



HIT Policy Committee Quality Measurement Task Force Final Transcript June 5, 2015

Presentation

Operator

All lines are bridged.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Quality Measurement Task Force. This is 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. Cheryl Damberg?

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

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hey, Cheryl.

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

Hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Kathy Blake?

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Kathy. Dan Riskin? David Lansky? Elizabeth Mitchell? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Present

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Floyd. Frank Opelka? Pelka, I don't know. Ginny Meadows? Jason Mitchell? Joe Kimura? Lori Coyner? And Sally Okun? From ONC do we have Stephanie Lee?

Stephanie Lee – Office of the National Coordinator for Health Information Technology

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Stephanie. Kevin Larsen?

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

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Kevin. Lauren Wu?

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Lauren. And Samantha Meklir?

Samantha Meklir, MPAff – Senior Policy Advisor, Office of Policy – Office of the National Coordinator for Health Information Technology

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Sam. So we do have a small group, but small but mighty. So just a reminder that this meeting is being transcribed and recorded so we'll share the recording with all of our members who weren't able to attend today. And with that I'm going to turn it to you Cheryl and Kathy.

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

Great, thank you so much for joining us this morning. I...just to reiterate, this group was formed very quickly, in part because there's time urgency in providing feedback to CMS as part of the notice of proposed rulemaking. And so that is our charge today, to review what's being proposed and to provide comment on it. And I just want to thank the staff at ONC for providing all the background materials; I know there was a lot to absorb and get your head around with all these changing standards and the vocabulary associated with it. So, very much appreciate all these background documents.

I think we could probably skip the introductions; I know Floyd. Kathleen, do you know Floyd?

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

And so certainly Floyd I very much know of you through the work that you've done over the years with Marjorie Rallins, who is a member of our team so I am delighted that you were able to join us.

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

Yeah, great.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Thank you.

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

And Floyd, do you need any clarification on our backgrounds?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

No, I think I'm good at this point.

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

Okay. Because I think really given the time that we've been allotted here and the amount of material, I think it would be useful to jump in and get some background on what we're supposed to comment on and then get into the discussion. So, hopefully you have the slide deck up and why don't we start going through the slides and if we could move to slide number 2.

Lori Coyner, MA – Director – Oregon Office of Health Analytics

Hello, this is Lori Coyner. I just wanted people to know that I've joined the conference.

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

Hi, Lori; welcome to the call. Glad you could...

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

Hey, this is Kevin. Since Lori's new to this, maybe we should go around and just have a quick introduction of where you're from so everyone kind of knows who's from where.

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

Sure, and can recognize voices. So Lori, I'm Cheryl Damberg. I am based at the Rand Corporation, have held numerous jobs both in the public and private sector, heavily focused on the development and use of quality measures.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

And Lori, this is Kathy Blake and I'm at the American Medical Association where I oversee the Physician Consortium for Performance Improvement, which is a quality measure developer. And I also oversee the natio...the work that we do on behalf of the National Quality Registry Network.

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

Floyd?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Okay, Floyd Eisenberg; I'm a physician, had background working with National Quality Forum in developing some of the infrastructure for electronic clinical quality measurement and currently I'm an independent consultant working with various groups on terminology measure development and immunization workflow.

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

Thanks. And Lori?

Lori Coyner, MA – Director – Oregon Office of Health Analytics

I'm...my name is Lori Coyner; I'm the Director of Health Analytics at the Oregon Health Authority. And I oversee the...our quality metrics Pay-for-Performance Program for Medicaid and some also IT pieces around collecting metrics for...through electronic medical records.

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

Great, thanks Lori. And also just so you know, on the phone from ONC are Lauren Wu, Samantha Meklir, Stephanie Lee, Kevin Larsen and Michelle. So Kevin, did I miss anyone on your end?

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

Nope, that's good. Thank you.

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

Okay. Great. So why don't we segue to the next slide. I just wanted to start by giving you a little bit of background on what's going on. So CMS working with ONC is trying to work towards better alignment around all of the quality reporting programs for eligible providers. And so what is happening is that the clinical quality measure reporting requirements are now being addressed in the context of CMS's notice of proposed rulemaking for the Inpatient Perspective Payment System as well as the Physician Fee Schedule rulemakings. And the notice of proposed rulemaking for the IPPS, or the Inpatient Perspective Payment System, is on the street right now and that is what we are focused on. The Physician Fee Schedule NPRM will pop up a little bit later in the summer and we will be re-convening this group to comment on that as well.

And the idea here is that by receiving and reviewing public comment on these quality programs at one time and finalizing the requirements would not only allow for better alignment and help consolidate a lot of input from different stakeholders to try to improve the value and consistency of what's going on across all these programs. Because we know providers as well as vendors who are supporting providers on the ground are kind of getting information from lots of different parties at different times. So, personally I think that this effort to align is a significant step forward. If we go to the next slide.

So this slide lays out what the charge is. So we have been asked to comment on the clinical quality measure provisions in the CMS payment rules, both the IPPS, which the comment is due back by June 16 and the information that we prepare out of the meeting today and follow up e-mail over the course of the next few days is going to be taken back and presented at the Health IT Policy Committee meeting next week. So time is very short here to provide this input. And then as I mentioned, the Physician Fee Schedule notice of proposed rulemaking will come out in...later in the month and we will come back together, provide some input on the areas that they're soliciting feedback on. And that information will be reported out in August of this year.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Cheryl, this is Michelle. I'm sorry; we should have updated this slide. We actually decided to move the June 9 Policy Committee meeting to June 30.

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

Oh.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

So there's a little bit more time.

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

Okay, well that's good news. So that will probably allow us to get some additional comment from folks who were unable to attend today. So, that's very helpful. If we go to the next slide; so the areas that we have been asked to focus on for comment are around these two items. So the ONC proposal for use of the 2015 Edition clinical quality measure reporting certification criteria and the associated standards. And then early comment solicitation on new type of measures using core clinical data elements.

There are some other areas contained in the notice of proposed rulemaking that we potentially could comment on, if we have time and folks have interest in providing input. And these are listed at the bottom of the slide; the first being, use of certified EHR technology in the 2016 program year to submit electronic clinical quality measures for the Hospital Inpatient Quality Reporting Program. The alignment of reporting periods for clinical quality measures. The reporting of clinical quality measures using the latest releases and CMS "form and manner" submission requirements. And then the frequency of requiring recertification to updated measures and submission requirements.

But, again, these are optional areas for us to comment on. And I would like to at least initially keep the focus of our discussion today on items 1 and 2 on this slide. And if time permits, we can provide input on these other areas. So if we go to the next slide.

So the information that's been provided to us for this meeting represents the information drawn directly from the rule. And ONC itself can't provide any more information or clarification, other than what's stated in the rule. And so as we progress through the conversation today, what we would like you to help us think through, and we would like to see represented, are the various pros and cons of the different options being presented and the potential effects on the various stakeholders involved in this process. Next slide.

So let me just stop there and see if folks have any questions. Kathleen, feel free to chime in here and add anything that you think I've missed.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

No, I don't think anything's been missed. I'd suggest we just launch right in.

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

Okay. Great. Floyd or Lori, do you have any questions before we proceed?

Lori Coyner, MA – Director – Oregon Office of Health Analytics

Nope, not here.

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

Okay.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Not here...

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

All right. Great. So, on the slide that should be up on your screen, if you're sitting at a computer, slide number 7. So let's start with the first item; so ONC is proposing a 2015 Edition certification criteria for clinical quality measures. And what this is going to require is a certified health IT module that will enable a user to electronically create a data file for transmission of the clinical quality measurement data using the base HL7 QRDA standards. So that will be the minimum. ONC is also proposing to allow optional certification for EHRs according to the CMS "form and manner" requirements that are defined in the CMS QRDA implementation guide.

And the proposed certification criterion would apply to eligible hospitals, eligible providers and critical access hospitals and if we go to the next slide; because this is really where they're asking for us to think about the options that they are proposing and for us to provide comment on these different options. So there are two levels of reporting that go on; one for individual, patient level quality reports and the other for aggregate level quality reports. So these are the Category I and III and within each of these, there are some proposed options.

So the current standard that's in place is what is listed under number 1 in each of these, the July 2012 QRDA Category I IG. The second option provided an update based on information that was fed back, corrections made and then option 3 is kind of going beyond the QRDA proposing what I perceive to be an alternative. And I can certainly ask Kevin and Lauren to maybe elaborate a bit on this, related to...I don't even know what the common pronunciation is here, is it "fir?" "Fir-based..."

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

FHIR.

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

...standards?

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

Yeah, so actually I think in a couple of slides there's a table, Cheryl that lays out what is the difference between each standard. So we can either go there now or if you want to run through the options and then we can go there during the discussion; we can do either way.

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

Yeah, I think I'll run through the options, but my understanding of this one is that this newly proposed standard may allow for some additional what I'm going to call enhancements or flexibility. And then the fourth option is the next release of the QRDA Category I. And all of this information was laid out in a fair amount of detail in the Word document, and it's highlighted in gray shading in the documents you were sent. Similarly for the aggregate level quality reports there are similar options, with the exception that there is no option 4 in that. So, maybe we should move into the next slide that lays out these different things.

So, the current requirement is the use of technology certified to the 2014 Edition and the proposal is to now certify to 2015 and that would start in 2018 and would be optional for 2017. And then as I noted, the clinical quality measures have been reported out using the HL7 QRDA Category I and so the new proposal would be certifying to report CQMs according to the CMS QRDA IG; so that would be optional. And there are some proposed updates to use the newer Category I and III. So let me just pause there, see if folks have questions. I know there are a lot of acronyms being used here and see if you need any clarification from staff.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So, this is Floyd; I can make some comments. I think the proposed requirement of certified to 2015 starting in 2018, optional in 2017 just wording; I ha...you have to really think when you read these things. Just a comment on the standards; QRDA actually has two levels and they are a Category I and III. Category I has already been balloted and is about to be published within the next 2-3 weeks, can't guarantee the exact time; it's based on when the publication group gets it out. And the Category I release 3 therefore is the most recent and has managed most of the errors that might have been in earlier Category...earlier versions, and it makes the most sense to use that.

Unfortunately we i...recently identified a new issue with that as far as reporting and there's one measure that it affects and that...resolution for that may be difficult to come by. So, I don't know if you want to go into detail on that, but it basically is to be able to express that a device was ordered and...or a device was not ordered for a specific reason, can't be successfully expressed in Category I. And that's a new finding that needs to be resolved. So, whichever version we pick, there's going to be an issue but Category I version 3 is the most...would have the most issues resolved; if that helps.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Okay.

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

Yeah, that's very helpful.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Category III, which is the summary, is going for normative ballot; meaning that we believe...the HL7 group believes that since the 2014 Errata were published, there has not been any significant issue and it's going for ballot in September/October for normative. So, I think the rule timing may be such that you can't go to the normative version, which will likely have some updates to it. But that would be nice if we could, because that'll be one that gets additional comments and additional updates. Just if it goes to ballot in October, it'll probably take several months, at least, to resolve comments and publish.

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

And do you think that that allows enough time for the different stakeholders to make sure everything's in place...

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

No; that's the issue. While that might be the preferred going forward long-term, it may be that Category III with the 2014 updates is...which has been out for a while, may be preferable, only because of time to...only because we don't know what comments will come in on the normative ballot and there could be changes that would require work. We just don't know.

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

And that work could go on for a number of months, making implementation...

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

(Indiscernible)

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

...hard. Yeah.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

I mean, ideally if it weren't...if the rule could deal with it later that would be nice, but since it can't that may be an issue. I'd look for others' comments on that as well.

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

And Floyd, this is Kathy, just to clarify. I think at one point you might have said Category III, but I think that you were really speaking for Category I version 3 as being...

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, in the first...

Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association

...as the one that is the most error-free but still, as you said, not completely free of errors or of problems.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yes, it was Category 1 version 3, but it will have...we know one error that just became available. When I say the term the...I'm not saying "we" as the royal we; I'm one of the Chairs of the CQI, Clinical Quality Information workgroup at HL7.

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

Um hmm.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So when I say we, I'm referring to the workgroup; sorry.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Oh, thank you.

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

And so it sounds like the biggest risk if we were to move to the newer standard is everything not being in place to allow vendors to do their work and get it out to providers. Is that right?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Correct. But if we are going with QRDA, which seems reasonable, then QRDA Category I, release 3 would be the most reasonable and does give them some time. Categor...QRDA Category III, the summary, the 2012 version with the 2014 Errata seems most applicable to this use.

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

Okay, thoughts from other folks on the call?

Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

This is Elizabeth Mitchell; I...no thoughts on this, I just wanted to let you know I'm here. I've been here, was on the wrong line so I had the benefit of the introductions in the background. Just letting you know I was on.

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

Oh thanks Elizabeth, sorry.

Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

Sure...

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

Glad you're here. Lori, any thoughts from your end?

Lori Coyner, MA – Director – Oregon Office of Health Analytics

I don't really have anything to add; I agree with what Floyd's saying in terms of timing and I...it would be helpful to know a little bit more about the option 3 for both. I think that working on the QRDA...continuing to work on QRDA rather than switching to some other QRDA-like standard seems to make a lot more sense from our perspective. We're developing a clinical quality metric to...or clinical quality metric registry to ingest QRDA data and so...and the amount of time that it takes to put that together is pretty significant. So to switch standards in the near future will be pretty difficult, from our perspective.

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

Yeah, so let's go on to the next slide...

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd; I might be able to give you some background on that as well.

Lori Coyner, MA – Director – Oregon Office of Health Analytics

That would be helpful.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Maybe your next sli...I think your next slide helps with that. The direction that the Standards & Interoperability Framework, Clinical Quality Framework is going and supported by work in HL7, is to move all quality-related standards to use the same expression language, that is clinical quality language; the same data model, which is the Quality Information Clinical Knowledge or QUICK standard and also the same metadata.

QUICK, which is the data model, has not been balloted as a draft standard yet and is to be balloted in October. So if it hasn't yet been balloted, it can't really be included in a future QRDA yet or some future FHIR-based profile. There is FHIR-based Quality Profile but all of that is still somewhat early and I would be concerned that it's still evolving and seems rather early to put into an HHS rule.

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

So Floyd, that is going...undergoing testing and do you have a sense of what the timeline is before they've identified all the bugs and is that sort of a 1-year, 2-year kind of cycle?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Well since QUICK is in development and isn't even balloted yet, I think it's a little early to say what that timeline might be; the ballot in October will help define some of it.

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

Um hmm.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

How fast things move to FHIR, I don't know that I have a crystal ball on that. And I think it's good to look at all that for future; there is a proposal in HL7 for a Quality Report using FHIR, but that has yet to be balloted, so I think that's very premature. It's not going forward in October yet so, I don't think there's...there's some testing being done, some work being done through Clinical Quality Framework, but I don't know that there's enough at this point to recommend that in an upcoming rule.

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

Very helpful. Others...

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

Yeah, this is Lauren; if I could also make another point that you may want to consider. This was made in the rule as well, in the 2015 Edition proposed rule. While the QUICK standards are not currently available, I think the question asked in the rule was whether...depending on how soon they become available and the industry desired to move toward those newer QUICK and FHIR profile standards, what is the trade-off in what we would require...might require now in terms of QRDA and then the amount of rework that would be required for developers. You know, if we moved to an incremental QRDA standard, it would require some deal of rework for developers and the question is how much rework in the next couple of years is really implement...on an implementation scale going to be a good balance in terms of where the industry may be moving in the next couple of years. So, I just wanted to also highlight that point that was made in the 2015 Edition proposed rule.

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

Do folks have thoughts about that?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So unfortunately we don't have as many people on the call who could comment from say vendor perspective, but I would tend to think the least rework now that we can address would be appropriate considering that there may very well be a move to use FHIR with a new data model QUICK and different structure. So rather than have people...the implementers be using different standards and changing on a regular basis, to have as little rework now as we can.

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

So to maybe probe a little more Floyd, since you're pretty involved in this work, I guess the question, one question leading from that comment is, of the options listed here, either staying with the July 2012 QRDA or adopting it with the September Errata or moving to the release 3 that's currently being ballot reconciled, which would require...what's the level of work incrementally for each kind of up-versioning of those standards?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

I'd actually want to hear from vendors to understand some of that and probably from CMS as well, to understand their level of effort. But, I believe that to resolve issues that were present in prior versions of QRDA, the release 3 of Category I still would be an appropriate direction. I don't think there are that many significant changes in that and it would give the most up-to-date information. I know that's what one of the suggestions the Standards Committee Content Workgroup is suggesting as well.

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

So but Lauren I think your question is really trying to get at whether we should be trying to move more quickly to QUICK, right? So that if there's going to be rework, is it better to get it started now and evolve that? Is that what you're probing for a bit?

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

No, I'm not trying to lead the workgroup in any direction, I have to say, since I'm coming from ONC, I just wanted to maybe better understand for each option what's sort of the delta in the amount of work required versus the potential benefit out of the work required.

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

Right.

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

And Floyd did mention, QUICK, there is no balloted standard yet and HL7 would expect to ballot a DSTU, a draft standard for trial use, I believe, at their September meeting which, like he said, would require, if it passes, ballot reconciliation into October. So, I think the risk that was pointed out in the rule is that the timing of things and the...may not match up with the desire of where the industry wants to go. But given, in rulemaking that ONC needs to name a particular version, we'd like some comments on understanding the balances and trade-offs of adopting one version over another. Does that help?

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

Yeah, but I do agree with Floyd, it would be helpful to get some additional perspectives from the vendors who are on our workgroup so maybe there's a way, since some of them couldn't join today's phone call, to pose some follow up questions, particularly since it seems we have a bit more time to play this out, is that right?

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

Yes and I know you mentioned Ginny; I think she said she would be on for the last half hour, is that correct? But yes, I agree, we could at ONC put together a list of questions to send out to the group and particularly probe for some vendor input.

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

Yeah, because I feel like they're under-represented on the call this morning, so it would be helpful to get their perspective, to try to understand sort of these issues of striking the right balance while trying to move things forward. And understanding the implications for rework and the timing of when things are going to be settled.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

The other thing, I think, this wo...that's worth bringing up is the difference between what's in QRDA and use there and what's in QUICK, which would be more future, is it's a different data model. Currently measures that are developed and in the 2014 and 2015 updates are using what's called the quality data model as their way of expressing information. And while that's evolving slowly, and hopefully will evolve in the direction similar to QUICK, so it'll be less of an issue going forward, there's no decision to move forward yet on the CMS side that I'm aware of, to replace the quality data model with QUICK. Eventually it will happen when QUICK is more stable. But if all measures are basically related to quality data model, moving forward to a new model in reporting could be a big challenge and that would be a concern. So it's also related...we have to take into account what CMS can accept and when their systems can be ready to make such change, or else we'll have EHRs reporting and no one able to accept it.

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

And Floyd, just to...this is Kevin; a quick comment on that. This is the CMS proposed rulemaking so presumably they have crafted this with ONC input. We have not historically, as you're aware, either ONC or CMS, put a data model into our rules.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

That's true and I recognize that and for good...that's for a good reason; it's just a matter of timing for implementation if all the measures are using QDM, they would have to be converted to QUICK when its ready, in order to try to report using it as well. That was my concern.

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

Yup, no, and again I'm not trying to lead the group in any direction, I just want to highlight that the data model has not been regulated historically.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

And please don't anyone take this wrong; I'm all 100% in support of moving to a new model, I'm just concerned about the timing.

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

And the timing again, just to remind myself as well as others, this is for implementation in 2018 reporting, is that right, Lauren and Kevin?

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

Right as currently proposed in CMS's corresponding MU3 rule, they wouldn't require the use of this 2015 Edition certified technology for Stage 3 until 2018 with, as currently proposed, providers having the option to switch over from 2014 Edition to 2015 Edition certified technology in 2017.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

So this is Kathy and I think that maybe what we're...we're trying to address several different objectives, obviously, through the rule and one is to have as many eligible providers, eligible hospitals, critical access hospitals reporting as possible. So to increase participation and at the same time, we face the challenge of trying to use the proposed rule as a mechanism for promoting innovation.

And so a potential way to do that is to say, or to include language along the lines of, either/or, so that the participants have the option of using a much more stable model ongoing and know that they can use that model as one of the tools in their tool kit to improve. And yet at the same time, if you have it as an either/or, then you're also acknowledging the need for continuing innovation. And I do agree with the comments made previously about the need for vendor input and whether there will be the, shall we say the bandwidth and the time for them to essentially be continuing to implement and make the decreasing number of corrections and fixes on the more stable model while at the same time also making the investment in the newer model. So in some respects I favor really a head-to-head either/or. I admit to being very uncomfortable committing to an as yet unballoted, not validated set of standards.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Just Floyd with one more comment on that one; I like the general idea of the approach, I would need to hear from vendors though. The problem with an either/or is, especially if they're dealing with certification, they have to be able to do both...

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

Um hmm.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

...either/or means you have both requirements and that sometimes is a big challenge for vendors because rather than working toward one, they do have to do two things at the same time. And that may actually in implementation mean they actually have to have both running, depending on what the individual organization customer wants to do. So I'd really need to hear from them what that impact would be.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Yes, and Floyd, this is Kathy; I couldn't agree with you more. I think that if we look at version updates on our Microsoft Office and things like that, I think this is one where the vendors...what I don't want to see happening is a situation where nothing is available. I want there always to be something available for eligible providers, eligible hospitals, critical access hospitals to use.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah and I think the other challenge we have is we really want to move forward to new things that are better, easier to use and because rulemaking kind of puts us 3 years in advance of the current time, it pushes out even further how to move to the new. So there is a tension there, I understand that.

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

Right, because by including it, it helps to potentially speed that innovation. But my question is is the language here constrained to implement in 2018 as opposed to 2019? I mean is this rule totally focused on what happens in 2018? I mean, what would be...is there an option to kind of signal this shift that the implementation is say pushed back a year?

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

So this is Kevin; so the...this is kind of a new way of architecting the requirements for certification of quality reporting out of EHRs.

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

Um hmm.

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

And as this is the first time, I think also comments on how this has been architected would be welcome. The CMS IPPS rule describes, as does the CMS MU3 proposed rule, the reason to put some of this into the fee schedule rules is to keep the measure alignment and program alignment more clearly in play with the regulation. But I don't think that either rule has stated anything about kind of frequency of rulemaking, frequency of change, anticipation for things like that. So that is, you know, this is what is and the committee certainly can discuss wha...this particular architecture of rulemaking.

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

Okay. Thanks for that clarification. I guess Floyd, what would help me, since you seem to have a fair amount of knowledge in this space, I mean, is it reasonable to expect if there was a longer timeline for playing this out that this might be a reasonable thing to signal the shift to?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Well I think it would, and even this time I might not be sad if we had basically a stable...somewhat stable even draft standard for trial use. The challenge with QUICK is it's not balloted, so I can't answer that question. It's been...there was an initial informative, but the actual ballot has not happened for the DSTU yet; that's the reason I'm hesitating.

Lori Coyner, MA – Director – Oregon Office of Health Analytics

This is Lori and I don't know if I'm going to be providing too basic advice or feedback, but what we've experienced in doing...in trying to capture data on the ground are a few things that I think might be helpful to share. So, and I think Kevin alluded to this but one thing is having standard and moving the vendors towards standards that are very prescriptive has been a plus.

But I will say that shifting them very quickly causes lots of problems on the ground because what happens is all the different ven...we have...still have so many vendors in the field that some will start a transfer and others don't in technology. And so it puts us...it hampers us in a way that we have to have a lot of different methodologies for accepting data. And frankly, in the State of Oregon right now we have about 70% of our providers are on EHRs or more, certified now and even with that, we are unable to capture QRDA I out of...from most providers.

So the way...what I would promote and really stress is to have standards that make capture across multiple EHR systems as easy as possible and not shifting standards in a substantive way until we get a lot of these early problems solved. So, that's why I think where we're talking about a version 3 of Category I would be very helpful, the more that we can eliminate bugs and problems with the systems, the better. But, I'm a little concerned about already moving to a new system when we still haven't even been able to adequately use the old system. So, I don't know if that's helpful or not, but...

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

Yeah, no, that is very helpful.

Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

This is Elizabeth; I guess, this may very well be far too general, but I really want to support what Lori just said, not moving so fast that we make ourselves go backwards. But I also just want to stress the urgency to move from the users that I work with in the field and understanding the burden it places on vendors but not having that determine the timeline. So, there's just a huge urgency for particularly going across the vendors and having...standards. So in addition to what Lori said, just emphasizing that piece.

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

So, let me see if I can try to summarize some of the comments thus far. It seems that people on this call, while there's a desire to stimulate, support innovation and recognition that work is ongoing, it's...somehow or other we want to signal that we support that, but that it may be a bit premature to move to that. Would that be a fair summary of the thoughts?

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Yes from my perspective.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd, I would agree and I agree with the last set of comments as well. Is there a way, and I realize we're not writing the rule; we're giving recommendations on what's in the proposed. But is there a way a rule could indicate these are the required for reporting, but that the...that there is interest and folks should be aware of and think about these new things that are coming out because they're likely to be the next phase; even though they're not specifically required in the rule? I believe that can occur, can't it?

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

This is Lauren; yes that is something that the federal agencies can do and if that's a suggestion of this workgroup that they believe the agency should highlight a future direction, you can certainly make that comment.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

And this is Kathy; Lauren, I would add to that and to Floyd's comment also we've alluded to it just a few moments ago, sort of saying at what point in the balloting and validation process, sort of at what point something starts to be, shall we say named as being our future expectation. So I think that, and this is where Floyd and others can help us, is saying this is really too preliminary but at such and such a point, we think we can see a line of sight to the point of this being something that can be implemented by a vendor. So, I'd encourage some thinking along those lines; when is the line of sight good enough and it's not that it's 20:20 but...and necessarily direct, but when is the line of sight good enough that we can start to talk about it?

Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

This is Elizabeth; I don't have a precise answer but I think the earlier the better and I think that the clearer and more precise we can be, they can innovate to achieve some of those changes.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

And this is Floyd; I'll like second or third that. But I do have a comment, and maybe it's the elephant in the room that nobody's brought up here that all of these standards are moving in a direction for reporting and others for expressing the measures. But I think there's also the issue of the measures need to address more feasible information and useful information that can and should be included in electronic health records and I think while the standards may be useful, at sometimes the content of the measures that's causing the problem. And I don't...I guess we can't address that in the rule but that's an important issue that needs to be addressed.

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

So Floyd, could you give an example, because I'm thinking when we try to summarize our comments that's always helpful to have something to point to.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Well, here's where sometimes vendors can give us very concrete examples from individual measures, but in general, when measures are looking for things that are basically that the provider has a care plan and has addressed goals when there's no clear standard for how to address a goal of a care plan. It's often creating something that the provider has to check a box to attest that it happened and creating workflow that may be happening, but in narrative text and they have to change how they do it. And that sometimes is important for clinical care, but many times is not and it's extra work.

And so sometimes they're looking for things that are just harder to collect. There's a whole controversy over whether or not it matters if we should really look for exceptions of reasons not done or if they should just be exclusions in the measures; that's a whole other large discussion. But there are additional workflow elements that are often included in the measures because they're process measures and they are somewhat problematic and that's what's causing some of the issues as well.

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

Okay, that was helpful. So can I maybe try to summarize, because I'm looking at the clock and recognizing we still have to go on to the second item that we need to discuss. So I think that we are starting to settle on and Floyd, you said it was QRDA I, release 3 is the most current and stable version. Do I have that correct?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

You do.

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

Okay and that's what we would be recommending with this add on set of comments about the need to support innovation, signaling future direction and that future direction should be happening...or the implementation of that future direction should be happening earlier rather than later. So, is that sort of the gestalt of this conversation we just had?

W

As well as...say the faster the better and the earlier the better.

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

Okay. And then Floyd's...in terms of the QRDA III, the most recent one is the 2002 with Errata, correct?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

2012.

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

I'm sorry, 2012.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah with the 2014 Errata; I...it may well be that the ballot in October for a normative version goes smoothly, it's very few changes and it's great. In that case, the 2012 with Errata probably is almost equal to it. But if it does have...it basically normative opens up everything in the ballot for discussion and while that might be something that should be looked at for say consider for future. I'm not sure if we can address that, I mean, I think I'd like to I just don't know what the challenges are because I don't know what will end up coming out from that ballot.

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

Right, right. Well, I think we still would like to get some input from the vendors related to their perspective on these issues, but perhaps we can craft some language both from the conversation we've just had to help them understand what we are potentially recommending and get some additional input to see if that influences any of the discussion we've just had. So just wanted to check in with people to see if they were okay with that process for moving forward?

Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

This is Elizabeth; as someone who's very new to this, can you sort of help me understand the rationale for that approach?

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

So, I think...so the idea here is there were several members who could not attend the meeting today, who come from the vendor perspective and have always provided helpful feedback in terms of where things are on the ground, what it's going to take to get there and offering very helpful suggestions on how we might be able to move down this path faster toward innovation. So I just want to make sure that their perspectives are represented in our conversation as we think about what recommendations we're making to CMS.

Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

Okay.

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

And I think what will help get some very focused feedback from them is if we can summarize the conversation we've had today, as well as our draft recommendation to make sure that they don't sort of flag any key problems with it.

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

And Elizabeth, one of the things...this is Kevin. One of the things we mentioned before you got on the call is that the timeline is short for this, the opening comment period for this Inpatient Fee Schedule Rule for CMS goes only for a couple of more weeks.

Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

Okay. Thanks, Kevin.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

And Kevin, this is Kathy; so then just maybe as a point of clarification, since the Health IT Policy Committee meeting has been postponed until June 30, does that also fall within that same limitation where we'd not be able to provide that feedback to ONC?

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

I don't know if Michelle's still on, we've...Michelle, did you have thoughts?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

So I think Kevin actually we are waiting for a response from you on this.

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

Okay. So...

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

And so as of now, I think we are going to work on...go ahead Kevin.

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

No, yeah; so Kathy, what we're working on is understanding from CMS what their timelines are like not just for public comment timeline, but with a need to...information and we don't yet have that information.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Sure. Okay, because we'll just, it will tell us whether there is...whether that next stage of providing feedback or that next opportunity including from vendors needs to happen between now and I guess its June 16 or whether it happens all the way up to June 30.

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

Yeah, I guess my hope, Kathy, would be that we could quickly solicit feedback from the vendors. I know Ginny is always very responsive and I suspect we can try to move this process along pretty quickly.

Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Yeah, it just...I think it might then just mean, I'm speculating, it might then mean that the whole health policy or the full committee would not have the opportunity to hear it or comment on it.

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

Right. So, I think we should probably shift to the other item that we were asked to consider and maybe we could move the slide down, because I recognize we have 25 minutes left and we need to allow time for public comment.

So the second area that CMS is asking for comment relates to new types of measures that would utilize core clinical data elements. And the idea here is that requiring hospitals to electronically submit core clinical data elements to enable risk adjusting, claims-based hybrid quality measures and also using core clinical data elements for quality measures that apply more generally to an all-payer population.

And so that's what is on the table and they had provided a list of core clinical data elements in the Word document that was sent out and this includes some patient characteristics, things around vital signs as well as lab results. So those would be the types of additional clinical data elements that would be captured. And the other issue here is the collection of additional administrative linking variables to link a patient's episode of care from the EHR data with the administrative data. And so those things might include admission and discharge dates, the CMS certification number and the person's date of birth.

And then the third aspect of this is use of content exchange standards for reporting these data elements.

So, if we go to the next slide. So these are the three things I just laid out. I would like to open it up for discussion to see whether people think that this proposal is a good idea, what might be some of the issues related to doing this and so I'll open up the discussion.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So, this is Floyd; I'll start with some of this. Where I'm confused is how will these core data elements be used? The current structure for quality measures specifically includes a section called...data elements. The reason that was included is so that even though the measure itself may not be able to express how risk assessment...risk adjustment, sorry, should be done.

If there are additional elements that are needed for such risk adjustment, then the information on any individual patient that accompanies the measure results will be collected and Category I QRDA, in any version, will be able to provide the data and then that data can be used to do risk adjustment, given that you have a...some expression to do that. The challenge is, if you're reporting out on a measure and then you're reporting separately on core data elements, I'm not sure how you combine those. You're going to have to identify which patient is which. So, I'm confused on what the ask is.

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

So Floyd, this is Kevin; I can do a little bit of clarification here. There's been a Yale set of measure development that's been ongoing for nearly 3 years, building towards this model and the measures they're specifically developing are two claims-based measures; one of readmission for acute MI and one of all-cause mortality for acute MI patient. The measure architecture and analysis as planned has continued to measure those using CMS claims, but to add a risk adjuster of clinical data sourced from EHRs.

And the work that they've been doing it's kind of public and been posted, is to take these 20 data elements from mostly the emergency department on a routine basis and bring that in, much like they would bring in claims in some way. And then at the end of the year, calculate both performance rate of mortality after acute MI and then risk adjust it with this clinical data. That's the general model of the Yale project.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

All right, no, that's helpful it's just it's...the way this is stated makes it sound more expansive than that. So that's why...so the other question is, in what content standard would they report the additional data and that's what number 3 is about.

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

Correct and this is, to be clear from the kind of Yale CMS standpoint, a pilot and potentially the beginning of a new type of measure, hybrid measure to measure in general using this kind of clinical EHR data more generally to do risk adjustment across other measures.

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

And Floyd, they're thinking of being able to link this, based on say admission and discharge dates, the date of birth of the person, so along with these elements would be linking variables.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Right, so they're asking basically for just reporting of data on every patient, in a sense, as opposed to the exact calculation that you're going to deal with for risk adjustment. But it's reporting the data to do the risk adjustment.

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

Floyd yes, that's my understanding. And my understanding is that as proposed, CMS would just require the submission of those data elements and that CMS would do the risk adjustment for the hospitals.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, so my...the only concern I have is if the data elements are reliable, I know in quality measures, and they may well be. But in quality measures we sometimes find that if we're relying on a problem list, we're not always sure we can trust that it is...it has the fidelity we need, that it's not kept up-to-date as much as we'd like or whatever. So as long those data elements have the fidelity that you need to do the adjustment, I think that makes sense, or could make sense. But, that's a concern.

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

And I guess, building off of what Kevin just indicated, it seems as though this is sort of the initial proposed list, but CMS is also signaling that they would anticipate future expansion of the list of these types of clinical data elements. And I suspect that's...they're trying to imagine the future where other types of measures might be constructed that would require risk adjustment or other clinical elements to compute.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, so in order to get a valid answer to this, I think we would really, similar to the other question, need input one, from the vendors. But we'd also need input, I think we have folks from AMA here, but do we have folks from, or I should say, PCPI, but do we have folks from hospital measure developers such as the Joint Commission and others to help...who have experience here as well and what that might mean, so we get additional input into our discussion.

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

Cheryl and Floyd, this is Ginny.

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

Hi, Ginny.

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

Hey, so I just joined late, sorry; I had a previous commitment earlier. But as a vendor, we've actually done some work looking at these data elements as to how they're defined, and I think that's a really valid comment from Floyd, as far as really needing some more granular input. But we do have some concerns because when we look at some of the data elements that are defined in the core clinical data elements that we would think should align with the same thing that's defined in the common clinical data set that ONC defined. They're not the equivalent and they're defined differently in many cases and that's one of the concerns and I shared kind of an initial analysis that my really good content team had done to kind of show where there were differing requirements across what should be similar same concepts.

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

Yeah, so that was the most recent attachment that was sent out with the meeting invite. Those were the findings that Ginny provided and I think this is especially helpful for information we might want to feed back to CMS because I guess in order to move down this path, they would need to get better alignment between these things, in terms of how they're specified. But, let me just probe a bit; provided we could fix the data element definitions and get those aligned, do folks on this call think that this is a good area for...or a good direction for CMS to be moving in?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So this is Floyd with a comment; I think where I see things potentially moving here is instead of defining measures...the concern, and this would be a concern for providers and hospitals and to see their views here. But that it almost raises the question rather than measures; just send me all your data and we'll decide what's valid care and not valid care as far as adjustment and I think there'd be some concerns there. It seems to be the beginning of potentially that era. I don't know that that's bad; I just think it needs discussion.

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

And so Kevin, maybe you know from your interactions say with the Yale team, because my sense was that they thought that the variables that had been proposed would cut across a number of different types of measures rather than in the future, as Floyd flagged, we're...all data.

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

Yeah, so I can speak a little bit to the methodology that Yale went through, so again, this has been a multiyear project. They convened a set of stakeholders including a number of EHR vendors and health systems to identify a list of what they thought could be routinely collected from EHRs in hospitals, and also looked at what has been shown to be able to risk adjust, especially around mortality in acute MI.

They then have done some testing on those data elements to see which actually impact the risk adjustment model. One of the things I think that's been highlighted about the difference between the ONC common clinical data set proposal and this is that the analysis for these data elements has said that they need some specifics about which encounter and context of the patient. So for example, identifying blood pressure; for the purposes of these risk adjusters, they want the first blood pressure in the emergency department, because that's what they have determined in the risk adjustment model is the one that is best used as a risk adjuster, not kind of generically any blood pressure that could be captured in the hospital encounter.

So, the...this is a developmental project, absolutely, with the hope or the thought that with kind of pilot and development this model could move to other parts of measurement. Like the project has been very specifically focused on these two measures; thinking about that broader context, but it hasn't been proposed yet that this would be the model for everything going forward nor that these would be the universe of data elements.

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

Yeah, I mean, while I support access to a broader set of clinical information for appropriately risk adjusting outcome measures, because I think the desire among many stakeholders is to move toward greater measurement of outcomes. I think these kinds of data elements are going to be important for that so I think I personally would like to signal some support for doing this type of thing. But I guess I share Floyd's concern about this could end up being the dump of everything. So the question is how to find the right balance between what's necessary to measure outcomes?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

And this is Floyd; there are two comments. One is Ginny, I really appreciate that summary; I didn't realize what that was when it first came through. I think one issue is that if the elements are different from the ONC data set, that's going to be problematic for understanding what we're looking for. And just simple things like the clinical data elements for male and female versus male, female unspecified. The issue of using systolic...blood pressure using SNOMED versus LOINC, like in the ONC data set. So I think it would be really helpful on the vendor perspective if there was standardization of what the data set content was.

I would also wonder if this has been done for specific disease entities. Would it be...the current method for collecting information for measures, allowing supplemental data elements, you don't need a rule, you could include those in any measure today and the specific measure is out...goes out for comment and gets both clinical and technical review as opposed to just sending this set on everybody. And it may be that certain elements don't apply or shouldn't apply in certain conditions whereas it might apply in others; managing it by measure may be a better way to get comment about that how it gets applied. I just think we should consider that.

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

Yeah, that's a very good point. Others on the phone, I know we're getting close to time and we'll have to wrap for today, but I just want to give folks another minute or two to reflect on this.

Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

This is Elizabeth and I'm sort of struggling with how to weigh in here but, I support the direction and would share, we just did a big pilot across multiple regions testing the effect of different risk adjusters. And having the complete data was critical to understanding that and risk adjustment was obviously critical to the comparability. So, if this is a method to accelerate that, then I'm supportive. Maybe it is, as Floyd said, sort of defining the standard data set; I don't know precisely but I do think that this is an area worth exploring. I anticipate concern from the hospitals, but, there needs to be some way to move this forward.

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

Thank you. Lori, just want to get your thoughts, too...anything? Okay, so Lauren, Kevin, Sam and Stephanie; my guess is we should probably move on to the public comment and maybe the next step here is we try to summarize the thinking related to the two areas we were asked to comment on and put that back out for folks who both have participated in the call as well as folks who could not join. And maybe we try to craft a little bit of language around summarizing the feedback for CMS and see if folks can help comment, tweak that, recognizing that the timeline's very short.

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

Great. Yeah, I think we can agree to do that. We've been all taking notes and I think Stephanie's on point to draft up a summary deck of what was discussed today. The other thing that we wanted to check with you on is, we did put on the books a 1-hour meeting on Monday at 10 a.m. Eastern time because we anticipated you may want to regroup to review that consolidated input. And then if you wanted to have a little more time, I think, to discuss this core clinical data elements or if we have more vendors on on Monday, we could revisit some of the issues. So I guess the question is whether you still want to hold that 1-hour on Monday?

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

Folks, how do you feel? I guess I'm of the mind that if the ONC staff could quickly draft something it might be helpful to take a look at that and get people's feedback on whether we think we've got the language right.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So this is Floyd; I think that's very reasonable.

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

So, I would propose we continue with that call and perhaps some of the folks who weren't able to join us today will be able to join that call. So I think we should move forward with it.

Lauren Wu, MHS – Policy Analyst, Office of Policy and Planning – Office of the National Coordinator – Department of Health & Human Services

Great, that sounds like a plan. Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you and it sounds like we're ready for public comment.

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

Yes.

Public Comment

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Lonnie or Caitlin, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

Yes. 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. If you are on the telephone and would like to make a public comment, please press *1 at this time.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

And we have no public comment. So thank you everyone, we really appreciate you being able to attend on such short notice.

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

Yes, thank you so much everyone and thank you Michelle.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you, Cheryl.

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

Have a good weekend everyone.