

**HIT Policy Committee
Quality Measures Workgroup
Vendor Tiger Team
Transcript
December 13, 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 Quality Measures Vendor Tiger Team. This a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Ginny Meadows?

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

Here.

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

Jim Walker? Mike Aswell? Chris Bontempi?

Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies

Here.

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

Annette Edmonds? Hi Chris.

Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies

Hi.

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

Chris can you say your last name for me?

Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies

Me?

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

Yes, Bontempi?

Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies

Bontempi, yes.

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

Thank you. Annette Edmonds? Joseph Geretz? David Lansky? Kip LeCrone? Maggie Lohnes?

Margaret Lohnes – Quality Measures Manager - McKesson

Here.

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

Stirling Martin? Jon Morrow? Karen Nielsen?

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Here.

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

Lynn Scheps? And Melissa Swanfeldt? Are there any ONC staff members on the line?

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.

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

Elise Anthony.

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

Hi Elise and with that I will turn it back to you Ginny.

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

Thanks so much Michelle. Hi everyone I know it's been a while since we've met so I'm happy that we're back to together again and I appreciate those of you that could join I know it's a busy time of year we're all juggling so many different priorities with work and holidays and everything else. So, appreciate those of you that could find the time to join us today.

And just before we get started in looking at the agenda I just wanted to let you know that we've definitely been talking this week with ONC about really trying to get the Vendor Tiger Team more involved so I think you'll see in 2014 we'll be scheduling some more regular meetings and we'll talk at the end of this call about some of the priorities discussions that we might want to have going in 2014 and look for some feedback from you all on those topics. Kevin did you want to add anything else about kind of moving forward for 2014?

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

Certainly, so this is Kevin Larsen from ONC we thank you all again for attending. As you know, the Meaningful Use timeline has been changed however the Policy Committee will still be giving a transmittal letter to ONC and CMS in the January timeframe so part of the reason to have this call is to review some of that and give input, however, there will be some really continued work from the Policy Committee and it's Subgroups really well beyond the transmittal letter.

So, the plan is to work with the Quality Measure Workgroup and the Policy Committee to really get a clear charge for this group so that the key feedback from the vendors to the Policy Committee and the Quality Measure Workgroup can be incorporated into future recommendations.

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

Great, thanks Kevin.

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

So far we've scheduled a monthly meeting between now and July so people can kind of get that planning in their head.

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

Okay, that's great.

W

We're working the schedule those Ginny.

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

I was going to say I don't think we've seen the meeting invites but we will right?

W

You haven't seen them yet.

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

I was going to say, did I miss that one, all right great, thanks so much Kevin. Do you want to go to the agenda slide?

So, as Kevin said, our main charge today is really going to review and provide feedback on the Stage 3 quality measurement recommendations from the Quality Measurement Workgroup so that they'll have our comments to use as they formalize their recommendations to the Policy Committee which they'll be giving to the meeting in January of the HIT Policy Committee and then again we're going to talk a little bit about future topics so that we can think about how we want to schedule our time at least for the next 6 months. Can we go to the next slide?

So, as the Meaningful Use Workgroup, excuse me the Quality Measurement Workgroup was going through the different areas of recommendations they developed this gap priority area and one of the things that we wanted to talk about in looking at these gap priorities was around the thought that potentially some of us may be working with customers that may have some innovative measures or things that they're doing that potentially could fill some of these gap areas.

So, that was one of the things we wanted to talk about and looking at this list and hopefully some of you had a chance to look at it earlier when it was sent around, but I know some of you may be seeing it for the first time. Do you have any feedback from each one of you about areas that you think potentially there is already some work being done by someone that you know of in one of these gap areas?

Margaret Lohnes – Quality Measures Manager – McKesson

Hi, so this is Maggie, and just for my own framework, this is for both the eligible hospital and eligible professional groups, is that correct?

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

Yeah, Maggie, this is Kevin, I'll give a little more context about what this is. In Meaningful Use 1 the Policy Committee and the Quality Measure Workgroup put together a set of what they would like to see for measurements to really demonstrate outcomes in Meaningful Use that's aligned with the National Quality Strategy in moving forward on this EHR supported quality measurement.

So, over the course of the subsequent years we've been tracking how well we've been filling those measure areas with measures either that have been developed and put into policy or areas under development.

What we have highlighted here is an analysis that we've completed of the parts of this that haven't been completed, the initial plan or the initial recommendation was to complete all these spaces, these are the gaps that still remain and we don't see a lot on the horizon in current development in these gap areas.

Margaret Lohnes – Quality Measures Manager – McKesson

Okay, great, thank you. The reason I asked that is, you know, just along the lines and in the spirit of alignment of programs and reducing the burden to providers, I mean, the first thing I always look through when I see a list like this is whether something like the hospital core measures that are required for hospital accreditation would cover some of them and I know these are general topic areas, but there are a few things here where we might be able to leverage what is currently a core measure and turn it into a measure.

I'm thinking especially about things like falls prevention, you know, if it's a hospital measure certainly falls prevention has been an initiative for quite some time and, you know, I know that there are some groups working on EHR safety although that's probably the least mature.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Yeah, I would concur with Maggie, because I know the hospital associated conditions as well when we look at AHRQ and they're patient safety indicators I'm wondering how many of these could be repurposed.

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

That's a really good point because we know that there is already work being done around some of those areas especially in the area of patient safety.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Kevin, could I ask another clarifying question?

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

Absolutely.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Yeah, this is Karen Nielsen again, so with all of the different regulations that were just published there were new measures in the hospital outpatient perspective payment regulation. Now there were new measures for 2016 that were introduced and they were chart abstraction measures that would then be reported through a web-based interface.

So, when we look at this particular list, are we saying any measure including like chart abstraction or is this supposed to be specifically an e-Measure construct?

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

Well, so that's a great question and I think the Quality Measures Workgroup would really like your input around that. The framework of the Quality Measures Workgroup and the criteria that they have put forward is really similar to what they've done since Meaningful Use 1 where they have prioritized e-Measures as the kind of measures to choose for demonstration of Meaningful Use, however, they're also starting to really think about what kinds of other measurement might be as effective or more effective in certain domains around demonstrating good care outcomes knowing that an e-Measure might not always be the best measure to do that task.

So, I think that if you had some particular recommendation that didn't necessarily fit that criteria they would be interested in knowing about that or some modifications to that criteria.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Thank you for that. One of the challenges I think that a lot of organizations are dealing with right now is the multitude of programs and I know everybody would love alignment and of course parsimony is a key terms that's used when we start talking about e-Measures but I'm starting to think that maybe there's some harmonization as well to that level that you just mentioned which is if we're looking at measures in general should we be considering both sides, the traditional and then the e-Measure construct because there will be times where e-Measures are just not going to be able to work.

And, so I think we would need to get clarity then as far as how much of this impacts work that's happening in the MAP where they're trying to understand the prioritization as well of measures to be recommended.

It seems one thing about this list is it really doesn't say which is the most important area to focus in on right now such as is the health equity a higher need than fall prevention versus – I'm just wondering how we prioritize the energy that's going to go into this as that's also being asked for.

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

Yeah, so this is Kevin again, I would say there's a lot of energy around number five, a lot of priority. If any of you have read the congressional letter around the SGR one of the things they direct CMS to do is look at some tools or measures that would affect resource utilization. So, that is an area that has been getting a lot of interest.

We continue also to have a lot of interest and guidance in moving towards the patient and family engagement. So, I would say those are two areas really of specific focus.

Margaret Lohnes – Quality Measures Manager – McKesson

So, again, this is Maggie, and I know the same players seem to be in the same meetings, but Karen and I are both part of the Supplier and Industry Council for the National Quality Forum and recently participated in the review of the resource use measure that was recently, just very recently endorsed by NQF and it went through a really extensive review process regarding feasibility and actually had a lot of active input. It didn't – in fact wasn't endorsed initially, it wasn't recommended for endorsement until it was again reviewed.

So, I would simply recommend, you know, under effective use of resources I'm certain many people are aware of that measure, that the new resource use measure be included there. I don't know that it specifically addresses appropriateness of care it's more of a cost per patient episode type measure.

I also wonder if some of this could be considered under sort of a modular framework and what I'm thinking is there are some – there are many measures that we have now that are great good starts on things like process measures that could be built upon rather than duplicated and added to.

So, for instance if you've got that, you know, cost of care resource measure that was just endorsed and could unify it with a clinical measure you would then turn up with an appropriateness of care measure, if that made any sense. If there is some initiative towards using sort of components, measures as components of each other.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Yeah and if I could just put an example, onto that suggestion. So, again, getting back to the new regulation that was published for the hospital outpatient quality measures there are new ones that look at appropriate recommendations being given for follow-up for colonoscopies and again that gets back to appropriate recommendations based upon clinical guidelines, correct?

So, when we think about measures that are right now in existence that might be in a chart abstracted modality for collection perhaps that's another area to start thinking about bringing some of these concepts together with existing measures.

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

That's a really good point Karen and I think, you know, really looking at how we can leverage some of the other work that's being done as you mentioned in all of these different areas can really help us inform how to move forward maybe a little bit more quickly than trying to start from scratch.

Does anybody else have anything else key to say, because we've got quite a bit to cover so I think we probably should move on from this area unless someone has something else they feel is really important to mention here?

Okay, let's go onto the next slide, I think it's actually slide number four. The next thing that they've been looking at is around the evaluation criteria to use for really as, you know, Karen just mentioned, looking at good measures and what would actually be the criteria to evaluate the appropriateness of these measures and I think as we look at these as implementers there are quite a few of them that we would absolutely agree with and think that they're high priority.

So, for example, the number one, including the HIT sensitivity to ensure that EHR systems can actually help improve the quality of care using some of the other functionality that they have, I think that's something that we would all agree is a very high priority for looking at appropriateness of measures.

Obviously, skipping down to number six the benefit outweighs the burden, I think that's something that we've talked about quite a bit and talked with our customers a lot about, you know, ensuring that by asking a provider to collect different information we're not adding a huge burden to their workflow and making them do things that are completely not really within the realm of what their normal workflow patterns would be.

Any other comments on these specific evaluation criteria as far as where we see – where we agree that they're important or maybe where we would have some feedback on one of them?

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Ginny, this is Karen, with number one does that include the limitations of current interoperability? I think one of the barriers that we have with some of the measures is the assumption that data can be passed between healthcare providers, in some cases it can, in some cases it cannot right now.

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

Right.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

And I'm wondering if that is a subset of number one?

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

That's a really good point and, you know, remember we were talking Stage 3 recommendations, so in Stage 2 we're hopefully going to see some good progress in the interoperability of information and see some of this data being more available, but I think that would be a good qualifier to put on that one as far as really thinking about the feasibility of the data being available to the provider.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

This is Jim Walker; I think we really ought to maybe state that pretty strongly. One of the – we've been out talking with lots of organizations who have a great deal of money at stake in bringing together different groups of providers into some kind of information ecology and these are some of the most sophisticated organizations in the country and probably the strongest theme in those discussions, even though it's really not the stated topic, is how expensive and hard it is to bring enough information together to really do any shared care provision I think. And this won't be solved by 2017.

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

Yeah.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

I think we really need to try to help the people making decisions understand that this is probably the biggest, hardest, deepest problem that keeps us from putting together real seamless patient centered care.

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

That's a really good point Jim; I agree it needs to be high priority.

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

So, this is Kevin, to that point maybe you should take a little time to talk about number seven.

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

Yeah, that's a good point Kevin. So, promoting shared responsibility it really all goes back to what Jim was just talking about the fact that it requires – being able to do this requires having all that data available to the different providers that are working together and the fact that we're just not going to be there probably in Stage 3 we're going to make progress but definitely still an issue. So, what comments do others have on this concept of shared responsibility and ensuring that systems are interoperable?

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

If I could just build on that real quick, this is Karen, maybe what we need to think about for Stage 3 measures is to ensure that they are optimizing the technology that was developed for Stage 2 that would also allow for appropriate testing prior to inclusion in Stage 3 so that we know that at least with existing technology we are able to go ahead and meet the needs of the measures that are presented.

Maybe then what we do is think about Stage 3 in itself introducing some new interoperability opportunities that then would be addressed in – or leveraged in future electronic measures that would be introduced after Stage 3.

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

Great point Karen, anybody else have anything else to add to that?

Margaret Lohnes – Quality Measures Manager – McKesson

This is Maggie Lohnes and I'm just trying to find the exact phrase that I heard recently used at one of the National Quality Forum meetings which is regards including patients in that shared responsibility and I believe the term that was used would be recognizing the patient as an authorized or empowered member of the team.

You know one of the biggest struggles that we've had as a healthcare community is that everyone is always looking for the captain of the ship, you know, who is responsible for the complete spectrum of patient's health care and records and it rarely can reside with a single provider, which is why we now have these larger Accountable Care Organizations being formed, but they often still exclude the patient and I – maybe it's a personal bias, see a world coming soon where the only way that we can have a full picture of the patient is to have a patient centric record and so –

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

And that's, yeah, that's definitely called out in number two, so it's so critical.

Margaret Lohnes – Quality Measures Manager – McKesson

Right, right so I would add it into this shared responsibility piece because that is one key component of shared responsibility unless seven is only meant to be the providers and payers.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

This is Jim; there is a complexity I think with talking about patient responsibility. One of the pits we've fallen into or stepped into repeatedly is imposing on all kinds of different people our professional's view of what care is and should be and I think we want to be careful as vendors to not say anything that could be misinterpreted as dumping on the patient responsibilities that many of them may not be interested in, may not be capable of, it could turn pernicious fairly easily I think particularly in a setting where there's going to be less and less support for patients of all sorts, there is going to be less insurance, higher co-payments. I think we just want to not get on the wrong side of that.

Margaret Lohnes – Quality Measures Manager – McKesson

Right, I completely concur with you and I think that's where the word patient centric is often a better word than responsibility, but it also – the term responsibility can be presented as including the patient in the process in empowerment rather than –

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Yeah, I think if we talked about patient empowerment that's spectacular, but when you're empowered one of the things you're empowered to do is say "I don't want to do that."

Margaret Lohnes – Quality Measures Manager – McKesson

Yes.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

And caregiver, I think especially for our seniors many times it's their caregiver that needs to be empowered on behalf of them.

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

Good point Karen.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Or maybe the patient just needs to be empowered to have a caregiver take over roles that they delegate to them. I think there again, the power needs to reside in the patient and sure, you know, the CEO of a company can say I want you to do so and so, fine, but it isn't as if you, you know, if you were going to a company to get something done you wouldn't start with so and so and say "I want you to do – you know, I'm setting you up to take over this responsibility." You'd go to the CEO and make sure it was okay first.

Margaret Lohnes – Quality Measures Manager – McKesson

Right.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Yes.

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

Any other comments on this or any of the other evaluation criteria on the slide?

Margaret Lohnes – Quality Measures Manager – McKesson

So, this is Maggie again, so just giving what we've discussed I would recommend that the term promote shared responsibility just be a little more clarified to shared responsibility for providers, right, or and payers.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Could I just ask a clarifying question real quick? This is Karen. For number nine measures can be used for population health reporting I'm assuming that that's more so for public health needs.

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

So, this is –

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Go ahead?

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

Go ahead, keep going.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Yeah, I was thinking is this for improved surveillance for our public health organizations?

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

So, this is Kevin, this came out of a lot of the work that the ACO Workgroup of the Quality Measures Workgroup was thinking about.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

But just –

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

And the people – the people on the group from these ACOs were saying that they're starting to need to be responsible for larger populations and so they had a view that they wanted to be able to – even within the context of their ACO or hospitals in the context of their benefit, what do you call it there, the hospitals have to prove they're not-for-profit tax status using their community benefit program, they want to be able to have access to that data internally that can be aggregated so they can use this quality measure data for those purposes.

So, this is a – it wasn't a criterion that has absolutely been established, but although it could potentially be used for public health surveillance, this was really for use by organizations to do population health reporting within those organizations.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

I would recommend clarifying that. I think the term population health gets confused a lot between – it really depends upon who is at the table and what lens you're looking through and the dialogue, because when you think "reporting" if you say reporting that sounds like you're reporting it to the federal government or to a public health agency for surveillance, but if this is for internal purposes for process improvements, for quality improvements whatever I think that has a different flavor to it. So, I would just recommend highlighting the difference there.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

This is Jim –

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Would it be adequate – oh, go ahead.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

I'd just like to add my vote to that. I think there are actually three meanings that get blurred continuously, one is I'm responsible for 500,000 patients how am I doing providing them care and there's another which is, can I aggregate the data in a way that I can say "you know given how many people with diabetes I have I'm going to need two more ophthalmologists next year" that's also population management but of a completely different sort.

And then the third is the one Karen is talking about which is, you know, can I provide care, health benefits to the population as a whole state or a country, vaccination programs all kinds of things, environmental control, and, you know, if we make it clear I think we're just talking about the first one, which is really being able to account for care provision to a specified group of people and calling that population management is either intentionally or unconsciously confusing.

Margaret Lohnes – Quality Measures Manager – McKesson

This is Maggie, I don't know if this is meeting what everyone's saying, but how about the difference between population health and public health is the surveillance type thing more public health uses, is that what you meant?

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

It's part of it, but what I think what people are often talking about, like in this context is it is about what is my provision of care to the individuals for whom I'm responsible and they are a population, but it's a very different focus.

See, because if you ask, what's the implication of this thing we're talking about now, well the implication is to go find those people I didn't do a good job and provide them the care I didn't provide them.

So, it's just a completely different – the orientation really is about the individual patient, but it's from the stand-point of an organization that is responsible for providing each of those individuals optimal care.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Yeah so what I –

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

So, for one thing care delivery organizations are concerned about this version of what we call population health.

The second version, which is how many ophthalmologists do I need given how many people with diabetes there are in my population is also something care delivery organizations care about and are responsible for.

The third one, population health or public health is something that they have very little control over and almost no responsibility for anyway.

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

Right. Yeah, I think this is definitely a very confusing term and lots of people use it interchangeably and I think Jim you had some good way to define all the different –

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Maybe one way to say it would be the first is taking care of a population as individuals. The second where I'm worried about how many ophthalmologists I'll need for my population of diabetics that's taking care of the population as a population, you know, what I mean, there's no individual contacted as a result of that statement I just might hire another ophthalmologist.

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

Right.

Margaret Lohnes – Quality Measures Manager – McKesson

Is that called capacity management?

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Yeah, you could call it that, I mean, there are other parts of it, you might say, you know, I've got all this depression in my population we're going to start a campaign next year to help people with depression. So, it's partly capacity, it's just – but it's managing the population as a population –

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

Right.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Not as a group of individuals.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Which has more correlation with public health because when public is looking at the population as a whole that's how they from a policy stand-point understand where to put their public health dollars, again, do we need more ophthalmologists in this zip code due to the fact that we are not able to provide the kind of resources to our population currently.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Yes.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

So, I think number two has a nice overlay.

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

Right.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

It is halfway to public health you're right or more.

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

Yes, but it also could involve things like providing additional education as a whole to the public.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Absolutely.

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

And all sorts of different –

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Outreach to schools, you know, you might say we're going to outreach all the schools in our area.

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

Absolutely vaccination programs, yeah, exactly. Yes, no those all make perfect sense and I think it would help to clarify that one in those kinds of ways as we move forward. Anything else on this evaluation criteria?

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

The benefit outweighs burden. I think one of the things that needs a little bit further clarification is what that really means to the provider level.

There was a meeting this week, one of the, I'm ashamed to say I don't remember the name of the quality improvement organization that held the webinar, but there was an educational session this week for the hospital outpatient program and there was a great deal of discussion as far as the new measures and the new burden that they would introduce and it was – there was a lot of feedback from the individuals who would have to be collecting the data and reporting on it and I think that sometimes the burden component isn't weighed in enough early on in the discussion.

Now I have no visibility to what happened with that measure and I don't want to provide any kind of feedback that would assume anything inappropriate was done or comments were not taken into consideration because I know the measure developers are very thorough in their work and the measure developers who created it are extremely, extremely strong in their ability to create viable measures.

I think though that what we consider a burden might be considerably different when you go to the people who are actually doing the work and asking them if, you know, try to give us some sort of assessment of how much of a burden this really is for you. I don't think we understand burden until we sit in the seat of those who actually have to do the work and it would be great if there was a better methodology of ensuring that that was captured in this particular assessment.

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

So, Karen, in other words how do we actually measure benefit –

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Burden.

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

And the burden so we can very objectively say that one or the other and understand where a particular measure might actually weigh.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Yes.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Right.

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

Absolutely.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Yeah.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

And, you know, I proposed this when I was not a vendor, yeah the idea is that would need to hire a team of healthcare economists who would actually make increasingly accurate estimates of both of these things because clearly if you have say 300ish potential measures it would be incredibly smart to be able to say, okay of the 300 this is the one that has the most benefit, reaches the most people with the most impact at quality adjusted life years probably is the way you'd measure them, would achieve the most additional quality adjusted life years in the population at the lowest cost and just rank them from number one to number 300 based on that methodology.

And then you would have something that certainly could be argued, that would be one of the virtues of it, but we'd actually know what we were arguing about. And then it would be something that would make all kinds of sense to AARP and to Consumer Reports, and to congress and to providers, and to vendors, and to regulators and you could just say we're going to – you could have an agreement we're going to start with number one and see how far we – how far it's feasible to get. But we're banging around in the dark without that now.

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

Yes, absolutely, great point Jim, appreciate that point. Anything else on this before we move onto the next one? I think we're – well, let's go onto slide five because I think we'll have some healthy discussion on this one as well.

Slide five is around the concept of this innovation pathway where participants would be able to actually waive a Meaningful Use objective by demonstrating that they're collecting data and doing something for quality improvement that shows that they're actually improving care overall and so this concept I think has taken the place a little bit of what we were originally hearing the conversations around deeming.

There have been a lot of discussions around the whole deeming concept but it was determined that that was really a little too complex to get into for Stage 3, so deeming has been put on the back burner and now we've got this innovation pathway that we've discussed a little bit before and they're looking at two different approaches to thinking about this whole process.

So, the first one, which I guess they consider more conservative would be allowing whatever a certified development organization would be to develop, release and report proprietary CQMs. So there would be some kind of process that a development organization would go through to show that they're doing this in whatever manner it's determined they have to do it in.

And then the second one would be an approach where any eligible provider or hospital could develop CQMs but they would have to be – it would have to be constrained based upon the current standards and the current methodology. So, for example they would have to use the measure authoring tool. Kevin, I don't know if you have anything else to add to this since I haven't been involved in the real detailed conversations?

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

This actually came up in the Meaningful Use 2 deliberations as well and the goals for this are I think twofold, one is that there was a feeling on the part of the Policy Committee that we're not making innovation far enough or more quickly enough to reach the goals that they would like and the other is there are a lot of areas that are important to individual providers and patients but will never reach national importance especially with a sort of parsimony point-of-view.

So, if you want really good measures of cystic fibrosis outcome care that's unlikely to affect enough people to be high on a national measure priority list. So, how could we support both of those things, both getting good measures for lots of individual populations or different kinds of conditions and people as well as really looking at a more drug development-like process where there's a whole bunch of primary research that ultimately the best things move forward.

Margaret Lohnes – Quality Measures Manager – McKesson

Hi, this is Maggie, I have a question, when I first read this I wondered if I was being too literal in how I read this, I wondered if where it says the ability to weigh one or more objectives I'm thinking very literally Meaningful Use objective measures but I wondered if it was really meant to portray that you could for instance only need to report, you know, 12 clinical quality measures if you had three more custom measures or local measures. Could you clarify that?

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

That's a good point.

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

I think both are on the table. Both objective measures as well as some CQMs are on the table.

Margaret Lohnes – Quality Measures Manager – McKesson

Okay.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

This is Jim from a stand-point of parsimony; well to me it's obvious that this proposal is the exact opposite of the one we were just talking about. These quality measures are costly to create, they will be costly to maintain and costly to build into health information technology and for organizations to make the organizational changes to deal with and so that's one thing.

And the second is that I think the cost of validating this 1000 flowers blooming it will be unsupportable and so they won't be validated or curated, and the cost of supporting them in Health IT, well they'll just have to be custom jobs, I mean, so I think that would be the minimum, it would say if we're going to have this 1000 flowers blooming part of the framework for that would have to be that these are no part of certification, you know, the whole point of certification is that something is a large enough problem to enough Americans that it rises to the level of justifying, you know, a very large lift but an appropriate one to build it into all of the Health IT basically, eventually that you can use anywhere.

So, you know, I think at a minimum we'd need to say that if the 1000 flowers are going to bloom they can't be part of certification, they will have to be custom services jobs from Health IT companies.

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

And I think this is a good time to actually go to slide six and look at the recommendations that the Data Intermediary Tiger Team made on these recommendations because I think those are really good points as we start thinking about the development of all these custom measures that this raises a lot of questions around how we could most effectively support them.

So, the Data Intermediary Tiger Team when they looked at this they came up with this set of kind of criteria of how they thought this program could potentially work and so short-term and I think we actually also said the same thing in an earlier discussion we had earlier this year that short-term we know that providers will receive credit for measures that are part of the EHRs in the program today, but long-term we were very much at the time encouraging the fact that there does still need to be a minimal set of standards that would be followed in order to support these more innovative types of measurement and some of those standards are enumerated here on this screen. Any thoughts around that an agreement, disagreement to what they've actually recommended here?

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

I think one of the key items, you know, this ties back to earlier comments for interoperability is the use of standards and codified data.

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

Yes.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Which again goes to Jim's point as far as time, effort and finances associated with that.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Yes, who is going to be responsible for validating that each one of these projects has used the standard terminology in a standard way, I mean, we'll be right back – and it maybe – we may have to live with that, we may say that these custom standards are that important but I think we're just going to have to say and we're going to have to kind of cross our fingers and, you know, recommend or require, but if we say we're going to require that they use standard terminologies who is going to check that and validate that they did? That will be money that no one is willing to appropriate.

So, it will have to be, you know, in fact it will be a suggestion that, you know, if you build one of these that you use standard terminologies and, you know, we can point them to National Library of Medicine Services and all, we can do all of that stuff but what we're going to end up with inevitably is badly curated, you know, things that are designed by people who – you know, there are very few people in the country who have the ability to do this and to think that every learned society or every hospital, or every IDN will have those skills, you know, that's just silliness.

And so what it will be is a voluntary program where we recommend they use standard terminology, we recommend other things, but there won't be anybody who can be accountable for it.

Margaret Lohnes – Quality Measures Manager – McKesson

Right and this is Maggie, I mean, I completely understand that perspective and I can give an example of where a provider might want to get credit for something that isn't endorsed and scientifically validated with, you know, double-blinded studies in controlled trials, but something for instance, I remember when I was wearing my provider hat here in Puget Sound and there was a sudden uptick in Avian Flu infections and death.

And the health system I worked for had hospitals throughout the Puget Sound in different areas and we immediately just started our own measure, which was, you know, we didn't wait for an endorsed measure to say, you know, what types of conditions did these patients have, it turned out we recognized there was an increase for patients who were pregnant that totally came out of the blue. We did it by zip code.

We came up with some, actually some pretty clever things, but it was a very practical use of a measure. I could see wanting to essentially give credit for that measure just to encourage innovation. I would be hard pressed to see again how you would be able to take credit for an objective measure by saying, okay, because I make this creative new measure I'm not going to report my, you know, health information exchange rate or something, to me they're so disconnected, but I could see using something like a local measure like that to give me credit for one less CQM.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Yeah and all I'm saying is I personally guarantee that with this program which seems like a political inevitability we will have a situation where someone has a measure that is the current equivalent of making sure that 100% of women are on hormone replacement therapy as primary prevention for coronary disease or a measure that 100% of patients in the ICU have a hemoglobin A1c less than 7 and then someone is going to do a randomized control trial and show that we're killing people.

So, I mean, if that is – I don't see any affordable, any feasible way to avoid that and as long as we're clear on that, but I don't think we are clear on that and certainly hemoglobin A1c less than 7 in the ICU in 100% of patients should not be part of certification.

Margaret Lohnes – Quality Measures Manager – McKesson

Right.

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

Well, that's a really good point because without some kind of endorsement process like we have today that's really looking at the evidence behind the measure and making sure that it's clinically sound there is no control as you said Jim so eloquently. So, I think it's definitely a concern.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

So, if we think about it from a strategic stand-point how could we actually help, if we take Maggie's great example of creative use of technology and data, right, to empower providers to do the right thing for their patients it gets back to making sure that there is interoperability so data can be transferred there, it's standardized.

So, again, maybe there's just some formats to be re-enforced, right, that if you're going to do this we expect certain things, we don't look at these measures as something that let's say – and again, to Maggie's situation, that would not be a year on year type of measure that would continue on, right? But it encouraged something really important which was providers coming together, those that are delivering care and those in the public health segment to communicate and to communicate data. And I think if we could do something that empowers that piece I think that's fabulous.

James M. Walker, MD, FACP – Principal Health Informatician – Siemens Medical Solutions

Right, but do we need MU to encourage people to use their data to find problems and deal with them that's the other thing, but if something doesn't have to be MU to be encouraged or possible.

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

Yeah, unfortunately I guess we're at the end of our time, is that right Michelle? Do we have to break for public comment?

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

Yeah, we do, thank you Ginny.

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

So, we've not – this has been a great conversation, we've not actually gotten to a couple of the other areas that I know Kevin wanted feedback on. Kevin, is there any other way that you would like to get any additional feedback especially on the flexible platform or the patient reported outcomes or –

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

So, certainly you can send us some input over e-mail, but again we'll have a meeting in January we can talk about those, just a quick highlight of what those are, there is a proposal by the Quality Measures Workgroup that there be an objective measure that people attest that they're doing at least a patient reported outcome of any type and the other is this ongoing request on behalf of the Policy Committee that we work on how to build a flexible platform for measurement so the measures aren't hard coded and either of those we can handle here in a minute, but if you have ideas send them in and we'll also discuss those in the January meeting.

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

Great, thanks, Kevin. So, can we go to public comments now Michelle?

Public Comment

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

Sure, thank you; operator can you please open the line?

Caitlin Collins – Project Coordinator – Altarum Institute

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

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

Thanks, Michelle. So, thank you everybody for joining today, Happy Holidays and we will be talking to you again in January as Kevin said, so looking forward to continuing our conversations.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

Thank you so much.