



HIT Policy Committee Quality Measures Workgroup Transcript May 9, 2014

Presentation

Operator

All lines are bridged with the public.

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a public call and there will be time for public comment at the end of the call. This is a meeting of the Health IT Policy Committee's Quality Measures Workgroup. As a reminder to those on the phone, please state your name before speaking as the meeting is being transcribed and recorded. I think instead of going through the whole list of people, I'm going to just list off the people who I know are on the phone. So, Helen Burstin?

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

Here.

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

Aldo Tinoco?

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

I'm here.

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

Cheryl Damberg?

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

Here.

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

David Lansky?

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

Here.

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

Hi, David. Mark Weiner?

Mark G. Weiner, MD, FACP, FACMI – Assistant Dean of Informatics – Perelman School of Medicine at the University of Pennsylvania

Here.

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

Norma Lang?

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

Here.

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

Alexander Turchin?

Alexander Turchin, MD, MS – Director of Informatics Research – Partners Healthcare

Here.

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

And from ONC, Kevin Larsen?

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

Here.

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

Lauren Wu?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Here.

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

Kim Wilson?

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention – Department of Health & Human Services

Here.

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

And are there any workgroup members that I missed? Okay, with that, I'll turn it back to you, Terry...I'm sorry, Helen.

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

Not a problem. Has Terry joined us yet? Just checking.

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

No, she hasn't.

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

Okay, great, so we'll just proceed. Thanks everybody, appreciate you joining us on a Friday afternoon. We are trying to wrap up some of our work and this is an important sort of summative call for us. So, if I can have the next slide.

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

I'm sorry, Helen, I just want to interrupt to say that Eva Powell is on as well. Sorry.

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

Hi, Eva, Welcome.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Thanks, sorry.

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

Not a problem. Glad to have you. So I was just beginning to say that part of the goal for this call is first talk about a little bit of the feedback we got this week from the Health IT Policy Committee on the MU3 recommendations. And then also we got pretty clear recommendations from Paul Tang and the Policy Committee that they really wanted a broader package of our recommendation, perhaps with more context for how it relates to sort of the bigger picture. Next slide.

And part of what we also heard, it was somewhat difficult to look at just a list of measures that we had looked at, which we frankly had some difficulty doing that task as well, in the larger context of the broader recommendations without being able to put it in some framework or context. So one of the things Terry and I raised when we were discussing it with the Policy Committee was in some ways, being able to wrap it back into the accountable care CQM framework for measurement might be a way to allow us to present more of the current state, intermediate state, future state, and perhaps give more of that longer term vision. The Health IT Policy Committee also asked that we consider making some recommendations on a set of core menus or a menu approach for MU3. And a corollary to that was also could we potentially make recommendations on which of these measures should potentially be required for MU3. And Kevin, Lauren, or Michelle, please stop any time if there's something you want to add.

Next slide. So what we're going to propose to do to try to create this package to hand back to the Policy Committee is first of all to go back through the MU3 recommendations we had talked about on one of our last calls. Reconsider the framework that we had put forward to the Policy Committee before, and really think about how we can bridge those, how we can bring those two together and put the MU3 recommendations in the context of the framework and perhaps talk about what might be next steps to move forward with. And then on our next call, we're not going to get all of this done today, of course, we'll come back to this issue of core versus menu and potentially which measures should be required. Any ONC folks want to add anything here?

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

This is Kevin, just that what I heard was that some overarching policy recommendations I think are what they were looking for, so the framework is great, but if there are some kind of near term or particulars into the policy. So that's, I think, where core menu is one of those types of policy recommendations, but you can imagine other framing things that the workgroup has discussed over the years around flexible platform, any number of other things. I think that's the thing we want to be sure to include in a package.

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

Great, that's very helpful. Laure or Michelle, anything else to add? Okay, all right –

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

Sorry, Helen –

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

Go ahead.

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

I just want to – I think that they're just looking for to kind of bring everything together. I think there was some confusion at the last Policy Committee about how that relates to what's been recommended in the past. So kind of reminding them of what's already been approved, because I don't think some of them remember.

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

Right, and I – that's an excellent point Lauren. And I think part of what we heard was that in some ways the list of the measures that are on those subsequent slides, as we'll see, in some ways looked pretty still heavily process oriented, didn't perhaps have as much of that sort of direction that we were trying to promote through the framework piece. And so they seem disconnected in some ways, from the prior work we'd been presented them and then giving this list of measures. So, I think we'll have a chance to talk about these as we go forward. So with that, just checking to see if, Terry, have you joined us yet? We'll weave her in as we can. Okay, next slide, please.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So Helen, this is Lauren.

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

Yes.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

For these upcoming slides, I pulled the full set of recommendations that we had made to the Policy Committee in January, which were approved and so I think there are a lot of slides, it goes through slide 18. I don't know if we need to read through every word itself –

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

Okay.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

– but, I just pulled it all so we had all the language here.

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

Yup, absolutely, no intention of reading them all. But again, I think particularly since it's a small group, anybody at any point around each of these slides, has specific questions about some of the recommendations, please let us know and we can take a quick break there. So, next slide, please.

These are the ones we had approved. This is the measurement framework going back to January of 2014; a lot of this work had been led by the Accountable Care Workgroup. So, not to belabor this, but just to show that was really – the idea was we wanted to be able to get to a measurement framework that emphasized a patient-centered view of health. With a focus as well on health and healthcare, considering expenditures, patient experience, really a very broad set of parameters with a very strong focus on outcomes, specifically functional health, health risks, disease conditions or sites of care in particular. Next slide.

This was the domain framework, kind of illustrated two different ways, just to remind ourselves that there may be some places where you'd be looking at the whole population, for some places where you'd have domains fit within different levels of the hierarchy. And then there might be some places where you're really looking more at the populations by the different domains across all levels of the hierarchy. And again, trying to make the case that we need to move from our current state, and apologies, this is a little hard to read – oop, I guess if you actually maximize your slide on your computer, it makes it a bit easier, as I just discovered. So really trying to move from where we are now, which is more of the sort of generic or disease-specific intermediate outcomes, moving up towards more generic health outcomes and even generic healthcare outcomes, ultimately getting to generic health outcomes, like PROMIS and total cost of care, etcetera. Next slide.

Oh, this is even easier to read, pretty much I've said this but just really again now you can see the two examples there of the subpopulations, one there for the frail elders, the other for disabled under 65. Where, for example the frail elder's status post joint replacement might be a really important consideration for across multiple of those key domains. Next slide.

So we also had put forward to the Policy Committee back in January, and something again Terry and I emphasize with them this week that there really are a whole series of key measure dependencies that will really allow us to make progress in some of these areas. And we wanted to also see whether there were some additional dependencies we should add to the list, and really this what additional work needs to be done to actually allow us to get further along and better progress towards outcomes of health in some of these areas. And the key measure dependencies we had put forward before, and again, I think if there are other ones here to suggest, we'd be very open to those suggestions.

For example, interoperable systems becomes the mantra, I think, in every single one of these discussions. And the recommendation at the last time Terry and I had presented this framework to the Policy Committee, was the idea of starting with a subset of key data that should be interoperable before trying to make all data interoperable, as sort of a starting place. Needing data sharing across providers, wanted to make sure there were tools for population health as well as patient encounters, really wanting to push towards measures that would actually require multiple data sources, so called hybrid measures that might pull in claims and cost along with patient self-reported surveys and information that might come directly out of an EHR. We want measures and data accessible by all providers and we want to be able to consistently capture the variables we would need for stratification to get at disparity. So again, other key dependencies would be welcome as we move forward.

Next slide. And here we went through each of the domains, and I won't go through each of these, that we had presented as part of this framework to the Policy Committee. And just briefly, again, highlighted for them the need to develop measures that get at some of these domain areas for which we have gaps, like falls prevention, HAIs and EHR safety. A couple of specific recommendations about some of these hybrid measures around claims, EHR and ADT, a focus on avoidable hospitalizations, perhaps, a couple of examples there. And then for some of these we specifically put in the HIT infrastructure needs, as you may recall, and some of those are listed here. And again, on every single one of these, you will see the need for interoperable systems across settings of care and data that begins to allow us to create hybrids across electronic and claims-based systems. So, first one being safety.

Next one please. Next slide, I'm sorry, thank you. Population health and equity, again we've mentioned some of this, making sure we have measures that address those key areas, both through the ability to combine these data, a couple of key examples here, but specifically the infrastructure need here is having access to race, ethnicity, language, etcetera, to be able to stratify. Next slide.

Domain 3 specifically around getting at measures that get at effective use of resources, such as appropriateness of care, sufficient use of facilities and this might be an example of where we might want to go back and re – the way we presented some of that to the Policy Committee. Which was just about saying we had no measures around efficient use of facilities, but have that – more of that broader lens, perhaps. Again, data sources here, some example measures and here several of the key themes we've already mentioned, in addition to more of the comprehensive and complete expense information as well. Next slide.

Domain 4 is around patient and family engagement, really getting at measures that get at outcomes, experiences, self-management, and patient preferences. Some specific sub-recommendations here from the ACO group, many of which I think would fit across, regardless of whether it's ACO or provider or eligible professional or provider, being able to improve decision-making, patient engagement. And some example measures there of trying to get at personal goals, which you'll see have been built into some of the newer measures that are being developed for MU3, patient's longitudinal care plan and experience. Again, I think some of the examples, the infrastructure needs here, specifically capturing patient-reported data is really important, patient portals, ability to get a shared care plan, some of those listed. Next please.

Functional status and well-being heavily related to the prior one, wanted to make sure we have post-procedure functional status, recovery time. And you'll see, again, some of these are well captured in the list of measures we preliminarily proposed to the Policy Committee this week. And infrastructure needs similar to the previous slide, so I won't go over those again. Next slide, please.

Care coordination obviously continues to be a pretty significant gap across all data sources, to be honest. And again, data sources here being able to cut across the different systems, including claims and ADT. Some examples of potential measures there and then HIT infrastructure needs, specifically, for example, having some capacity to get at some interoperable registry for discharge diagnoses and disposition, as an example. Next slide.

And these were the criteria we had put forward of how we would actually go back and evaluate what measures should be developed and used for MU3. And just very briefly, here, preference for eQMs or measures that use data from HIT, more of a patient-centered, patient-focused view, across providers, across groups of providers, etcetera. Wanting to support health risk assessment and outcomes, a preference for reporting once across multiple programs to reduce provider burden and allow for aggregate data reporting. Next slide.

We want to make sure that the benefit is worthwhile, that measurement is beneficial and meaningful and outweighs potential burden there. And ensuring that the measures ultimately are useful to end users as well as providers. Wanting to promote that shared responsibility, collaboration and interoperability across those systems, interoperability again being the theme here. Promoting efficiency and then lastly, making sure measures can be used for population health reporting and building measures where the denominator can help support that. Next slide.

We also, as part of our prior recommendations to the Policy Committee, had suggested an optional innovation pathway, where MU participants could potentially waive one or more objectives by demonstrating they could select data for innovative or locally developed measures. And specifically here that potentially could specify those gaps that should – that need closing and a bit more description here of what that would look like, including a more conservative approach and a more open alternative approach to allow any EP or EH to come forward, but constrain what could be allowable for example, using the authoring tool. And then we did take commentary from the Vendor Tiger Team as well about considering the costs of maintaining and building into these systems. And again, it wouldn't be required, it was really more of an optional approach. Next slide, please.

Did we just flip by – so this – is this – I'm sorry, can we go back one, I didn't see what we were shifting between. Oh, okay. I thought I saw something flash before my eyes, clearly not. So, patient-reported outcomes, here again I think we've talked about this a lot, very much strong view that PROs should be MU objective measures that would allow the flexibility to incorporate different PROs. And there was a strong need for the HIT infrastructure and guidance for developing PROs. And a couple of additional things I don't think we need to get in to. Next slide.

Ah, that's where I thought. I think we've just gone through the accountable care clinical quality measure recommendations, didn't we?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So there's another framework table that they put together that I think Paul and others, maybe David Lansky requested we kind of tie this back to. And I think that it has been re – has been presented in earlier form to the Policy Committee, but never actually brought back in it's sort of final form.

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

Gotcha. Okay. I thought we just did that, but, okay, let's see if these look any different.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, you'll see there are definitely relate – there's definitely a relationship to our recommendations.

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

Okay, well, it's part of the goal, if the Policy Committee would like us to tie this all up with a bow, then I think it is helpful to see how these may be different. Just wondering if Terry or Joe are on with us, who might want to assist here.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So I think Joe said he might be able to join us at 4.

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

Okay, not a problem, so let's just keep going then. So, next – so –

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So if maybe we could turn to the document that says the ACQM Measurement Framework.

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

Okay. And you sent that to – oh, here you go. I see, you've put it on the –

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, and actually, can we display that?

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

It is, actually.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, great, sorry, I'm not looking right at the screen.

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

I was relieved to see it on the screen before I went searching for it in my inbox. So, again, this goes back to the original recommendations from the ACO Quality Measures Subgroup, some of which have a strong relation back to I think the meeting is trying to – oop, there we go, I just got kicked off, but I'm back on. Specifically listing out here some of the key domains, and I think we did match the domains, but there may be greater specificity here, in terms of some of the concept metrics and the data elements required. Kevin, anything you want to add about this?

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

So, for – this is Kevin Larsen. The context of this is that we were charged with thinking about measures that ACOs should do in a kind of forward thinking way, as we would create the new measures. And so we would sometimes – we sometimes tried to leverage what was there, but the workgroup often was more thinking about what was the infrastructure for measurement and the types of features and attributes and potentially specific data to be collected. So this was definitely a future looking exercise, but tried as much as possible to link into what was currently around. And again, I don't know that it's necessary to go through all of these detail by detail, but it might be helpful to think if there are any things in here to pull out as specific recommendations in a more near-term policy recommendation.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, and this is Lauren. I think you're right, Helen, the recommendations you just went over we tried to pull out pieces of this framework and funnel them underneath the relevant NQS domain. So where we talked about data sources, you can see here is the second to last column, we did pull that out in some of our recommendations. And also, the last column on potential HIT infrastructure, we did try to link that back to our larger set of recommendations.

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

Right.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

I think Paul really liked this framework because if you move from the left to the right most column, you can kind of see if we're looking to measure in a certain domain. If we move all the way to the right, what are actually the data infrastructure needs that need to be developed or worked on in order for us to get to that point. And so this was sort of our future vision and while it started out from the Accountable Care Workgroup subgroup, we thought that it was pretty broadly applicable for kind of the future vision for measurement in general.

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

Which is actually why actually much of this is on the slides I just presented, including the infrastructure needs, but perhaps this – maybe this is the way to display it that might get at more of that. And perhaps one thing the workgroup could consider is, having seen the list of measures proposed, maybe one way to pull this all together is actually to add in the MU3 measures either in process or completed, to see how they align to the key domains and the infrastructure needs. That's one way to pull that together, because for example, we've got some of the functional status measures already listed on the other slides. But again, I think there's a way to make that work. Okay, next slide.

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

Yeah Helen, this is Cheryl Damberg. I really like this table, I found this much easier to follow than some of the previous tables I've seen.

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

Great.

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

So I would certainly encourage you to, as you noted, try to map in those other concepts to this type of –

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

Great, that's really helpful. Yeah, I think that would be really useful to kind of –

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

And again, Cheryl, this is Kevin. What would be helpful, too is how this becomes near term policy recommendation. So, like this was discussed as what do we need in the future. I think the step we're at now is what's the right thing to do as the next stage?

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

And so, I guess to that point, Kevin, is it such that what's on this list is currently – vendors are able to execute this, because I think the thing I always get – what I always struggle with is, where are we in terms of the capabilities to implement any of these things?

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

So, this is Kevin, again. What I would – we really welcome any conversations that this group has about that. I think that as the ACO Workgroup talked about it, there was the notion that all of these things are done in some way somewhere, but that they aren't system-wide capacity. Many of them are small scale or pilot or regionally focused, like a Beacon or some other project.

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

Right. And so how much of trying to do some assessment here is – is this sort of 1-year kind of fix that can happen to make that possible or are we really looking at 2-3 years to be able to implement? Because I think that has implications for what's recommended for MU3, right, as a required.

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

So I guess I'd leave that open to the group to discuss. What we're talking about here is a policy lever and only certain things are really amenable to policy and other things require other motivators to happen, or there's just incapacity. So, this is really putting this through a policy framework, what in the upcoming policy is the right next steps?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Although, this is Lauren again, and I would say for some other arenas of MU, we have heard some suggestion that we allow pilots of certain capabilities count for one or more MU functional objective, in lieu of to be kind of building toward the future. So that's just something I would throw out there to consider, if the group feels that that's one way they can make a recommendation.

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

Okay.

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

This is Norma Lang. Could somebody help me understand a little bit, these measures are cutting across several kinds of providers. How do – can somebody speak a little bit to how that will work since providers seem to be individually reporting and then being rewarded?

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

So this is Kevin again. Remember the context of this was in ACOs, so the framework to think around this is there is some larger agreement or organization by which these providers work together in a group collaboration. And presumably, they have some capacity across that group to do joint measures across that group. What we see in the marketplace is sometimes that's a registry, sometimes that's a health information exchange, sometimes that's a data intermediary. There are a number of market solutions to that, but that was the context of this discussion was ACOs.

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

So – okay, thank you.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

And I would add – this is Lauren, that at the end of this table, there are some supplemental questions that the subgroup discussed and some of them talk about, how would roll up from the individual provider occur up to the ACO level? Should ACOs only be required to report at the ACO level or should they also be required to report at the individual physician level? So, the subgroup did discuss those and there's a summary of those at the end of this table here. So I don't know Helen if you think it would be useful to go through those.

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

What does the group think? Or Kevin or either of you? I mean I'm happy to go either way.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, I mean, I think just kind of bringing this back to our charge to what pieces of these kind of separate recommendations have we been building – should we kind of pull together for a more comprehensive set of recommendations. And thoughts on whether it should be in a table form or PowerPoint slides, text, etcetera.

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

Okay. I think Cheryl's point was well taken, I think what we need is some sort of table that actually brings this all together between the current concepts, the specific recommendations here, the broader concepts, the HIT infrastructure. So I think we could certainly start with a table and pull out key elements. I mean, I think the PowerPoint should follow what is the most important information we just need to transmit and start with the table, if that's what people think would be the most comprehensive and the ability to see across these different documents we've now got floating around.

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

Yeah, and this is Kevin. I would say I think another thing that would be really helpful to us is priority. So, we're unlikely to be able to do every single thing we want to do in Meaningful Use 3 policy, so if we have a sense of what priority is –

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

Um hmm.

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

– that really also helps in the kind of recommendations that are given.

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

So Helen, it's David. I just – I'm really interested in how this all comes together at the level of the proposed rule.

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

Yup.

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

In particular, back to the core menu and those kinds of questions because I think to Kevin's point just now, we would like to come out with something that's elegant and parsimonious and drives the next generation of MU users. In some ways takes as a given that people have already passed MU2, and we don't need to replay some of the lengthy process measures we've previously had in the requirements. And we could almost leapfrog to the next platform with MU3 and say, we're going to grandfather in the assumption that you've been able to capture and report these other quality measures previously – in previous generations. And now we're going to come up with a way to give you recognition for building some of these capabilities, even if you're a single provider or small practice, and not necessarily an ACO, these are the – directionally the capabilities we want. And we're going to find a way to take the measures like on this table and make them available for getting credit to different either EP, EH or even ACO or group practice model. That would be a real step forward.

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

Okay.

David Lansky, MD, PhD – President & Chief Executive Officer – Pacific Business Group on Health what I'm trying to think about is a way, could we walk away, I don't know Kevin – could we walk away from the old measurement list and just say, that's done, congratulations. And simply now focus, for quality measurement, only on iterative progress toward these kinds of capabilities.

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

So David, this is Kevin. We really welcome and hope for your wisdom, you know that the Meaningful Use Program has always been designed as an infrastructure building program and so part of the reason we don't focus all of our time on what are the specific measures is that that's the role of the measure application partnership for many of the CMS programs. The Meaningful Use Program is just as you said, focused on what are the capacities and infrastructure we need as a country, to really move forward quality measurement and improvement.

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

So the implica – I really like that, I think that's right.

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

Yeah.

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

And I think our opportunity is to signal what's the next ca – this is not a reporting program or a payment program, it's really to signal what capabilities are needed to monitor quality for the public purposes.

And if these are the things on this chart are tho – is what we think in the next few years is needed, we should try to incent people to build these capabilities –

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

Right –

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

– not worry about measuring – sorry, Helen.

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

No, I was going to say David, I completely agree with you although I think if I just pulled up the other set that we had presented to the Policy Committee this week. And there's an interesting blend on those slides that I think some of them felt like more of the same, but some of them actually were pushing us in that direction. And so maybe part of it is to actually pull out from that broader list of the measures under construction for a variety of programs, eMeasures to fulfill CMS programs as well as MU, the ones that actually do fit that broader vision and prioritize those on that list. Knowing full well some of these other measures may be very appropriate as eMeasures for the broader program to actually specifically prioritize the ones like the wellness assessments or the functional status, that get us closer to what I think – the reason we want to adopt the ACQM framework in the first place, because it really fit our vision of where we wanted MU3 to go.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So do you want to go through that exercise right now Helen, we can pull those slides up on the screen now.

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

Well I'd be curious if people think that's a reasonable approach. I mean I certainly heard what – I think there are ways we can take the prior work of the ACQM, that table, and build it out. But I guess my question for the group, Cheryl, for example, since you talked about using that particular table. Do you think it would be useful to specifically pull out some of the measures under development, but either build on prior concepts or completely new de novo? And add it to that table to sort of put some more of that in rather than giving examples of measure concepts, actually put in some measures under development as well as measure concepts?

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

I think that that's helpful, this is Cheryl again. But, I don't know whether to save you time if sort of the first step in this journey is to prioritize among those different domains –

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

Yes.

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

– where we want them to build infrastructure. Because it seems to me this whole area around patient outcomes and being able to have the capabilities to assess that and track that is a serious deficiency in, I think, virtually most systems. So that seems to me like it's a priority to build out in this next stage, and I could point to others. So, is it such that you really want to map all this over versus trying to establish your priority first.

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

Yup. No, I think establishing the priority would be first, I just wasn't sure we were really going to choose among those key domains. But I guess that's an open question.

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

So this is Kevin, I'll just weigh in and say I think if read what happens when we present to the overall Policy Committee, I think sometimes when we get into so many details and so many topics and domains and areas, it's hard for them to really understand the priorities. So I would reiterate that I think some bold, high-level priorities that aren't quite so much details of – with multiple dimensions, might cut through better.

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

Yeah. Okay. Does that work for folks?

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

Yup.

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

Yup.

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

Great. So how do we proceed, Lauren? How would you like us to, in terms of the materials you've got ready to post for us, what makes the most sense?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well I think we could do what Cheryl suggested and maybe just start with the 6 domains and see if we want to prioritize any of those. I mean I think Cheryl suggested functional status, well-being, we can start there.

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

Okay, that sounds fine. So do we have something where we've got all of them listed out, maybe actually – or maybe just flip to the next pages here, just so everybody can re-familiarize themselves with what we're prioritizing. Thanks. Is that all of them?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

There's another page.

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

Okay. So, all right, so let's go back if we could. Any candidates for prioritizing? Certainly have heard a call for prioritizing the more patient-focused outcomes, I would also add to that care coordination.

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

Yeah, I would agree.

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

Yeah, same here.

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

Because I guess what I've observed going out to facilities is, they have very limited capabilities to pass information back and forth, unless they're part of an integrated delivery system. So, helping them build the capabilities to talk to other providers in their communities is, I think, going to be essential.

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

Okay.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

And when you look at just the difficulty with exactly that and the interoperability issue that we've had with Meaningful Use and moving things forward in Meaningful Use, that's the one thing that really requires it.

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

Yup. Okay. So that's two, other candidates to put on the top prioritize list? Maybe you could scroll up one more time there, Lauren. Thanks.

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

Well I had a question about appropriateness or efficiency.

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

Yes.

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

And I was thinking about on the earlier slide where you talked about it Helen. We haven't addressed, we've been kind of fixated on the EHR products.

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

Right.

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

And maybe we need to be, I'm not sure if maybe Kevin has an opinion. I was thinking about the ACC Cath Lab, the National Cardiac Database and they have a measure of appropriateness for PCI that they compute routinely in a Cath Lab, which isn't ever propagated through the rest of the clinical IT system. So we've got these sort of departmental systems or registries that are doing some of that. Is there anything, which is both an interoperability issue and a leveraging systems outside the EHR per se?

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

Yeah.

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

So this is Kevin, I can take a quick stab at this and say that I was just on a MAP affordability task force for the last two days where there was a considerable discussion. And discussion about how we could potentially as a country use an HIT measurement for the purposes of affordability. One of things that that group surfaced was measuring the use of the alerting of ADTs for admissions to ERs and hospitals, and that group thought that would be potentially a quality measure of your – sort of a process or structural measure of your ability to do certain kinds of real-time care coordination, because you can get these ADT alerts. It's a different way to think about quality measures in our current eCQM framework, but it – that was something that was highlighted at that committee.

I would also say that if you look on this list, the data source and concepts talk about the need for data that has typically not been the kind of data in eCQMs, this claims and ADT data. So that's one feature across all these efficiency domain.

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

Yup. So this is Helen. I would actually – I would have actually proposed efficiency as the third prioritized area. I think because we have to get it and it won't all come from EHRs, but I think we're increasingly, to David's point, really need to figure out how we're going to have the whole clinical registry EHR interface, as well as how we begin to really incentivize more hybrid measurements across claims and EHRs. So I see this as having really strong infrastructure implications that I think we need to continue to work on, to say nothing of the fact that we need measures of efficiency and appropriateness for the nation. So I would propose that that be the third domain.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Yeah, this is Eva, I would agree with that totally. And I think it has particular relevance when you think about the other two areas that we've highlighted of patient centeredness or patient outcomes and the care coordination, because efficiency is heavily tied to both of those things. There's a patient centered way of looking at efficiency in terms of repeating tests that aren't necessary only because you don't have the information in front of you, and that poses often times harm to patients.

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

Right.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

And then obviously the coordination issues inherent in that. So I think the three of those buckets really fit together quite nicely and provide, as Helen said, infrastructure that we desperately need that we don't have.

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

Yeah.

W

Is that how we –

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

– speaking to Kevin's suggestion, somebody suggested to me, it's going to come out in a report next week, a recommendation to use a sort of process eMeasure of whether physicians can provide their patients with cost estimates of – when they're making referrals, which would imply very sensible and appropriate, but seems hard to do, integration. As you were saying Helen, is the claims infrastructure with clinical infrastructure. It would be nice to give someone credit for solving that problem.

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

That would be good. Okay, so it sounds like we've got three. Could we go back to the slide there to see if there's anything else in this list –

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

So this is Kevin again, that's – this prioritization is great and it's great to prioritize these domains. But I don't know that that necessarily gets us to a policy recommendation. So within those – within – by prioritizing those domains, what does that mean for a policy recommendation to the group?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Well, I think if we look at the last column in the table – this is Lauren that might be a good place to start. We already kind of went through the thought exercise of for this domain, what are some example concepts and following that through, for the data sources that you'll need, what infrastructure would you need? So, we could look at that recommendation and see if its complete or not, Helen.

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

Yeah, I think that's a good idea, Lauren. Go ahead.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So if we maybe go up to the previous page, let's see here – so, efficiency, so the last column here is about consistent collection of claims data across payers and claims warehouses.

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

This is Helen, I think that's way too limiting in terms of there are lots more infrastructure needs about how to actually combine them with other data.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Right, right.

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

This is – I mean, we have reasonably consistent claims data, what we don't have is a clear way to link it to clinical data or think about which data would logically, most appropriately come from a clinical data source versus claims. For example, indications of utilization, sometimes the best source is actually claims, whereas the ability to risk adjust, the best source is often the clinical data. So, there may be some additional infrastructure things to flesh out there to make that real.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So to David's earlier point, can we envision some kind of step-wise approach where a provider or hospital in Stage 3 would do something on the path to get us there that could possibly count for MU?

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

Um hmm. Don't you think, what to people think?

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

Helen, this is Cheryl. Per your example, because I agree the linkages are challenging, but how much of that is a health IT infrastructure issue. I guess it kind of boils down to having that common identifier across different health systems for any given patient, right?

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

Yes.

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

Which I know has always been challenging for a variety of reasons. How much of it is – is that the issue we're trying to solve versus, I'm looking at like appropriateness and to me it's trying to build inside an EHR these tools that providers can use in the moment –

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

Right.

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

– to potentially limit use of resources for people where using that procedure is equivocal or potentially harmful. So –

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

That's an interesting example, Cheryl, because I guess the question is, is it really – I mean, this is, I was being perhaps to measure centric. But I guess the question is, at the end of that, do you get a sense of whether the person did something that was appropriate or not, or is it really more decision support to get them there.

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

Well, I mean ideally you want these tools to be built such that physicians are acting on it in the moment and working to deliver services in the most efficient manner. So, from my perspective, while it's nice to measure at the end of the day, I mean ideally we want it to be used in practice.

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

Okay.

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

Could – this is Norma, can I add my concern that I've raised before and that's the dealing with complexity. So much of this data is still focused around a single diagnosis or a single procedure and decision support for physicians or – and for patients and the real world out there, that doesn't happen as often as we think it does. There's the complexity of usually multiple diagnoses or patient problems that have to be dealt with to really get an efficient system. And I know – I don't know where we could at least acknowledge that.

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

Good point.

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

And some of that actually may be a key principle going forward, there should be less emphasis on entities – approaches that are too limiting in terms of single diseases and be more patient-centered, which I think is actually in our –

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

Yes.

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

– recommendations already, but maybe how to operationalize that in terms of perhaps to David's point about credit for MU3 or even which direction the measures would largely go.

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

If somebody could keep working on that, that this person not only has the knee problem, but they also have rheumatoid arthritis and diabetes and we're dealing with all of these, you cannot just run this on an efficiency for one of those diagnoses.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Right, right.

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

And so I think the more often we say that, the happier I know I would be.

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

Yeah, absolutely. And we just had an example this week of some rheumatology measures that we were looking at where the claims could give you information about whether the medication was actually dispensed, in terms of the pharmacy claims data. But in terms of the registry, all they had was whether it was ordered, and what a loss to actually not be able to combine those in a way and be able to actually see what was ordered and dispensed and when there were patient issues around cost that limited their ability to pick up their high-end biologic. We're just losing information there is why I think this issue of being able to think through what should come logically from where and how to make sure there's a way to put them together is really –

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

And not solely around a single diagnosis, as the only option.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Right, right.

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

Absolutely. Right – should have nothing to do with that, right.

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

I wonder if we could try, you could imagine two paths for satisfying the criteria. One is long and one is deep and the wide one would be, to Norma's point, some crosscutting measures like transitions in care and things that are not diagnosis specific. But then having a channel where you can go deep in say cardiology or orthopedics and say, I'm linking in rich clinical data from registries or Cath Labs or whatever it is –

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

Yup.

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

– so that I can do risk adjustment and outcome measurement and so on with better clinical data that is generally available. And certain providers might go down either of those paths, depending on the structure that they're operating in.

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

Hi, this is Aldo. I'm hearing something slightly different as well, which might be a third item, and Norma, please tell me if I'm off base, but, if we're talking about patient-centered measurement of quality, we don't currently have a mechanism by which to mash up all the single patients different quality measures into a single patient-centered profile or value. So, have we discussed that here or did I miss something where instead of creating independent, disease-specific measures, we just don't have a way of being able to paint a picture for a quality for each patient?

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

This is Eva. I don't necessarily have an answer to your question. I think we have talked about it in the past a little bit, or maybe on another call this came up. But, the notion of centering quality measurement around a robust and evidence-based care plan, not just evidence-based though, it would also have to include patient preferences. That that then gets a little bit at what you're talking about, it's this notion of a patient-centered perspective of what quality is, and that should include both across whatever conditions the patient has, it includes both what is evidence-based in clinical practice, but also accounting for their preferences.

And so as I've listened to the conversation and thinking about specifically from a data and EHR perspective what pieces need to go into this puzzle. And elements of them come from each of these data sources, it would be the availability of information, which gets at some of the things that we were talking about earlier with regard to claims and whether it was ordered or dispensed in terms of a drug and other things of that sort. It also comes down to patient preferences and are we recording those, and are we building the pathways within our systems to check whether care provided according to what was reflected in a claim, is that consistent with those patient preferences that are recorded in the EHR? And then the care – the role of the care plan in all of that is very similar in that, is the reflected in the claim consistent with what data is in the EHR and the care plan? And there need to be pathways to do checks among all of these things, to make sure that they are all consistent with one another.

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

So this is Kevin. Aldo, let me rephrase what I think I heard you say, but I might be wrong. I think that you're talking about a more incremental step, which would be potentially a report that would aggregate all of the measures by a single patient for that patient to see and the provider to see, Mrs. Smith comes in and these are the five measures that pertain to Mrs. Smith and where she is today.

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

Correct. There – that's kind of something that I have in mind, I don't believe we have the technical infrastructure laid out to make that possible. We have individual measures, but there really isn't a – there's no set of instructions we can provide an EHR programmer to support that, this across – patient-centered across measure view of how well am I addressing the different aspects or different facets of this patient's care. And then rolling on other aspects such as preferences and how well am I adhering to that one, that's another set of functional capabilities which I don't believe that are, as of yet, specified. Yes, Kevin, I think you hit the nail on the head with what I'm trying to express.

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

Okay.

Alexander Turchin, MD, MS – Director of Informatics Research – Partners Healthcare

This is Alex Turchin, I just wanted to know that I think while it would be very helpful to have an integrated measure like this, we should also keep in mind that many of these measures we're trying provide to individual providers and when we do that, it's very helpful to keep the measures actionable for the provider. So if we only provide an integrated metric, then it may be difficult for the provider to know what exactly to do and how to improve that. So, I think it would continue to be helpful if we provide an integrated view to also provide a view for individual components that is easier for a provider to understand how to improve their performance on.

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

Okay.

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

Should we move to one of the other domains? Move up to the prioritized domains, either patient-centeredness or care coordination?

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

Um hmm. I think we did care coordination, unless there's anything to add to that infrastructure needs already listed there. But let's go up to the previous page there if we could, Lauren.

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

And just a very quick comment about care coordination, it's Aldo again. I know that proposed MU3 functional objectives include notification of significant events, such as admission to or discharge from a hospital. So it's nice to see this on this list that we have on the screen right now, and that these are also supported by proposed objectives. And maybe I'm trying to address the question about policy is, we wouldn't want to necessarily chase down a quality measure that isn't clearly supported on the side of the functional objective. The other thing about care coordination is let's look at both sides of care coordination field, it's not just notifying folks that there is a patient that was just discharged, but what is the outpatient side of things supposed to do. And so those are the – for each of these measures proposed, look at both sides of the care coordination relationship.

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

And Aldo, this is Kevin. I happen to know that you are an expert at this particular space, since you've been working hard to try to build some measures around here. What are your thoughts about the next step opportunities in this area?

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

Under the could – it's Aldo, I'd leave that – there are opportunities to clarify some of the details surrounding care coordination in a fashion so that when you go into a practice and talking about team-based care, coordination of care within their own walls. Those are challenges that are not yet met by clinical workflow as it's currently defined, and obviously across settings, those are challenges as well. We believe that health information exchange is providing some of these technical gaps and some Beacon communities have, in fact, addressed some of those gaps in their work. It's just making sure that some of those lessons learned are making their way into the practice-specific EHR systems. And that there is also the community will to make sure that they're going to connect the two nodes, to make sure that information is going to flow between them and everyone knows what to do with that information when it comes.

The last thing, and then I'll stop talking about this one is, actionability. Providers in the field have tremendous differences of opinion in terms of actionability of care coordination measures. So to the earlier comments with regards to making sure that our quality measures are actionable from the perspective of all people being measured, that clearly needs to be spelled out a little bit better than we have in the recent past.

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

So any specific policy recommendations?

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

Whoa. So, to review, making sure that all quality measures have those underpinnings in the functional objectives, interoperability is one of those challenges I believe that will continue to persist. So, how can we continue to incentivize and motivate interoperability? The – in terms of policy, Kevin and others, I'm struggling with regard to the actionability angle. But there is one final piece addressing policy is, and someone mentioned EHR our lust for EHR solutions versus health IT overall. And for care coordination, I believe that health IT needs to be the focus, not specifically the typical generic EHR that we have in mind. Care coordination seems to be very modular in the field, so we have to continue to think about the modularity of all the different pieces that make up this care coordination puzzle.

Mark G. Weiner, MD, FACP, FACMI – Assistant Dean of Informatics - Perelman School of Medicine at the University of Pennsylvania

This is Mark Weiner. Looking at the care coordination elements, some of them are a little check-boxy so, there's contact without patient services, without necessarily a look at certain elements of that contact and it still becomes possible for patients to fall through the cracks. And I know it's extra – it might add some extra challenge, but to be able to look for the scheduling of follow up appointments as necessary. Obviously, that applies to some patients and not others.

And then even that medication reconciliation, I've been whining about this for years how I can totally modify a patient's medication list, but until I check that medications reviewed box, I don't get credit for it. And still there ought to be ways where we can look for redundancy or duplication of similar meds in the med list, as a verification of medication reconciliation.

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

Helpful. The other piece of care coordination – this is Helen again, that's important in terms of infrastructure is, I think increasingly there's a sense that to really get at this, we've got to get the voice of the patient and their family engaged, so there's also the connection between somehow getting information directly from the patient into the system as well.

Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health

Yeah, I'm – this is Eva, I agree. When I think about actionability, the patient is the one constant, so really in some ways the patients still the best, if not the only real way to judge whether or not care was coordinated. Of course, there needs to be knowledge on that – on the patient end exactly what that constitutes, which – so, I agree with Helen. I think if we can figure out how to think really differently about this measure and not do check boxes, from the provider perspective, but rather think about what coordinated care really looks like, which really has – kind of has to be defined from the patient perspective, with input from clinical folks, of course. Then that might be a way to get at this a little more effectively.

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

Okay.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Do we want to move to the functional status and well-being as the last priority?

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

Sure, that would be great.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So here, we have kind of very generally infrastructure to collect patient-generated health data, and some examples here, what else is missing here for HIT infrastructure to drive this space?

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

And/or – this is Kevin, what are the policy levers we should be using here?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yeah, I mean again, trying to be responsive to what the Policy Committee asked us to do, I'm trying to think of this in a way where we can make a recommendation for something for Stage 3 or for Meaningful Use that someone could actually perform.

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

Yeah, this is Kevin. David, I'll put you on the spot here, I know you've thought long and hard about these particular issues. Any particular thoughts here?

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

I was trying to follow back to the – is the slide up now that shows this – oh, I just lost my connection, okay. It'll be back. I have some trouble with this one because of the question of whether we're living in an EHR world or in a networked world. It's analogous to me to the claims data issue and I don't think collecting patient reported outcome measures or even the patient-generated health data is strictly an EHR infrastructure play. So, the question then is how do you interconnect selected data from those other channels into the EHR when it provides value to the clinician, and I'm not as concerned, I think, as Aldo was about giving data feedback for the clinician on the quality measurement side as I am generating it for external purposes for recognition and payment. So I don't mind the idea of mashing up data from different streams, as long as they're linkable and you can capture the clinical data for risk adjustment and that kind of profiling.

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

That's interesting, David. As a clinician I'd have to disagree somewhat that I think that information is incredibly helpful at the point of care, when you get some of the patient-reported health information back. It's what guides the discussion, it targets the areas of need. So I don't see it as an either/or. I think having that information fed in and having the connectivity to those tools would be actually very useful for quality improvement on the ground.

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

Yeah, that makes sense to me and I think, not doing either/or is fine. But I think the infrastructure, it's not clear to me that every EHR has to have the infrastructure to capture that data from the patient.

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

It's Aldo and I'll just jump in. I definitely want to echo and support that there are some well-known registries, even under the realm of behavioral health like I think the State of Washington and Oregon, and there's serious work, I believe with PHQ-9s. I believe that is all provider driven, but housed within an electronic registry, and they have some very interesting metrics coming out of that. So policy-wise, expanding it beyond the walls of the EHR system would help, so long as at some point, the information can roll back to the point of care and inform decision-making or ongoing assessment by the folks that are going to be accountable.

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

Yeah, this is Cheryl, I guess I was envisioning the EHR component as being one where the data are somehow or other being actively used by the provider to track changes in functioning over time and to then take appropriate action, depending on what somebody's status is. So, I agree David, I think it's important to be able to link in data that's collected through other vehicles, but I'm looking at this more as a tool that physicians can use to manage patient care better and make better treatment decisions.

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

Well, let me just, a couple of reactions to the – on that last point Cheryl, it's been a while since I looked at it, but there hadn't been a lot of good field examples of people routinely using this kind of data for clinical management, partly because of timeframe and bandwidth, familiarity. So it's a ways until we get that further developed, although I'm in favor of it and I'd be happy to see it happen. And then I'm wondering if there's a laser shot in a way that we – Kevin, you and I talked about PROMIS becoming a more prominent –

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

Yup.

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

– part of public programs. And I wondered if we could create kind of a quality measure, I haven't thought this through that would say, if an EHR is able to essentially send a message to a PROMIS platform to go and collect a patient-reported outcome measure from patient X. And then capture that data on the PROMIS platform and push it back into the EHR, that round-trip sort of case finding, a trigger and then a captured PROMIS measure would satisfy all the things we've been talking about in a fairly finite way, which would advance the larger policy agenda of building on the PROMIS platform.

Mark G. Weiner, MD, FACP, FACMI – Assistant Dean of Informatics - Perelman School of Medicine at the University of Pennsylvania

This is Mark –

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

I don't know what infrastructure's needed for that. Does that already exist, Kevin? Can an EHR –

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

So I think it depends. There are some large healthcare vendors that are building in PROs as a consistent component of what they're doing. There are other vendors that connect their source system to another vendor that does the patient-reported outcomes, but it is seamlessly presented to the provider. So I think that there are multiple architectures that currently have shown success in both the US and abroad, to routinely use patient-reported outcomes in practice and for the purposes of broader scale measurement.

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

So could we generalize the capability from a technology point of view, that an EHR in Stage 3 can trigger a request for a patient-reported outcome measure to be applied. It may host it itself, maybe Partners wants to host it themselves or Kaiser does, but maybe not, and if they don't, they could send a message to a PROMIS platform, trigger an inquiry to a patient to capture some data, and then send the scored result back to the EHR. Would that be a capability enhancement to our current environment?

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

Aldo or others, I mean I –

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

Yeah – it’s Aldo, I’d be happy to comment. I believe that it would – it is a necessary feature/function to consider. To get very concrete tools such as PROMIS, aren’t very easy to score correctly because what’s generated is a T-score and it may or may not be appropriate to expect a local EHR system to try and generate a T-score so that the provider can actually do something with the result that was obtained through the tool. That type of population-based statistic, to be able to interpret a score, may vary in fact require the EHR system to reach out to another system to get that population level of metric, rather than try to generate it on its own, based on its own – based on the local panel of patients.

So I think there might be folks out there who say, well you absolutely can’t do anything really valid with PROMIS results, for example, unless you have access to external calculations of statistics like the T-score. So that’s just one quick example and whether or not it’s going to be – let me make this a constructive statement, it’s not clear to me whether or not we should have the expectation written in that all EHR systems would be able to reproduce what the computer – testing that the PROMIS applications is known to do. So we have to bake that in to some of these measures that require FSAs.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Although – this is Lauren, I wonder if for some of these that are a little more forward thinking, we can’t go down the innovation pathway. And say, these are optional things that if you can do, we understand that not everyone has the capability to do it, but if you can, you might be able to get credit for one or more MU functional objective or for partial CQM reporting.

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

Sort of, like a poor man’s deeming, so we might say something that, if you measure a patient-reported outcome, you’re deemed, in some way to our earlier talk – our earlier thoughts.

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

Yeah, I think that gets at what David was saying earlier as well, pushing on the functionality.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Um hmm. Great.

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

All right, I’m just noticing the time, I just want to do a quick time check and see if there are any other of these domains at all that we’d like to explore. We can certainly – I think there’s going to be some work putting this table together, pulling out some of the measures under – already under development, perhaps adding in some more of the discussion today. But I just want to make sure at least to date we have talked through care coordination, patient-focused outcomes and appropriateness and efficiency. Was there anything else anybody wanted to add to that mix? So I think that’s quite a good list, but I just want to be sensitive to that before we need to open up for public comment.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So Helen, I think this is a really great start and I think Kevin and I can get working on the table for the three priority domains.

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

Okay.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

And maybe one thing we can do next time is to look at the measures under development for these three domains –

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

Okay.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

– and see if there are some key ones that we want to pull into this table and also we feel might rise to the priority of maybe being required, I don't know, that's a question for the group. And then if there's any additional infrastructure that needs to be built to support any of those measures.

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

Well, and this is Kevin again. I would also ask the group to put their creative juice hats on, because part of the point of this call was to talk about the policy framework, not just the particular measures.

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

Right.

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

So that policy framework might be deeming, core menu, the innovation pathway.

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

Um hmm.

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

There were many of those things that we've talked about, I don't think we have a concrete – it would be great to have a concrete policy proposal that this group could bring to the Quality Meas – to the Policy Committee, that felt like a really concrete, actionable item.

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

Okay, I think that's very helpful, Kevin. I think in some ways, a lot of those things are using different words, but I think they're kind of describing the similar motivation to get towards innovation for MU3 and rewarding it.

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

Yeah.

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

So perhaps, I think there's actually less difference there than it sounds. But I agree, there's more work to do to put that together and we can certainly bring that forward.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So, I think we're in the middle of scheduling the next call, we're hoping in May, pending schedules, so, be on the lookout for that meeting invitation.

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

Okay. Very good.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Great. Thanks everyone for spending your Friday afternoon with us.

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

Do we need to do public comment, Lauren?

Public Comment

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yes.

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

Yes. Operator, can you please open the lines?

Rebecca Armendariz – Project Coordinator, Altarum Institute

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

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

Very good, thank you so much. Okay, so any final words from anybody. Feel free to send additional information our way as Kevin and Lauren valiantly attempt to put all this together.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

I guess Happy Mother's Day to all the moms.

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

Oh, thank you. Happy to take that one. All right, thanks everybody.

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

Bye, bye.

Public Comment Received

1. As a measure developer for MU, please be sure to vet all new measures for standards maturity, availability of a tested eCQM definition and that all data points in the measure are available with minimal manual intervention post-discharge. Also, please be cognizant of the total number of new measures required. These measures each require significant design, development, quality assurance testing, documentation and client implementation time. Thank you.