I see the first bullet is it's not just that we're taking advantage of data or leveraging data from Health IT systems there is just something about the Health IT systems and model that is uniquely set up or geared to helping the provider and the patient improve quality of their patient care and I just don't know how to phrase that succinctly but I think it's missing from that first bullet. Health IT sensitivity might be that term that could be resurrected as well.

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

Yes, yes and actually could you say one more time your definition? I was actually – so you said, uniquely set up or geared towards – what was the rest of that?

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

That's a great, you know, sometimes I wonder what it is I say myself, but there is something inherently valuable about the EHR technology that is an advantage over Non-EHR approaches to improving quality and clinical decision support I believe is one of the hallmark examples of being able to implement a guideline and turn the curve on a measure for a provider.

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

Right.

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

CPOE as well in terms of the adversity and the content of what is being ordered, referrals – you know, structured referral documentation, structured documentation, there are certain things that inherently increase the quality of the transactions or information being exchanged across providers or functions in the healthcare system. That might be a little bit more meaningful than just leveraging data from Health IT systems.

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

Great point. Anyone else?

W

– I was wondering if I could just – I like the idea I just wanted to express that I did like the idea of clinical decision support because I think it's a lot easier to look at how the tools for clinical decision support can improve – especially if you have a baseline where you're at and then looking at putting in the rules and promoting or supporting people doing the right things at the right time.

The other thing I was going to mention is clinical – is the use of evidence-based measure sets because when you look evidence-based orders, you know, they're structured around, you know, what is the right way, there is evidence behind it, if it was some form of measurement around the use of more – use of evidence-based order sets and looking at outcomes based upon that.

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

Great, other thoughts?

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

Hi, this is Maggie Lohnes from McKesson, and I'm also the Vice Chair of the HIMSS Quality Cost and Safety Committee. My question is whether there should be a goal of looking first to other programs that address these clinical concepts and see if there are measures available and the first one that just jumps to mind is the falls measure for instance there have certainly been national initiatives for falls prevention and I'm wondering if that might be a goal to try and unite across programs.

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

Yes. So, probably could make that criterion a bit crisper about preference for even searching out measures that are already within existing programs that could accomplish the other goals.

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

Yeah, this is Terrie, I like that making that a little sharper. So adding it to, Helen, the reporting once across programs or –

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

Exactly, yeah.

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

Yeah, yeah, I like that that's a – I mean, interesting enough I think that's what we were trying to do with that so we obviously were not a 100% successful so we'll need to just make that clearer.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

Well and I think some of the programs are not payment programs, not compliance programs, I'm thinking of like core measure reporting for accreditation purposes.

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

Right.

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

Are there other – this is Terrie, are there other ones that people think aren't precise enough? We're kind of weighing precision with being broad to some extent but –

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

It's Aldo, I think the second bullet enables patient focused view of longitudinal care, I think we all agree what patient focused view is, as someone who has been in the clinical setting though there is some inherent ambiguity to it.

So, for example, is that – am I focusing on the patient’s perspective or is it that, you know, a patient really is more than just one diagnosis, as usually we carry multiple co-morbidities and are current measures really just focused on one disease at a time.

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

Right.

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

A patient with hypertension, diabetes and risky behaviors for example there is no one measure that really addresses whole patient care. So, my question is, is patient focus really on patient perspective or the fact that the patient has – there is a constellation of issues at hand.

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

This is Helen that’s a very good question, it’s interesting, I guess it’s written in such a way to be a bit of Rorschach for you, so my interpretation of that was really more on the fact that it was longitudinal care not just sort of in the classic episodes framework way but really from a patient’s sense of their view of an episode are you able to see their care over time.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

So, this is Ginny, as a better word instead of patient focused, patient centered, is that what we’re really thinking about is the fact that the longitudinal care all revolves around a patient and all of their –

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

I think that’s the idea, yes.

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

Thanks, that clears it up for me, so thank you.

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

Although I do think Aldo that in some ways actually being explicit about leaving in something that goes beyond a single disease more of a whole patient view or something might push us towards measures that may not be quite as narrow as some of the measures we’ve had to date. So, maybe it’s –

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

Yes, it almost seems like we need both.

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

Yeah, exactly I agree. I agree.

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

So maybe we can expand that Helen to something else.

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

Yes, yes.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

So, this is Maggie Lohnes again, I’m just thinking about this report once to meet many concepts. I should have also said, you know, why is it that it should apply both to group reporting and to EP and EH, it’s a big deal for physicians.

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

Yes.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

To be able to report and meet many.

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

You're absolutely right and some of this is just – this is Helen here, that's just sort of an artifact of our old – as we were presenting on deeming before and the two groupings, but we left them up there because initially those were the ones conceptualized for the population or group, but I think what we really said is people felt pretty comfortable that those were applicable to the EPs and the EHs as well.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

Okay, thank you.

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

Yes. So, we've talked about preference reporting once, we've talked about benefit outweighing burden and the promotion of shared responsibilities potentially being linked to more strongly to interoperability. What about a criterion that sort of pushes towards measures that could also be potentially applicable at the population level? Is that an important criterion for MU3? Not hearing much on that one –

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

Well, let me, it's Aldo, let me jump in, some of my training is in public health so if a public health provider could receive incentive funding from the MU Program than I would say, yes, as a public health provider I'd love to see that some of my broad population focused interventions are in fact in the set and if I were to implement say for example, increased funding for methadone clinics for example, again, thinking population level and some of my opiate related safety measures improve across population that makes sense.

I think the struggle I'm having with the population focus is the fact that the MU Program historically has been squarely put on, you know, the EPs or the EHs, or the EHR vendors benefit from the incentives, right?

It's hard to see where a population level measure or reporting to a population measure would give us information to take some type of action and then to deploy a population level, you know, intervention to improve quality that's where I'm struggling I don't know if other people are having the same struggle.

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

Yeah, Kevin any response on that for Aldo and our degrees of freedom for MU3 here?

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

Well, so we've heard from ACOs and hospitals in general that for example the hospitals are, not-for-profit hospitals are required to put their tax exempt status show their community benefit so many of them are busy doing a community benefit analysis and they would want some way that that feels more supported and systematic than what they currently do.

And we've also heard from ACOs that they're goals are much bigger than just a list of all of their providers outcomes. Their goals extend into places that have been more – have long been considered mostly public health.

So, I think that there is some opportunity here. I think that that's where we really want some creative thinking from the Policy Committee to help, pardon the Workgroup, to help us think about what that could look like but some of the work around measurement in an HIE, the work that the beacons have done for example I think can lead the way. And so, I think it's a question that we would really like input on.

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

So, in some ways Kevin, this is Helen, just to follow-up on that, so in some ways if there was potentially flexibility for MU3 that it could be at the group level then I suspect this group would be supportive of that. I think less of the individual EP, EH, clinician is probably a harder sell.

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

Helen Burstin, MD, MPH, FACP – Senior Vice President for Performance Measures – National Quality Forum
Does that sound right?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator
Yeah, I mean, there are any number of ways this could happen right? So, for example as we talk about the hybrid measures which are coming up so claims and clinical measures the Yale Team that has done the analysis for that essentially wants to take outcomes-based, population-based outcomes measures out of mortality and then use some clinical data like lab results to help do risk assessment. So, that's a mortality no matter where you're living as a population-based measure and that is already in the works and the construct is being created by the Team at Yale.

So, I think its thinking not just about reporting options but also thinking more creatively around what the data flow and sources are that create these measures.

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

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
Well and I think, this is Terrie, I do think the larger issue is the perception that this doesn't help. You know what I mean? Like –

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
This is Marc, what doesn't help?

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
What I'm thinking is that the fact that population health continues to be an afterthought.

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

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
That the EPs are thinking "I don't really need that, what's that matter."

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
Right and it's not their job.

Theresa Cullen, MD, MS – Director, Health Informatics – Veterans Health Administration
I actually don't think they're thinking – yeah, I'm not sure they are thinking that way, but that seems – I think it's why we continue to have the dialogue of what we do with population health because it's not embedded in the ongoing clinical care interaction between location and the individual patient and the provider.

J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare
And that maybe so, this is Marc – probably realize that in Europe for example the public health primary care really aren't separate they're one thing but here in the US they have sort of split off into separate arenas and that's for a whole variety of reasons.

And so I think you're absolutely right what we are doing or hopefully doing through a variety of things is transitioning from a one patient at a time to one patient in the context of all population – care so one patient at the time, but you're absolutely right it is a culture shift that we're trying to encourage and ACOs are a way to do that, bundled payments are a way to do that, you know, and this is going to take multiple years.

But I think you can think, as Helen mentioned, that some of the quality measures that CMS is looking at like the 30 day that will cost around the hospital episode start to encourage that because now you can't just say, you know, I'm the hospital I stop at the door and I can't just say I'm a primary care provider, you know, I don't start until they come back, it really is – so I think that we're doing, as a country, a lot of things to align incentives or begin to align incentives to make that transition happen but you're absolutely right.

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

Yeah, but, this is Helen again, I mean, it's really interesting, I mean, in some ways if the point of MU3 is to sort of signal what should be, you know, a change in culture or a change in dynamics then one could see for example that there might be some of the more classic measures we've currently got for example around diabetes or hypertension control and which, for example a clinician visit is not required to be in the denominator, but there is an expectation that if they're yours they're yours.

So, there may be ways to kind of push towards that potentially without necessarily going quite as far. So, maybe there is something, a way to phrase that to be, you know, measures that would, you know, promote more of a population-based view of the care provider or something like that.

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

I think you have to change the attribution formula a lot which is one of the big challenges in doing that.

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

Yeah.

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

But I think you're absolutely right Helen.

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

Yeah, yeah.

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

Helen, this is Terrie, I agree with you too and I think it does change the attribution formula and it pushes on that whole area of group reporting.

I mean, you know, we have, on the second column, we talk about population or group reporting even though we don't have that option right now so a real gap is can you even do group reporting and if you can then how do you define it. And I think you're absolutely right Helen who is in your denominator.

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

Right.

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

So in some ways that measurement gap is the definite – the constraints put on the current reporting options as well as the denominator definition.

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

Yeah, this is Kevin; I can make a couple of comments about group reporting. With the CMS program alignment, so aligning PQRS as well as CPC which are both fully aligned with Meaningful Use and the intention is to continue that way. Both of those programs have a group reporting option.

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

Okay.

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

Because their rules were written after the Meaningful Use Rule currently it's a one-way alignment where if you do Meaningful Use it aligns with those programs, but presumably in the Meaningful Use 3 timeframe the CMS priorities will stay the same and they will continue to prioritize this report once alignment across programs and so there are opportunities to leverage the group reporting options that already exist in these aligned programs.

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

That's great.

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

So, Kevin does that need to be spelled out because while there are opportunities that exist that reporting option – are you saying it's going to be there?

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

I would say that its rulemaking and so, you know, rulemaking is rulemaking; I would say that if this group thinks that that's important that calling it out would be great feedback.

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

I think it sounds really important that we call that out Kevin, because in some ways you can push further on the more meaningful measures for MU3 if that group reporting option is in there, otherwise you continue to kind of be stuck in the who's in the individual clinician panel which always trips up the denominator measurement and I'd be curious to hear from some of the vendors on that as well.

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

This is Aldo, I'm still chewing on Marc's, excuse me someone else's comment with regards to changing the attribution model in our minds. I – number one that in and of itself might be a criterion for what's measurable at the population group reporting or just a consideration to say, if it's not appropriate to report at an EP level or a single EH level, you know, then it may make sense to report at a larger level.

I mean, one of the classic things, measures we've had since MU1 and before was immunization status, and since I helped re-specify that measures it's kind of interesting because, you know, you're giving credit to the EP that is capturing status but it's not necessarily that particular reporting eligible provider that went out and got that immunization for the patient, the patient went to Walgreens or to Rite Aid or to another local pharmacy to do that it was more of a patient initiated activity.

So, there are a few things happening here that are clouding my senses but I just wondered if that should be reflected explicitly as a criteria.

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

And Kevin I think that also reflects a patient centered view of the world, right, we don't care how they got the immunization done maybe they did it because they were well educated by their primary care provider that this was important and that was the convenient way to do it or maybe they're well read and went and got it back, you know, it doesn't really matter to us at the end of the day, and it doesn't really matter whether the cardiologist or the primary care physician who titrated the dose of the Lipitor it's really that it got done and the patient's cholesterol was reduced, the LDL cholesterol was reduced by 50%, you know, that's the criteria there. But, you know, I do think the other thing it does in a way is simplifies measures.

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

Yeah, thanks Marc, this is Helen that was exactly why I was sort of teeing that up for a question for the vendors.

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

The only question is –

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

Yes?

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

Yeah, I think it actually makes it easier –

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

I think so too.

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

Rather than harder.

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

Yeah, I think so too. I think figuring out who is the attributable provider is often very, very difficult particularly in a setting where, you know, people routinely share the care of their patients across their practice.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

So, this is Ginny, and I think the only difficulty when we start thinking about that is when we think about the fact that it's often – it's not just across the practice but when you think about an ACO and all the different entities that would make up an ACO.

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

Yeah.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

You'd be looking truly at a patient centered view of the world because it would go across anybody in that ACO that might have contributed to the care of that patient.

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

Yes and maybe that raises one of the foundational issues we potentially could tee up for 2014 is, you know, really beginning to perhaps work with this group to think more about the attribution model.

Ginny Meadows, RN – Executive Director – Program Office – McKesson

Yes.

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

You know, and one would hope that from the vendor community, I think it goes back to what David Lansky keeps saying about capability, so what – and perhaps what we need to do, and we obviously aren't going to have time to do this today, is really define for you what the capability of – what's the clinical capability we need to do – changes in denominator and panels and how can we ensure that that can happen.

And I want to hearken back to the fact that, you know, and I don't know who it was who said it, about oversee, you know, public health not an afterthought because I think the real goal would be to get that capability in there for reporting for some very specific things but hopefully that capability would then be integrated and transcend that one pocket of reporting and just be an option for anybody that's using that Health IT system.

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

Okay. So, it sounds like we've got – certainly gotten a lot of really good advice here on the criteria, perhaps we'll work with ONC staff to make these a bit crisper and specifically make sure that what we report out to the Policy Committee is that we think that it is going to be really important to explore as part of the NPRM this issue of the group reporting option and some of the underlying foundational issues that will go along with trying to move towards that level as well as ensuring we're talking about the bidirectionality Kevin of the, you know, measure it once rather than the unidirectional as it is now for MU.

All right, that's the sense unless anybody has any other comments, but we're probably ready to move onto the innovation pathway. Any other thoughts on this? And I guess since we've got time, correct me if I'm wrong Lauren and Kevin, and Michelle, I assume we probably could do some of the wordsmithing of the criterion and share it back out with the group certainly before we need to present this in January, correct?

W

Yes.

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

Yes, certainly.

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

Okay, great then we'll take good thinking and see if we can do a bit more on this and then come back to you, but that was a great discussion, thank you that's exactly where we needed to go and thanks for, specifically the vendor input which we didn't have enough of before, so thanks.

So, let's move onto slide 14 if we can let's just scoot ahead there if we could Michelle. Perfect. So, we've talked about this before when we talked about – I talked about this with the Policy Committee just a couple of days ago. We've talked about whether there would be a pathway that would allow MU to, in a sense, waive one or more of the objectives by demonstrating they're collecting data for measures either for internal QI or within a registry.

And I think the issue was there was support from the Policy Committee but definitely a sense that we needed to put more meat on those bones perhaps and here are the two approaches for example that are listed, would one option be for example to have certified development organizations who might be able to develop, release, report CQMs for MU. Alternatively, you could open up the process to any EP or EH but potentially constrain that development via some standards and for example the authoring tools as an option.

So, I think this harkens back to some of the work of the Data Intermediary Tiger Team which is more so the first approach and the second approach of being more so potentially allowing any EH and EP to do it potentially with some constraints. Kevin or anyone please jump in here if I'm not capturing that correctly. Next slide.

We did ask you about this as part of that survey and overall there was general support for the use of an innovation pathway in Stage 3 and a couple of preliminary suggestions here to further define it. The first, which actually got a positive response, particularly from Paul Tang, at the Health IT Policy Committee meeting last week, was the idea that we would specify, and I don't know who suggested this, it came from the Workgroup, we would specify the gaps that the measures for the innovation pathway should help close. So, it can't just be any measure but specifically that you're using measures that would help specifically help close some of those gaps we've got.

And the second one there was also just being very cognizant about the fact that there are still gaps in the clinical specialty areas and there might be an opportunity for a collaborative effort there to focus in on where the biggest gaps are in terms of meaningful and useful measures. Pause there for a minute. Kevin do you want to add anything to this, this is a little telescoped about what you need us to do here?

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

So, the innovation pathway is something that's been discussed at length by the Quality Measure Workgroup for both Stage 1 and Stage 2, it got a lot of activity right before the – during the like final parts before the – during rulemaking for Stage 2 and the reason that the Workgroup was really interested in the innovation pathway had to do with the fact it's not all the specialties, it had measures that were applicable.

There were a number of challenging areas like care coordination that they felt there hadn't been much progress and the Workgroup felt like their crowd sourcing this would be a much more effective way to get some really of the best things out there.

So, the deliberations that the Workgroup has had in the past have been around this concept of an innovation pathway but I think what we need now is some specifics about what could the innovation pathway look like and how could CMS and ONC really support innovative measurement in a way that is in line with our national quality strategy and the policy priorities.

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

Great, very helpful. Any comments from the Workgroup?

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

This is Kevin again; I think there was especially interest in finding what's being done already that is already being used by vendors or sites and finding a way to bring those forward.

For example, I was talking to a vendor at the eHealth Summit on Friday who mentioned that they have a routine measure of right patient, right medication, right time for in the hospital and that that was a really effective monitoring tool around patient safety using an EHR.

And so it's finding the places where there are tools that exist that maybe could become an innovative measure and figuring out how to give people credit for those and what way could they enter into a pathway to eventually be nationalized.

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

And in some ways the advantage, this is Helen again, of allowing people to use this innovation pathway is we've also heard that some folks don't want to maybe beyond some of the measures that are already here have already built them into their systems for example with their vendors can't they use what they've already put forward if they're innovative and help fill gaps.

And then, you know, to Kevin's point allows us to potentially prospect for those measures and think about ways to bring them in and get them to be national standards others could use.

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

This is Aldo, just hearing this from standards in that context actually triggered a thought, part of this pathway – so we develop and specify measures for different programs in our day job and we have to adhere to a collection of conventions and standards for those measures today.

It's not clear, from what I'm seeing here or heard before, whether this pathway would allow some of these innovative measures by non-traditional developers to have less rigorous adherence to those national standards or from the get go if they're thinking to present one of their innovative locally derived measures should that adhere to the vocabulary standards, should that adhere to the HL7 specification standards, should that adhere to the CMS blueprint, should that achieve NQF endorsement criteria, you know, there might be a scale or even a sliding scale that we can think about or just say, you know what from the very – from day one you've got to meet all the same criteria as the traditionally classically developed measures that are out there. So that's not clear to me – so far.

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

And actually Aldo, this is Helen, I think that's quite intentional because we've not talked about it. So, I think that's an open point of discussion. So, what do people think? What do you think for example Aldo?

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

So, I would love innovative measures that close gaps. It would be ideal if the innovative measures would be squarely founded upon the ONC EHR technology certification criteria so that all EHR systems have an opportunity to report out those measures that are being presented as innovative or that there is a pathway to say, okay, this is today's certification criteria but these are the specific additional things that need to go into these technologies so that everyone has a chance to report out on the measure for the patient artifact, you know, that CMS comments about – regarding blueprint, if these are going for the Meaningful Use Program then, you know, many interventions would apply I think but maybe not all of them.

And then lastly, I mentioned NQF endorsement criteria. It is not clear to me as to whether or not that would necessarily be a high – it's a high bar I don't know if that's the high bar that's needed for innovation, again, it's just not clear at this point, but I guess –

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

Yes.

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

Please, go ahead?

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

No that's very thoughtful Aldo, I mean in some ways just I think on the NQF side I think some of this is also a question of staging, it maybe that the innovative measures go out there first to kind of get there, you know, get some use and then come forward for endorsement.

I mean, there could be lots of different models to do this but I think what we'd like to do is be able to ensure that the pathway of innovation comes from those who may already have those measure rather than always starting de novo with brand new measure development and not necessarily picking up on where there may be important pockets of innovation already.

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

This is Kevin, again, another maybe helpful example or frame might be the clinical data registries that will now be part of the PQRS Program. So think of the surgical quality improvement registries for example and they may already have measures that they've been collecting for years those you could imagine could be part of an innovation pathway if that was – if there was some clearly laid out process by which that would happen, the criteria, you know, how does CMS and ONC decide which of those are in and which of them are not.

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

So, this is Aldo another area, these use cases, because we live in the world of HL7 sometimes and the use cases are fantastic, traditional measure development relies on evidence-based in the form of clinical practice guidelines because someone else has gone through the work, reverse work of evaluating the evidence and we base the measure on that.

So, if each of these stories of innovation comes forth and, you know, we'd like to be able to review those stories and see whether or not that's something we want to reproduce at our local institution.

So, making sure that there is a story behind the measure of how they took a problem and used something innovative and achieved a, you know, improvement of quality I think that would be helpful as well.

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

Yes, great. Actually, one of the things we've been talking about for 2014 potentially is perhaps having one of these meetings where we invite a couple of the lead innovators to kind of help us think this through a bit for example some of the large health systems that have created these, you know, remarkable data platforms they can drill into and pull out data, merge with other data really just beginning to get some insight from some of the innovators and certainly if any of the vendors have thoughts about folks we would be all ears as well.

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

Yeah, this is Cheryl, Helen I would strongly support that there be some, you know, whether it's a web meeting or some opportunity to try to understand where are people focused on developing measures that they use internally, because I know there's a lot of development work going on and I guess the question, you know, that ultimately arises is what is used sort of internally for CQI, you know, good enough for performance measurement on a broad scale.

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

Right.

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

So, there is always that tension that –

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

And well, this is Kevin, Cheryl another point of clarification, the Workgroup has discussed in the past that this would likely not supplant all other measurement that this would be, you know, a bit like deeming perhaps in that if you're doing things that meet a certain amount of your internal measurement that then you would be excluded potentially from some portion of the other measurement that doesn't apply to you for some reason or another.

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

Right.

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

So, most specifically you're an oral surgeon and you have a set of innovative oral surgery measures that include care coordination and a patient reported outcome or something therefore some amount of the other required measurement is not required of you.

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

Right.

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

That's what the Workgroup has discussed in the past.

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

Yeah, yeah that makes a lot of sense.

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

This is Terrie though, I think it does go back to the old framework of what are you using measurement for, are you using measurement for improvement or are you using measurement for reporting and occasionally they're the same but many times they're different and I think in order to make this the easiest we can for the provider at the point of care it's related to the capability of the system.

So, we obviously want to support anybody doing anything related to improvement whether it rolls up to be a measure or not that the assumption would be, and we see this in the VA, is that if we don't have the flexibility in the Health IT system to help them – to have that happen electronically we get a zillion Excel spreadsheets and a ton of people spending their time figuring out how to track whether an intervention has actually resulted in improvement.

And people are going to continue to do that and so what I think is that from the Health IT system from an infrastructure and the capability we should make that the easiest we can for those providers.

And I don't think tracking measurement outcomes for improvement is a different capability set in the software then tracking interventions for measurements. It may be different voracity for the data that process itself, the Boolean logic, the A's and the B's shouldn't have to be a lot different.

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

All right.

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

But I don't think we've spelt that out. I still don't it's spelled out.

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

It's not anywhere, I agree.

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

I mean, instead we hardcode measures that's what we're doing we're hard coding measures.

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

This is Paul's flexible platform question and that has been a constant priority as well to understand the flexible platform is whether that's a measurement, whether that's the same as this innovation pathway or different I think one of the things that would be really helpful to articulate.

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

Right and some of this just to build on that I think just one other issue, this is Helen again, is also a question of whether the measures will be ultimately used in terms of payment for performance such that, you know, you really want to ensure you've got a reliable, valid measure for comparative purposes and, you know, can you create a flexible structure that you could then add on what's needed to make it something that is something that could be used for accountability I think that's still the route.

Sure, you can use a lot of great things, get all the internal things that you want done but at the end of day if somebody is going to be paid differentially based on performance we need to have sort of a different level of rigor as you've used the word Terrie.

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

Yeah, so, the flexible platform concept, Kevin, is that something we should address or Paul has that or –

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

So, that's another thing that's been discussed many times in the past by the Quality Measure Workgroup and the Policy Committee which is this idea that there is somehow a way that the EHR serves as a, to your point, flexible platform measurement for lots of local improvement activities and as a way to think about what are the ways through policy that we can encourage that flexibility as opposed to encouraging hard coding of measures.

So, I only brought it up because you sort of went there with this innovation pathway and as I said maybe they're the same but maybe they're different, I don't know.

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

Okay.

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

So, would it be helpful –

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

Well –

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

I'm sorry Helen; would it be helpful if we were explicit about that here Kevin?

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

It certainly could be, I mean, maybe if you support the innovation pathway and have some recommendations for how the innovation pathway would work maybe you could, if you think that this also supports a flexible platform, articulating that as well would be great.

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

Okay and we should just reference it using those words because that's what –

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

That's been used over and over again by the Policy Committee is flexible platform for measurement.

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

Okay.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

Hi, so this is Maggie Lohnes and I think there are some other vendors on the call but I just want to add a couple of notes.

So, regarding the difference between flexible platform and hard coding measures part of the problem is in this transition period we're in right now where we don't have completely stable measure value sets for the same concepts but, you know, different programs require different specifications that the data standards aren't settled, we almost have to hard code in order to make sure that that measure can pass a certification test or a particular program.

And someone mentioned how the logic shouldn't be any different from local code versus standardized codes, they're absolutely right, the problem is when everything else is moving around it you've got to lock it down.

So, part of the initiative should be making sure that we continue to stabilize and reuse as much as possible the concepts that are consistent across measures because if you keep those constant yes you can be more flexible with the EHR.

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

Yeah and it is Terrie, and I – you know what I do not want to minimize how hard this is because I was the CIO at Indian Health when we hardcoded all our measures not just for Meaningful Use but to do on clinical quality so I understand why we're there and why the software industry is there.

I'm just trying to think ahead like what would be the best – yeah, we want to make sure especially because this is Stage 3 that we have a pathway that's going to get us to where we want to be at the same time recognizing, and really my hat is off to all the vendors that are doing this, because I know how hard it is, recognizing what we need for right now.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

Right and just – my hope for – I've only been a vendor for one year, so it's been a really eye opening experience to be on this side of the fence.

I mean, today we are provided, you know, for e-Measures the HQMF format, HQMF XML and if it's stable, and if we know that's what's going to be the standard going forward people program to be able to incorporate that.

But it's such a new standard that, you know, if you change your whole architecture to meet it and then are not sure it will be there in the future then you have rework to be done. So, that's what's influencing that.

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

It sounds like a really important discussion for the Workgroup going forward this whole tension between plug-and-play versus flexible platform and I think other than the fact that we need – we would encourage perhaps discussion as part of the NPRM about the idea of having a tentative flexible platform as it potentially supports the innovation pathway I get the sense Kevin this is something we could cue up for further discussion in 2014, yes?

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

Absolutely, I think that there is a lot of shared goals around this. I think getting some specifics about how it could happen with some of the kind of technical expertise of the vendors would be fantastic.

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

Yes, agree, okay.

Margaret Lohnes, RN, CPHIMS – Quality Measures Manager - McKesson

And just a taste of things that are required I think the Workgroup would support that and if we look at the world of iPhone Apps, you know, Apple is very strict about what can be built and considered an iPhone App and that allows so much innovation because everyone knows what standard to meet and it's so easy to implement and so I think we have to get to that point where the guidelines are strict enough so we can all innovate around it.

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

Yes. Perfect. It seems like we should probably move onto the Workgroup priorities, just looking at the time, next slide please. And again, if you have any thoughts on this feel free to send e-mails to Kevin or any of us and we'll build it in.

I think we've actually captured the first one here which is this whole question that we've just been talking about of this issue of feasibility and value of plug-and-play and perhaps – and how it might relate to a more flexible platform. So, I think we've heard a strong "yes" for number one, perhaps still thinking about how you build on some of the important building blocks like standardized set, etcetera that would make that easier even with a flexible platform.

Let's see, what are these other issues listed here, what kinds of data need to be collected in EHRs/HIT? So, some of this I think was the idea that we potentially go back through those measurement concepts that we had prioritized going forward for MU3 and look perhaps do an exercise of pulling out three very different kinds of measures and begin to understand what are some of the data needs that those would logically engender as a way to get to the exercise of what is the capability that would be required to make that happen.

Further discussion about intermediaries and registries and reporting quality measures, and again some of this goes back to the platform but also some discussion at the Policy Committee again with Paul the other day as well about understanding some of the governance issues involved there.

And also, I'll just mention from the registry side there has been a lot of discussions to date about understanding how the growth of clinical registries perhaps can better tether to the data already collected in EHRs and it seemed like that might be an important discussion for this group going forward.

And then finally, we talked about this a little bit as well, but can we begin hearing from some of those innovative models and systems on how they've been building their quality measurement and improvement systems like the Intermountain, LSU, Query Health, etcetera.

Does that seem like the right set of priorities for us going forward? Additional priorities you think would be useful as we try to move towards making sure we've actually got the right capability and infrastructure to move towards the next set of measures for measurement and improvement?

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

Helen, this is Cheryl, this looks right on. I think the underlying challenge of what data should be collected because obviously we can't collect everything.

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

Right.

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

And trying to better understand what are core data elements that should be routinely captured to, you know, create what I call this more flexible space to, you know, as performance measurement evolves and we need to populate different types of measures, you know, what does that core look like and then what do you use to branch out from there.

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

Yes.

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

So, I think – and it feels to me, and Kevin, you know, I don't know this space or I'm not as deeply wedded into it as you are, maybe this group already exists but I sort of wonder has anybody really been trying to do that kind of detailed data mapping even with the existing measures to understand what the core is?

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

Yeah, this is Kevin; we have a couple of different activities I think that could really inform this group. There are, as I mentioned, Yale the Core Team there, which is a measure development team that has a contract with CMS to look at which data elements from hospitals could be routinely used for risk adjustment and they did a big analysis with a large dataset as well as a number of experts in the field about a number of kinds of data elements based on the quality data model that are routinely captured and so we can certainly have Yale present some of that work.

There also has been some analysis; I just was on a call earlier today, with the Massachusetts eHealth Collaborative doing a comprehensive look at the data that they have received through their health information exchange from Stage 1 –

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

Right.

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

To look at how filled out the data is mapped to Stage 2 measures. So, it's a really preliminary analysis but it's the kind of thing that we're starting to do in an empiric way and we're, as you know, trying to get this be more and more empiric and build a kind of learning health system for measurement that gets us empiric data tells us where we our experts are on track and where we need to refine our activity.

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

Yeah, it would be very helpful to hear more about that and I guess the other thing I was trying to think about is so, you know, we've identified some of these areas where we want more information whether that's around appropriateness measures or functioning and, you know, as you kind of look out ahead to MU3, you know, and you were to take like the PROMs are there a core set of elements in there that, you know, we know we need to be, you know, building the data collection mechanism for and how to prioritize that. Because I sort of feel like all of a sudden the problems are going to creep up on people and they're going to go "oh, my God I don't capture any of that data" what does that look like and, you know, are we ready.

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

And this is Terrie, so you guys may know DoD and VA under scrutiny are mapping seven domains and we actually just got a report this morning about within those domains how many data elements are really critical, what needs to be mapped, what's our consistency and quality of the data as we go across two different systems with two different EHR systems and then in addition what are the next domains we are going to be recommending that we map within our two agencies, but obviously to help inform the national stage.

I think that thing that this points out is – and – but this is really, really hard work it flows into interoperability. So, I guess my one question Kevin is there another group that's dealing with this or are we the right place to do this, this mapping and standards?

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

Well, so there is a Workgroup –

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

For standards, right?

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

On the Standards Committee called the Clinical Quality Workgroup that they can take direction from us on the policy side.

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

Okay.

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

So, the way those standards groups typically work is they don't go looking for their own agendas they wait for a policy area that needs more standards analysis and the Policy Committee or one of its Workgroups asks that Workgroup to dive in and do some recommendations at current state or future state. So, we could absolutely –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

This is Michelle we can try and coordinate that but that's not necessarily true, the Standards Committee gets their directives from ONC.

So, what would happen is something that comes up through the Policy Committee would have to go up to ONC and then back down through the Standards Committee Workgroup, but we can certainly try and arrange that for you.

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

Okay.

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

The other option that can be open is a hearing. So, this Workgroup had a hearing about a year ago maybe on quality data and so if there are certain topics that really you need for exploration hearings can also be proposed.

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

Yeah, because Kevin I think this data issue is really central and again not knowing where this work gets done, because I sort of think back over the last 20 years and the development of measures using claims data was fairly opportunistic but I feel like moving forward we're trying to be much more directive rather than opportunistic and trying to understand – obviously we can't envision all possible quality measures but I think there are some kind of similar types of data elements and trying to understand in a more systematic way this data structure I think would be really helpful so that we're not trying to advance a set of measures that are impossible.

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

Yeah, this is Helen again, I think that makes a lot of sense to me and it may be that we may want to, as an exercise for ourselves, pick out for example three of the big concept areas like appropriateness of care and patient reported outcomes and perhaps one other more clinically oriented one and do the data exercise and then potentially ask the Policy Committee and ONC to do the hand off to the Standards Committee to think through the standards piece of that. But, I guess the data side is us, is that right Kevin?

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

Well it depends on what you mean by the data side. So, the policy around the data is the standards around the data –

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

Okay got it.

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

Is the Standards Committee.

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

Perfect, okay, well, I think we would start with the data side, you know, what kinds of data would you even need for example to do a domain of appropriateness of care, which I think at times will go beyond, you know, the question of just what standards you would use but actually the capability of the systems to even capture some of that data, you know, the level of clinical detail for example you might need an appropriateness guideline is more, to me, a data issue rather than a standards issue, as well as, I think it then also logically brings up this issue of the connectivity or relation between the emerging clinical registries and EHRs as being a really important one.

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

Right and, you know, I think if you look at current appropriateness guidelines, I mean, some of that is captured in registries and that's terrific to the extent it is, but, you know, I think a lot of the stuff that are in the prongs if we're really aiming for outcomes, you know, none of that is systematically collected and it goes back to the earlier slide where it talks about burdens.

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

Yes.

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

I think until we really kind of get our head around where does this come up in the workflow, you know, how do you – does this really get embedded in an EHR, is it more appropriate in some registry.

I mean, I think somebody's got to do what I call that in depth thinking and analysis and maybe using some existing measures as to what prototypes to illustrate this stuff.

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

Agree.

Melissa Swanfeldt – Associate Vice President – Meditech

This is Melissa Swanfeldt from Meditech and I just want to kind of reiterate what Maggie mentioned and I think when we really want to look at reducing the burden on the providers is it gets really to that data.

So, how do we, you know, look at value sets, look at data collection, look at standards because that's what's going to make, you know, if we do a good job with the standards then the other stuff sort of falls into place more easily both from a vendor perspective as well as the providers that we, you know, provide systems to.

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

Great, so is there anything on this that's not on this list that you would think we'd want to bring forward as a priority again? This isn't your last chance to come back to this but I think we've hit on every one of the ones on here was a strong recommendation that "yes" these are some of the things we'd like to explore. All right, super. I think that was a great discussion.

So, next slide is a sea of blue and the next few slides relate back to some of the additional questions that were put forward to you as part of the survey and more informational I think, can have some discussion. Next slide, please.

There you go. So the question specifically about the issue of PROMs and patient reported outcome measures. And a question was put forward of whether potentially those should be put forward as core or menu objectives and we heard from several of you that yes there was support for inclusion of PROMs as an objective with the ability to capture the PROs as an objective but a fair number of you cautioned that we not be – potentially that MU3 not be prescriptive about specific tools or measures, but again more so I think the capability.

And again, this issue came up repeatedly as we talked about today focusing on the development of the data infrastructure and specifically, I think this was David Lansky's comment here at the bottom, about specifically thinking about how we focus on the functional and data management issues that would actually enable adoption of PROs moving forward. So, that again goes back to the Workgroup priorities for 2014. Any comments on this one? Kevin anything you want to add or does that capture it?

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

Well, I think we would like this flushed out a little bit, again the brief discussion that we had around this was that there is a high priority placed on patient reported outcomes and there are a few in the current measure set as well as in the pipeline but there is a lot of work to be done to have a broadly applicable set of well validated and well tested PROs and what we were hoping with this, at least the people that recommended it were hoping, that this would support the infrastructure creation without requiring people to have performance measurement based on outcome sort of things that don't have as much use and validation.

So, I think the discussion for the Workgroup will be in, is this recommendation going to be one to put forward and then what are some more details around this recommendation? What exactly would it look like? What would constitute a PRO? What's the kind of box of requirements around it?

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

Is this something we need further discussion on Kevin for the sake of the short-term NPRM?

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

I think that the more specific that the group can be about it so that it would be better but I think that, you know, if the group supports this it could go as stated, but you could imagine constraints like as long as you use from the PROMIS tool set for example or use from, I don't know that that's the right answer, but some kind of more specificity around this would help us on the federal side be able to effectively execute on this recommendation.

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

Right, so perhaps going further than just PROMIS the idea that you would at least have your PROMs build off and existing validated tool whether that's PROMIS or something else?

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

Yeah.

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

Okay. Any comments on this one?

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

This is Also, I mean, this would be a great example if we had some concrete use cases would be extremely helpful because obviously the types of PROMs that are out there and the tools, they're myriad tools out there each with a varying degree of validity testing and such – properties that have been demonstrated to be valid and collected to this information, so that's one thing.

So, I think I'm echoing what Kevin said. They've got to be valid; they've got to be tested. We may not actually want to hand pick them or "prescribe" which ones go it, but of course that depends on the measure.

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

Right.

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

There are some real implications in trying to develop a quality measure that's based on a PROM because you have to find a site that actually has attempted to use or is using these in order to develop a measure around them.

And then lastly, and this might be slightly beyond the scope of this group, but I used to be in the Health IT vendor space back in the day and if the Quality Measure Workgroup or some other group didn't give me a specific list of PROMs to pick from I'm not really sure what to tell my developers, say, you know, can we include this in our technology at all or is the calculation against the actual interpretation of the score beyond the scope of our software. So, there are certain implications for us to say, oh, let's not pick someone else down the road is going to have to select what those tools are.

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

Very good point.

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

Helen's it's David, it seems both what Cheryl said and the last couple of comments I wonder if there is a – I don't know how it fits in the process maybe Kevin – we could do three or four use cases or case descriptions that would educate our audiences of what we're thinking about and would identify some of the technical requirements that we anticipate being needed as a capability model.

So, I don't know whether it's just educational to do some information or a webinar or something around some use cases or whether there is a way to put it in the NPRM or to have a list of candidate measures that we already know are appropriate for this kind of implementation without it being a closed list. I do think there are some good case studies we could bring forward.

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

Yes.

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

I was also going to add to Cheryl's point earlier that I was, you know, looking at for example the way the UK is doing risk adjustment for the total hip and total knee measures they have a specific list of risk adjustment and variables that are included in their model for the public use of the outcome data and it's a good list to look at in terms of IT capability, in other words, do our EHRs capture these risk adjustments systematically and if not do we have to think about that and that maybe kind of a capability to consider for all the PROMs not so much the capture of the PROMs and the sampling and case findings and all that the PROMs themselves, but the EHR's capability of capturing the risk adjustment variables.

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

Yeah and some of that actually, David, this is Helen, hearkens back to what Kevin was saying earlier that the Yale group is working on in terms of thinking about what are the core set of variables needed for risk adjustment, for outcomes broadly. So, we might be able to keep it broad about outcomes but make sure we also include PROMs as part of that as well.

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

Yeah and this is Kevin, just a lone caveat about what Yale has done is very inpatient focused.

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

Yeah.

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

So, their work is fantastic and we'll show that to the group but it's really very specific to inpatient.

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

Yeah and I was wondering Kevin, you know, in the Minnesota case where you've got both the asthma and the depression measures being captured on a patient reported basis there if we could look to them for some examples of what they're needing to do for either case finding or risk adjustment on the outpatient side.

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

Yeah, certainly, I'm sure we could get them on the phone, the group that is doing that actually presented at – just a couple of weeks ago some really thoughtful discussion about, you know, how they decided to move forward and what they found as they've done that.

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

Yeah and Kevin I think there are a number of places that are trying to work with their ambulatory physicians around appropriateness above and beyond like the ACC, appropriateness measures and again it would be really helpful, I know Dartmouth-Hitchcock is doing this and Partners in Boston to try to understand what it is they had to build into their Health IT to support this, because I think, you know, putting the spotlight on, you know, what data needs to be collected and kind of where in the workflow it happens and getting at these issues of burdens sooner than later I think is going to make MU3 either more feasible or at least help vendors start moving down the path towards making it more feasible.

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

And this is Aldo, speaking of workflow, you know, when I trained in medicine I was not taught how to use these tools, that was a while ago granted, but I imagine that, you know, one downstream implication of wide-spread measures that look at these tools will be helping to support the practices out there so that the information provided by them is useable and actionable and it's not a reflection of the tool it's a matter of does the provider know what to do with the information.

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

Yeah, this is Kevin, that's another place we could ask Minnesota because they've been doing PRO measurement for 5 or 10 years routinely in both asthma and depression and are now starting total joints and I think one other one as well.

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

Yeah, it definitely sounds like that's an area we should tee up for either a hearing or a discussion to follow since it's so fundamental to the work we want to do for MU3.

And an interesting distinction as well for the Minnesota folks is often times it may not necessarily be patient reported but it's patient reported to a provider at a clinic visit. So, there is some interesting nuances there that aren't, you know, directly from the patient's voice outside of the clinical encounter that we may want to think about as well. All right.

So, to look at the time here let's just wrap up the last two slides if we could. So, next slide specifically, we asked the group around risk adjustment and social determinants and very much a sense that we want to make sure these variables would also be collected and I think fits nicely into what we just talked about around risk adjustment, standardizing the definitions and thinking about how we might leverage some existing tools.

We've talked about much of this although not specifically around the social determinants of health other than the health equity discussion earlier about making sure we've got the right variables for stratifying consistently having the ability to stratify.

And then lastly, we talked a little bit on the next slide about this question also teeing up for the group around how we might get to that set of broader measures we've teed up in terms of the framework, how we might leverage both claims in the EHR data together to help us get towards the crosscutting measures as well as being able to look towards how teams might be accountable, a couple of people raised as part of the survey.

And then mapping which elements would logically come from claims, which from clinical data, and then how do we make sure that the claims data also are validated and available in a timely manner, which has not been the case usually.

And then at least a reflection of a couple of you that although this sounded great there was certainly a lack of maturity of these melded data sets and we would need some further help thinking about the variables that would need to be linked across those data sets to merge data and the importance of having time and date markers was raised.

So, this might be, for example, one of those use cases we just talked about if we for example pulled in one of the efficiency measures or something along those lines we might be able to do a use case that thinks about how we pull in these kind of data as well. Any thoughts about this claims EHR data question?

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

Well, Helen we also know that the ACOQM Workgroup is really probably going to push on this to make sure that there is some way that we can combine these data sets.

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

Okay.

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

Yeah, this is Kevin, I think that I would recommend the group look at a few early examples of where people are working on this and so I have the examples from Yale, I don't know Cheryl if you have come across this in the work you did on efficiency, but I think for a lot of things where we've historically looked at claims or people moving around the system –

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

Yes.

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

Or where we look at claims for things like medication adherence –

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

Right.

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

How did those typical kind of high quality measurement activities and claims become even better when merged with something from the EHR?

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

Absolutely, I think medication adherence is a nice example of what's traditionally only been claims-based in terms of what you get back from the pharmacy claims managers for example.

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

Right.

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

Okay. I think that's the end of our slide deck. Any other issues we haven't talked about that anyone on the phone thinks would be important to tee up in terms of conversations going forward in 2014 or potentially areas we want to get further advice on as part of the recommendations for the Policy Committee for the NQRM, NPRM, too many Q's in my life. All right. Well, perhaps we'll take the chance to do an opening up for public comment Michelle?

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, thanks Helen. Operator can you please open the line?

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're 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, FACP – Senior Vice President for Performance Measures – National Quality Forum

Great. Sounds, great, all right, thank you. Any – from Michelle or Lauren, or Kevin, or next steps?

W

So, we can summarize the feedback discussed on today's call send around to you and the group for feedback to refine for the January 14 Policy Committee.

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

And this is Kevin, just a quick plug, there is both a Vendor Tiger Team meeting and a Data Intermediary Tiger Team meeting scheduled for December so if you're part of those Workgroups we, you know, remind you here, if you're not you're welcome to join, let us know we can make sure that you're aware of when those meeting dates are.

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

That's very helpful. I also would like to express our thanks for the vendors who we invited at the very last moment, we'd be delighted to have you keep joining us and I hope everybody has a great holiday and we'll definitely be in touch. Thank you for all this great input today.

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

Thanks, Helen for leading the charge.

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

My pleasure.