

Quality Measures Workgroup Public Hearing
Draft Transcript
May 19, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to a joint meeting of the Quality Measures Workgroup and the Clinical Quality Workgroup. This is a Federal Advisory Committee, so there will be opportunity for the public to make comment at the end of the meeting. We're also having a transcript made of the meeting, so please remember, workgroup members, to identify yourselves when speaking. We also have a number of people listening in over the phone.

With that, let's go around the room and introduce members sitting here at the table, beginning on my right with Tom Tsang.

Tom Tsang – ONC – Medical Director

Tom Tsang from ONC.

Josh Seidman – ONC

Josh Seidman, ONC.

Ben Hanlon – NCQA

Ben Hanlon, NCQA.

Norma Lang – University of Wisconsin and American Nurses Association

Norma Lang, University of Wisconsin, and also the American Nurses Association.

Helen Burstin – NQF – Senior VP, Performance Measures

Helen Burstin, NQF.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

Tripp Bradd, Private Physician.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Karen Kmetik, AMA, Convene PCPI.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Jim Walker, Geisinger.

David Lansky – Pacific Business Group on Health – President & CEO

David Lansky, Pacific Business Group on Health.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Joachim Roski, the Engelberg Center at Brookings.

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Eva Powell – National Partnership for Women & Families – Director IT

Eva Powell, the National Partnership for Women & Families and the Consumer Partnership for eHealth.

Daniel Rosenthal – National Quality Forum – Senior Advisor, HIT

Danny Rosenthal, Inova Health System.

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

Gene Nelson, Dartmouth.

Patrice Soltz – CMS

Patrice Soltz, CMS.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

Westley Clark, SAMHSA.

Judy Sparrow – Office of the National Coordinator – Executive Director

We do have a number of members on the telephone. David Baker, are you there?

David Baker – Northwestern – Chief, General Internal Medicine Division

Yes, I am.

Judy Sparrow – Office of the National Coordinator – Executive Director

John Derr?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

Yes, I am.

Judy Sparrow – Office of the National Coordinator – Executive Director

Phil Renner, are you on yet?

Phil Renner – Kaiser Permanente – Principal Consultant, Metrics Development

I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Aneel Advani? Neil Calman? And Tim Ferris? Did I leave anybody off on the telephone? Okay, with that I'll turn it over to David Lansky and Jim Walker.

David Lansky – Pacific Business Group on Health – President & CEO

Sir?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, David. We want to thank you all for coming today. We are embarked on a remarkable enterprise. It involves fundamental changes in the way multiple stakeholders interact with each other. We need to understand and serve multiple needs, multiple wants, multiple perspectives, and to do all that with a very complex set of tools and policies and learnings.

One of the critical activities that we need to participate in regularly is assessing the effect of what we're planning and particularly what we've done and learn from that and make sure that the next iteration is optimized in every way that it's feasible to optimize it. So your presence today is a critical part of that, to help us understand from the perspective of many, many different stakeholders what the effect of MU1 has been, particularly we're interested of course in the quality measures, and to get your ideas about what we can do in MU2 and MU3 to make quality measures and the rest of the meaningful use apparatus as useful and usable as it can be. So we thank you all. We encourage your frank participation.

I'll turn it over to David.

David Lansky – Pacific Business Group on Health – President & CEO

I just want to add my thanks to you all for coming. I know it's a great imposition to come and do these conversations with us, but it's really helpful in the policy process. We had a number of meetings of this kind last week that were very instructive, and I think we all really got a lot out of them. The only

contextual things I'd add, this is one of those fairly rare opportunities when the Standards Committee and the Policy Committee really come together to try to have a shared view of what needs to happen over the next several years and make sure we put the right policy and standard infrastructure in place to support that.

As Jim said, we want to learn from the experience. It's already been gathered in the field with the early part of meaningful use. There are some things that are really on our radar, front and center, that I think we'll come back to all day long. We need to make recommendations to the Policy Committee at least about the structure of the quality measurement reporting system going forward. So the experience we've all had with crafting something for stage one was our best shot and now we want to understand that that's working and not working. We heard from some specialty societies last week about some issues that they perceive with the way the measures are structured, so we really want to gain more of that perspective today. In this afternoon's committee meetings we're going to think a little bit about the structure of the core menu, alternate core and so on, if that's the right way to go forward, and if so how to compose it going forward.

I think there's a lot of sense we don't want to burden everybody with lots and lots of measures. We want to look for parsimony and efficiency in the selection of measures in these different templates for reporting, so we really want your guidance on what's high value. I think high value means not only to clinical improvement and awareness but also, as Congress stipulated originally in the law, making sure this information's available at a population level for a variety of purposes. So thinking about what does value mean to you and your constituency and how do we take advantage of that in our work going forward is important.

Thirdly, there are a series of domains that the Clinical Measures Workgroup has been addressing for the last year or so, including care coordination, patient engagement, patient safety, affordability, and appropriateness, efficiency, that are really huge opportunities for improved measures and improved data availability, but it's new, it's rough stuff. We don't have as much of a body of work to build upon in those areas, and getting some measures into the application pipeline quickly in a way that provides value to the process of health reform and health system improvement is a real challenge for us. So again, another theme throughout the day is where can we go to improve the availability of measures that are valuable to you and to the public as a whole in those new areas, would really benefit from that.

So again, thanks for providing the written testimony. I thought the written testimony for today was just fantastic, just a great overview of a lot of important issues and I appreciate you doing that. Just as a word of encouragement, because we've all had and probably read the written material, you can be pretty efficient in your verbal comments and try to just highlight for us things that you really want to make sure we really give attention to in our conversation. So thanks again to all of you for coming.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

We'll start with the Care Providers panel. Just a note to all the presenters, we're going to stick to the times for presentations. I think it's everybody's experience that overall everybody benefits if we do that. A lot of the most useful conversation comes in the discussion that is prompted by your brief introductions, and so we want to preserve that time for all of the committee members to really get in deep with you and understand the implications of what you're saying. Judy, how does the timing work? Is it going to be –?

Judy Sparrow – Office of the National Coordinator – Executive Director

There's a note on the screen right there, so you have seven minutes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

You can tell where you are at all times. We expanded the time because the panels are smaller than we had expected, so we wanted to give you as much time as we could. The panel members, first is Stewart Stephen, who's the CIO of Henry County Health Center, who is not able to join us; and Jerry Penso, we're glad to have you; Susan Chauvie; and Doug Spotts. We'll just go in that order. Jerry, if you'd like to start.

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

Thank you very much and thank you all for inviting me here to speak. Today I wear two hats. First, as a medical director of Sharp Rees-Stealy Medical Group, a 400 physician multi-specialty group based in San Diego with a strong emphasis on quality performance. Second, I currently chair the Technical Quality Committee for California's Pay for Performance Program that's administered by the IHA, Integrated Healthcare Association. That pay for performance is one of the largest in the nation.

So with my medical group hat on there are three issues I want to highlight. One, which I think David already alluded to is the issue of harmonization. Sharp Rees-Stealy currently participates in a number of performance measurement systems, including meaningful use, the Pay for Performance Program. We have a pilot ACO with Anthem Blue Cross with performance measures, the Medicare Star program for our Medicare Advantage Program; we're considering the ACO program, and through our health plan HEDIS measures. The problem is that each program has different clinical quality measures with different specifications, patient populations, product line specifications, targets, inclusions, exclusions, date ranges, and so forth. In response to this, we've developed registries, and we've developed all payer registries to improve overall quality for all of our populations. But a single measurement that I think you realize would provide economies of scale and would lessen the burden of performance measurement reporting and improvement.

Finally, it just drives my physicians crazy when they have different patients and they don't know why, for example, a 56-year-old patient with diabetes and one PPO doesn't count in the measurement set, but a 66-year-old with SecureHorizons does. That drives them absolutely bonkers.

The second is clinical relevance, and I think David mentioned that my physicians want measures that really make good clinical sense. They want it to add value to their practice and feel that it is worth the extra time and effort that we would devote to it. At Sharp Rees-Stealy, for example, we focused very heavily on the diabetes care measures because we believe, for example, blood pressure control, LDL control really improved the quality of care and outcomes for our patients, and the physicians buy into that. We will resist, I guess is the right word, performance measures that we don't feel have value. In essence, we just try to prioritize which ones we'll do and we won't do the ones that we don't feel have value unless of course we are forced to do them for regulatory reasons, but we don't like that.

Then finally, the issue of which level to measure at, my organization strongly believes that the future of ambulatory healthcare is team-based care, which means that the measurements may need to be not just at the individual physician level, but at levels higher, including the systems. For example, I read the care coordination concept and your measures concepts, and this document itself lends to the idea of a care team, so if you can move towards examples of measuring not just at the individual physician level but at the care team or the systems level, and examples of that include things like care transitions and readmissions.

Now with my second hat on, which is the pay for performance hat on, the Integrated Healthcare Association currently coordinates and administers the Pay for Performance Program in California. It uses exclusively administrative data, so there's no chart review, to derive the performance measures. That's one of its core prime directives in order to adjudicate this program for over 200 physician groups in the state of California, 35,000 physicians, and over 10 million patients. The P4P performance is measured at the medical group level or the IPA level, not the individual physician. We, and the Technical Quality Committee, evaluate and incorporate measures based on the four main criteria: is the measure important, scientifically valid, feasible, and useful.

I'm pretty confident that the health IT enabled clinical quality measures that will be adopted will meet the importance in scientific validity criteria, but with my P4P hat on I'm concerned about the latter two criteria for incorporation in the California P4P program. First is feasibility. For the P4P program, we will be required to disaggregate the data by product line so that the performance of a group could be measured for the commercial HMO population. We can compare groups for performance on like populations, not based on case mix. Another feasibility challenge will be the issue of how to handle continuous enrollment. The P4P program in California demands that the patients be continuously enrolled for a

certain period of time depending on the measure and that has been very important to the program because medical groups and physicians only want to be accountable for patients that have been with them for the entire measurement period.

The second issue of usability, P4P requires strict standards and specifications across the medical groups and IPAs so that there can be a fair comparison of performance and public reporting. This means that no matter what EHR is used, the specifications have to be so tightly aligned so that there is comparison between the two medical groups on that performance. That concludes my testimony. Thank you very much.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you very much for your wonderful testimony. It's exactly what we want: crisp identification of important issues. Great, thank you. Next is Susan Chauvie, and I'm going to let you introduce yourselves because I hate it when people read my short bio and I realize how badly written it is.

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

Good morning. I'm Susan Chauvie. I'm the Vice President of Quality and Practice Transformation at OCHIN, headquartered in Portland, Oregon. We are a Health Center Controlled Network with over 50 organizations, 1,200 providers, and 400 separate clinics in 7 states. We're also the designated regional extension center for the state of Oregon. I work with the medical directors primarily, but also with a lot of mid-levels and nursing leads concerning a lot of team-based care and quality improvement. I also want to, like Jerry, thank you very much for the opportunity to come and speak with you today. Our organization appreciates it and it's great to be able to contribute to this.

For meaningful use one, I just want to say that we have found the meaningful use criteria for meaningful use one actually to be a great rational starting place. We had already been working on those measures and most of our organizations had already successfully, I feel like they've already successfully met them. I think that as we move to meaningful use two and three, I would second a lot of what Jerry had to say, which is measure specification. There's a high degree of interpretation that's required and there's a lot of clinicians and technical people arm wrestling about what the technical specifications are, from inclusion and exclusion to what level to be included, and even numerators and denominators.

Then, as Jerry also said, you're going to hear a lot of cross-sectional themes, I believe. Even in our own local communities and at state levels in the seven states we support, all the payers and quality improvement ... all have similar measures but they're all microscopically different, requiring different registries and different EHR fields to collect the data. Oftentimes you can't get to that change quick enough and so it essentially forces workflow changes for clinician and care teams, which really makes them crazy. I think clinical relevance remains a really key issue, and the fact that a lot of the measures are process measures, very valuable, rational, but they really don't get to outcomes.

Again, I think for a level one it really made sense, and our medical directors felt it made sense, but I think moving forward, looking at more in-depth process measures and clinical outcomes, clinical relevancy across, again, the teams and not collecting data just because it happens to be there, but what would be the most useful data. And then what are you going to do with it, if it's not actionable data then it feels pretty useless to our clinicians. I think that it's really important to derive the measures from the highest level of evidence that exists and that it actually does more good than harm and is cost effective. I think that as we move to level two and three, I think that there should be a real close scrutiny to make sure that it does more good than harm. It should be looked at very carefully, particularly as it relates to overuse and gaps in care.

I got a lot of feedback from our medical directors and they really want to make sure that we strike a balance between keeping the threshold increases meaningful and useful, but achievable given the variables, particularly I think the community health arena is very stringent, they're very convicted about the fact that they don't want to have special measures. But the social determinants of care and caring for homeless people when they have a churn of coverage and out of coverage, they may have patients, families that have coverage for 3 months out of 12 and sometimes on and off in the same program for the

same patients in a given year. They actually view their responsibility of that patient throughout the year even when they're not covered and they want to be sure that whatever measures are used, that they really are achievable and meaningful.

We think it's very important to include socioeconomic and race and ethnicity data somehow. If you don't include that, then I think we're not looking at reducing disparities, and I think that somehow having an integration of public health, hospital emergency room, basically a whole community of care, the accountable care concept would be very useful. One of the biggest safety gaps that there is, is the fact that lab orders and results are not standardized. We support something like 30 different labs across the country, and they all require intensive data mapping and it's just a huge issue, and I think that there should be some quality measure that really speaks to standardization of labs, which would require labs to receive and transmit data using LOINC codes. I believe I'll just wrap it up there. Thank you very much for this opportunity.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you very much. You did a spectacular presentation and we appreciate it. Thank you. Dr. Spotts?

Doug Spotts – Family Practice

Good morning, and thank you for the opportunity to speak to you about the implications of health IT enabled clinical quality measures. My name is Douglas Spotts and I'm a family physician and owner of a 5,000 patient private practice in central Pennsylvania. I'll interject here that I'm on the opposite end of the spectrum, still struggling to get through MU1. That's my perspective. We're dedicated to providing personal, high quality and individualized and evidence-based primary care to our patients. I, and the majority of the staff, are lifelong residents of the communities from which our patients come, and those relationships contribute to the personalized care we are able to provide.

We have been using electronic health record systems since February of 2010. The entire staff at my practice is convinced that the EHR is a great tool for enhancing the quality care we provide our patients. We believe the clinical quality measures data it can generate will contribute to the personalization we already have in place. We are excited about the potential to identify population groups by problem, monitor status, and provide additional education and support, all with the goal of improved healthcare from the provider and improved quality of life for the patient. The ability to accomplish this is at the heart of what it is to practice primary care and to be a patient-centered medical home.

As excited as we are with the potential of the EHR to enhance the personalized care we provide at present, we do have some cumbersome issues in some key situations. For instance, trying to bring in reports from outside institutions, nursing homes, other hospitals not affiliated with our hospital system and getting that data in a form that can then be pulled and reported in a meaningful way. At present, our practice has three full time practitioners, myself and two physicians' assistants, and one part time physician one day per week. Our clinical coordinator is an LPN who also covers tasks in the nursing station, including staffing, and our business coordinator is also our primary billing specialist. Half of the nursing and the office staff are part time employees by choice, in part to provide depth of coverage when someone is sick or on vacation.

I tell you this to highlight the core challenge of implementing meaningful use criterion in a small, independent primary care office, namely dedicating staff to the tasks of running reports, mapping data, and implementing measures. Reimbursement rates for primary care do not provide enough income to support additional staff time for this purpose at this time. Incentives for showing meaningful use can offset some of this additional staffing needs, but we do need to provide the upfront investment of staff time to get to the point where we can apply for all of the MU incentives. A similar challenge to primary care in the independent setting and it has funding initiatives to address the clinical quality measures with patient population groups. Reports have little use if they do not result in engaging patients in additional education or support around their clinical issues. There needs to be reimbursement for such measures to cover staff time and materials.

Another challenge to full meaningful use of IT enabled clinical quality measures is the ongoing training necessary to understand this new paradigm of practice. We have excellent clinical and office data, but implementing EHRs is much like learning a new language or being immersed in a different culture. In this case the culture itself is not fully developed. We use one of the major EHR systems throughout the country, one of the top five, and our system is not yet ready to report MU1 criterion. It won't be until September. So we're really hoping that in the last quarter of the year we can do that.

The timeline of the system certification and that of the incentive for implementing MU are not necessarily in sync, and this constant state of learning an updated system and new reporting, while being exciting, can sometimes serve as more of a distraction to the staff than encouragement for engagement in new initiatives. The quality clinical information we know intuitively or experientially is not always readily accessible from that EHR system, as we continue to tweak that with our vendor.

I'd like to give one brief example which highlights the limitations and challenges of our current EHR in tracking one clinical measure, namely, reporting the pneumonia vaccine in the appropriate populations. If that vaccine is given again at an outside institution, a nursing home setting, the hospital setting, another tertiary care center, unless our staff member puts that in on the flow sheet on our chart it's not reportable. If it's free texted in, if it's copied into the chart in some way we may know where to find it. But pulling up that report is not going to bring that forward.

All this being said, we proceed with working toward the MU implementation, and we're excited about it. I'm not so sure that we would be able to do this on our own as a private, independent practice without partnering with the Keystone Beacon project that I've been a part of, I was a member of the Board, and then also recently kicking off our own Beacon group initiative in our own office as recently as yesterday. So that enables us to have a part time nurse that's going to be in our office and in the nursing home, at least for these next two years, without any upfront cost. We're hoping to provide data and information to continue that and show that that can be successfully continued into the future.

I thank you for this opportunity to be with you today and to provide my testimony, and look forward to moving forward with all of you in the next exciting steps. Thank you very much.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, Dr. Spotts. Thank you all. Now the challenge is to the committees, the panel has done a superb job of focusing on really critical issues and I want to encourage all of us to really probe within and make sure that our questions are questions, not disquisitions, and work to understand more about their experience and how it can inform our work going forward. So I'd open the floor to questions from the committee. Karen?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Thanks very much, everyone, very helpful. I wanted to focus in on, several of you commented about the need for harmonization and you talked about measures and you also talked about what I would refer to as the specifications. If we assume for a second that the measures were the right measures, that you and your provider colleagues felt they were the right ones, clinically relevant, what exactly would help to have the same interpretation of the specifications? Because part of what we're trying to think about going forward for stages two and three is what else should be done in parallel with identifying those measures, and so are there additional pieces of how-to's or is there confusion around vocabularies? Can you say anything more specific?

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

I can start. First, is the definition of the inclusion criteria, which patients are included and how. So is, for example, a patient with diabetes because of two codes, 250xx, or is a patient with diabetes based on certain medications, or is it based on an acute admission or an ER visit, or is it based on the problem list? If each measurement system, let's say the ACO has one, meaningful use has another, and P4P has a third, then what you get are then diagrams of diabetes patients. That would be one example.

Exclusions is another one. My physicians need to know what are the exact exclusionary criteria and the codes or the problem list or however to exclude patients, because that's another issue that's very important to them, that the right patients be counted for the measurement and for intervention so that we're not calling or doing outreach to the wrong patients. Those would be two examples. Date ranges is a third one. What are the dates of inclusion? Is it calendar year? Is it rolling 12 year? How exactly are those, and if they don't align, then we start, when we report out two or three different programs and we have two or three different numbers, everyone starts scratching their head going what, why are numbers this with one program and this with a different, especially if they're markedly different.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Could I probe that just a little bit, please? Some implementers have said to us that the exclusions are burdensome if they were requirements, because they exclude such a small fraction of their population they'd rather leave the exclusion out and just take the few percentage point hits. Do you want to say anything about that?

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

If you look at it from a measurement standpoint, that would make sense, because if it's a very small percentage, it's noise from a measurement standpoint. On the ground level, though, this is one of those issues that really irks the physicians. If they get a patient on their list that says this patient has diabetes and knows she has polycystic ovary disease or she has gestational diabetes because of either a miscode or lack of exclusions, those are the things that really undermine my effectiveness to implement quality improvement.

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

The only thing I would add, I second everything that Jerry said. The next thing I would add would be the true intent of the measure, and I think this is where the more sophisticated an electronic health record, typically the more flexible it is. So what we're finding is that, and let me just give you one small example, and this isn't a clinical issue, but the PCP, there's five different locations where it can be documented. So if you're going to be pulling PCP, if you're really explicit about where you're pulling it from, do you need to be that explicit or can you just pull it from any field where PCP is collected. The same is true for problem list and diagnosis. A lot of providers manage their problem list in a different way. Some people document all over it. Some people put it in a progress note. Whatever the intent of the measure is I think needs to be really explicitly defined, along with everything Jerry said, because what happens is with the best of intentions the technical people get a hold of that and they say you have to do this one thing, it's just one check box.

Let me give you one other very relevant example, checking medications every time a patient comes in. There's one box that a physician can check that says I've reviewed all the medications with the patient. There's also another opportunity, you can go medication by medication and check each one individually. Without any conversation our technical experts read the definition and they said there's only one workflow that will work here. You have to check this one box, you check it and it says everything's been reviewed. I had one of my medical directors call me and say, now, wait a minute. I checked every one individually and you're saying that doesn't count. And I'm like, okay, we need to go back and fix that. But I think what happened was the true spirit of the objective of the measure was lost, and so I think more specificity there would be helpful as well.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you. Dr. Spotts?

Doug Spotts – Family Practice

We have less experience, so the reconciling med list was a great example of that. We also have a similar system like that, and some people can check that box but we'll still find errors. So we have different practitioners that want to do the individual check each medicine that way, and it especially gets complicated if you're then doing care in the nursing home, care in the emergency room, care in the hospital setting, because you may have three or four med lists that need to be reconciled, so that's one concern. Some of the concerning is the coding changing, just again, as I mentioned, as we're moving

forward with this new language and this new culture coding is changing, so a sophisticated system should automatically change that and adapt that. But are we going to lose measures because we're switching over from ICD-9 to ICD-10 and so on and so forth.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

If I could probe just quickly again, particularly Ms. Chauvie, but everyone, it sounds like part of what you're saying is that we should be careful about dictating workflows with our specifications to the extent that we can, would you want to say anything about that?

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

I think that's an accurate statement. If you have the measure that's very clearly defined and the intent of it, then does it really matter what specific workflow was used? If it really truly doesn't, then I would be careful to mandate a particular workflow.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you. Other – Peter, oh, everyone understands to stand up your card, good. We'll just start on the right and work around. Peter?

Peter Basch – MedStar Health – Medical Director

Thank you. It's only taken me about ten years of being on committees to know that we could do this, thank you, and I'll forget it tomorrow. Panel, thank you again for your testimonies; very informative and instructive. I had just one brief clarification and a new question. To the same issue about the importance of quality measurement for measurement sake versus what you're doing with your providers. I have heard comments from people in the quality measurements world or in the reporting world or the database world, I think your description of the Venn diagram view of a measure, so what, in fact, it could be invisible to the provider, we could just pull out all sorts of different interpretations of data, why would you care. Again, I want to clarify, I think you all addressed that, that you all are looking at quality measurement not necessarily as reporting, but as a way that you want to change practice. I think I heard that from all of you.

Okay, so here's my new question, I think, Dr. Penso, you raised this one, and I apologize if I'm misrepresenting you here. I thought you said something about some concern about provider attribution during a measure period and how we attribute quality measures to providers. Clearly this is something that we're just beginning to look at in terms of how people who run organizations think about attribution of quality measures versus what we might submit. So your name is on a claim, therefore, we attribute the quality measure to you, versus I think what you said was a patient has been with a provider for a period of time, therefore the measure makes sense to them. So could each of you comment on quality measures and provider attribution and what would make it easier for you as we match quality measurement to quality improvement?

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

Thank you, I'll qualify. For the continuous enrollment that I mentioned, that's part of the California P4P program and it's at the medical group level, not at the individual provider level. It's unfortunate in my organization that every patient is assigned in the electronic health record after one visit of primary care physicians, so attribution at the physician level is not a challenge for me. But you do bring up an interesting issue is the whole attribution issue for quality measures. I did not speak to that. But we have had some experience with that with our ACO work on patient attribution.

The issue with continuous enrollment is as follows. Let's take a patient with diabetes, and we're measuring for a calendar year, what we want as part of the Pay for Performance Program is that patient has been continuously enrolled. These are HMO patients, so we have the enrollment data for 12 consecutive months during that measurement period with only one gap allowed, because sometimes there are technical and enrollment issues. So that if an A1C is measured, medical groups and IPs do not feel it's fair, for example, if a patient with diabetes enrolls in the medical group in November and then we only have two months to get an A1C and get their A1C under control. This way we, if you will, own them for the entire 12 months and therefore feel accountable.

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

Well, it's a huge issue in community health with a highly mobile population and it is an issue that's alive and well and concerned about by all of our providers. It's not uncommon, with a million patients in our system we have between 5% and 8% of our patients at any given time that are highly mobile, between our clinics that are on our system, and who do you attribute the performance to. We do have identified PCP, but then they will go to another clinic and they will maybe be there for a couple of visits and then come back. So how do you make that decision? The same issue exists if I was an identified PCP and they went somewhere else and they had been gone for six months. We have a lot of seasonal migrant farm workers, and they've come back after being gone for six months and their A1C now is 9, the chance that the provider's going to have any influence over that A1C's getting down in the next two months is negligible. So it is a huge issue with our population.

Doug Spotts – Family Practice

A further example of that would be those of us who do nursing home work as more practitioners decide not to do nursing home. Pennsylvania, I believe now has become the third most aged state, they lost out in second place, I think, to West Virginia, but we know the population is aging, living longer, living better. We're having people come into the nursing home setting for sub-acute care, maybe in recovery from hip fractures or other surgeries, and if that person's own PCP does not take care of them and then our practice temporarily assumes care for six weeks or so, they then become a part of our data set. But in a system that talks more about team than ever, and I believe the EHR is transformational in moving toward that goal when we still largely have a payer system and everything else that is very provider directed, and I see that confusion. I would be in favor of having more of the practice receive the attribution of the grade.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Eva?

Eva Powell – National Partnership for Women & Families – Director IT

Thanks. First of all, thank you all for your time. I know that taking the time to come here is significant, and then also thank you for your words of wisdom. One of the most significant things that I heard you say and that struck me is how so many of the quality measures that we have now are of very little, if any, use to practitioners as they try to evaluate and improve care. It sounds like from your testimony that that's for a number of reasons. We've not yet heard the consumer testimony, but having read it I suspect we might hear something similar for them. If you take from that what I do, which is the charge that we really need to make a significant tack, to use a sailing term, in our approach to quality measurement, I would love to get from you some ideas of what that might look like.

I've got three questions. One, what are some examples of measures that you feel like you're collecting now that really provide very little in terms of useful information. Then two, the harmonization issues you've mentioned, notwithstanding how might we change those or replace them, if that's what's called for, with something that would provide useful information. Then the third question—and this is my Pollyanna hat coming on. And hopefully some of what I've heard you say makes me think that maybe I'm not such a Pollyanna—is there potential for quality measurement to be a way to engage patients and providers in a partnership in care if we can ... on measures that are meaningful and useful to both groups?

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

I'll start on this one. I think the A1C is a great example. We need to collect the A1C, but again matching it up or just reporting it for the sake of reporting it. When you're really looking at the trend over a much longer period of time than every three months, I think any of those kinds of measures, just reporting them and if you get focused on just reporting them but not looking at the clinical picture that's how we make decisions as providers and as physicians. So that would be just a quick example. I'm not saying not to do that, but just how to use it in a more—

Eva Powell – National Partnership for Women & Families – Director IT

In a longitudinal view instead of a point of time.

Doug Spotts – Family Practice

Yes, and I think that when we're reporting it as outcomes I think unfortunately some physicians feel it's almost a penalty or it would be penalizing people, not empowering them to make better decisions and to continually improve their practice in medicine, which is what it should all be about. Then engaging that, taking it to the next level, where you could do patient groups, you could bring everybody together that don't have their A1C to goal and provide a nurse practitioner, a physician's assistant, again, in the team fashion. It doesn't have to be the physician, but have our session each week of bringing together and having patients share stories, what worked for me, what didn't work for me, how can I support you, those are very powerful parts of this process. But in a typical small, independent practice where you don't have other ways of supporting that right now you just can't do that in a day. But that would be my hope that that would take us to that step.

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

Just to add on a little bit to what Doug had to say, I'm going to give you two current examples. One is, you've got a patient with an A1C of 9 and they've been your patient for a while but they're maxed out on 3 medications to get their A1C down. What do you do then? I think that's the perfect place, and you should probably start before then, I think having team-based care, having groups of patients with a nutritionist, whatever, that that can somehow count that they're working towards a goal. I think that it would be great to have some kind of a comprehensive measure that would account for the effort going in the right direction, even if the values weren't going in the right direction in spite of everything being done. One of the medical directors I work with said, you know, I'm increasingly frustrated. I know what good care is. I'm doing good care. I've already maxed him out on three medications. I'm doing all I can and yet it still counts against me. I don't know what else I can do.

The second example is someone drops a hammer on their toe. They're seen in the clinic periodically, but they dropped a hammer on their toe and their toe's killing them and they come in, does it really make sense that they be included in having to have a blood pressure and a weight taken when you're not going to address either in that visit? They need their toe taken care of. That was actually an exact example last week when I was asking medical directors if they had any input they wanted to give me for this testimony, and they said that this is just a small example, but we get issues like that all the time and you don't have these huge comprehensive visits. Someone comes in for a specific reason and to waylay them, actually sometimes patients get really irritated or mad, and so you have to think about, again, exclusion and inclusion. Does it really make sense that that be included?

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

First of all, three great questions, and I'll try to be brief because I think you covered quite a bit. I'd add to that first bucket examples of measures of little value. It's probably not politically correct, but the BMI measures. Obviously obesity is a huge issue that's growing in this country, but the evidence that measuring BMI alone makes a clinical outcome different is scant if nonexistent. Yet we are training all our staff to do BMIs, we're buying these special things so we can measure the height accurately, we're training, if you will, thousands of staff and using thousands and thousands of minutes in an orthopedic clinic to measure BMIs. I'm just not sure the value is there.

If you ask me what would I change or replace, I'll give you two things. Number one, there's an urgent need for blood pressure control measurement that would be NCQA approved. Right now the NCQA measure is a hybrid measure and that means that the health plans are being held accountable for that hybrid measure. Yet we need a specified electronic one that NCQA would approve for HEDIS so that we could then have one that's in alignment and harmonized, if you will, between the medical group and the health plans. If you ask me where else would I focus change or replace, I think the imperative right now is the cost of healthcare, so I would also focus on things like inappropriate emergency room use, readmissions, and disease specific rates of admission and complications, because I think that's where we need to go as a health system.

Last on engaging the patient, which I think was the spirit of your last question, we have a patient portal, we believe strongly in pushing as much and as fast information to the patient, and I think that's where we think is appropriate and will begin to engage the patient in self-management in their own healthcare.

Doug Spotts – Family Practice

I actually thought of another measure, and that would be around the advanced directive. Again, it's meaningless if you just check off that box that you have someone's living will or you had a discussion with them in the chart. Then looking at the amount of money and unnecessary care at end of life that we do in this country and in this system—so there's another targeted area where we can take it to the next level with patients and really keep people out of the ERs, out of the hospitals, at home, in a nursing home setting, and private in-care home, that type of thing.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you. Joachim?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Hi. Thank you very much for your testimony. This is a question for Dr. Spotts. I think you probably represent here today many physicians around the country who are working in small practices, many of which might be working in rural settings, and so I was very intrigued when you were talking about what your challenges are and what solutions you're finding to your challenges. One of the solutions that you mentioned is being part of the Beacon community in your area. Could you talk a little bit more specifically about what support you're getting from that community and how that is helping you? Then number two, if that wasn't available to you what would be your options for your practice where you live to allow you to use health information technology meaningfully and what supports might you need in order to do that?

Doug Spotts – Family Practice

I'll take question number two first. I think that if I didn't have some of the resources available to me in central Pennsylvania through the Beacon community we'd still be able to get an EHR up and running. But an example is, although I was on board with the concepts at least five years ago, maybe even longer, this is my 15th year of clinical practice, two of the practices that were private at the time bought their own systems. They had no connectivity to one another, to the hospital system, and to any hospital system, and those practices are out of business; those physicians don't even practice family medicine any longer, and that's just five years ago, not fifteen years ago. I think you would have to reach out collaterally in some way, and I think that would be much more difficult to do if you didn't have a Beacon community program in your area providing some type of support beyond a Web site to go to.

I think it would be very difficult, but that is a consideration to think, moving forward, what can we provide for that person that may be, for instance in rural Montana or Idaho, who doesn't have something close by. I've been really privileged to be a part of the Beacon community and what that has done for our practice is probably moved us ahead faster. I consider myself fairly knowledgeable about this and was asked recently to be the chief medical information officer to assist our chief information officer at a small, independent hospital to add the clinical perspectives to these issues, and that has enabled me to be more in the know, I think, than some other people. I think we could have found it on our own, but it would have been much harder to navigate the various agencies and Web sites to do that without the help of the community.

The community provides some things right now, some grant money which is much needed. We'll have, as I mentioned, I believe in my testimony, an RN who will be part time in my office, part time in the nursing home, which is right across the street from my practice, and we'll be looking at a population of about half the census of that nursing home in our little practice. We take care of about 80 patients in that nursing home. We're going to start with CHF as a measure to look at and see what we can do to keep people out of the ER, out of the hospital, try to be checking in daily, are those weights being done, are they accurate, what's being done around that. Is that answering your question?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

It does. One small follow up, would you otherwise access the regional extension centers, and do you have any experience with that in terms of allowing you to become a meaningful user?

Doug Spotts – Family Practice

I've had more use with them, first through some of the initiatives from Keystone, and then I also am very actively involved with the Pennsylvania Academy of Family Physicians. Recently we've been having some more assistance with them, but again our vendor is ready to go until September, so we're waiting for that version to roll out.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Rosemary?

Rosemary

Thank you for your well thought out testimony. You alluded to how critical it is to have information exchange between facilities as patients move through the continuum of care. A thought that comes to mind is this whole domain of care coordination and I was wondering if you could speak to the opportunities related to care coordination as patients move from the hospital, typically many of them going to home care, with an increasing number of home care visits, and then to primary care. So could you expand upon that a little bit?

Doug Spotts – Family Practice

I don't want to dominate the microphone, but yes, another take off of what just was launched yesterday in my office was getting the consents from patients to come in. It's a blanket consent, if you will, that involve five area hospitals and hospital systems, area nursing homes, home health agencies, and our office, and that has been developed through the Keystone Beacon grant community and will be the first small private office to kick that off. And it's the whole idea that that document will move with the patient, not an individual record, so a med list, significant interactions, surgeries, interventions.

Now again, that will be downloaded into our EHR and won't automatically populate all of the places things need to go to, to be able to report the measure. Someone is still going to have to manually enter that in the office, but it will at least help us when you think of somebody who maybe has a broken hip and is operated on at Geisinger. They come to the RiverWoods Skilled Nursing Facility for rehab and they develop chest pain in the middle of the night and go to the emergency room across the street at Evangelical Community Hospital. You can see that there could be three med lists, not a seamless flow of information, and that's one way in which that one document that would travel with the patient that anyone participating in that patient's care would be able to access should help with that issue.

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

I'll tell you what we're doing at Sharp Rees-Stealy, we believe strongly that these care transitions are critical, especially discharge from the hospital, and we measure the following, and I hope this may be helpful. We measure percentage of patients who have a follow up appointment within seven days with their PCP, all patients discharged, medical or surgical. We also measure what percentage of patients show up for those appointments, so we measure the no-show rate. We measure if the discharge summary is available at that appointment. Our hospitals have access in the hospital to the ambulatory electronic health record, and we mandate that a discharge task be sent on every discharge.

On that discharge task, now that's separate from the discharge summary, but on that discharge task is the discharge diagnosis, when the follow up appointment should be, and any pending labs or tests that need to be followed up by the primary care physician, or tests that should be ordered in the next few days to prevent readmission. We measure what percentage of the patients have that discharge task done. We also have what's called the continuity of care unit, and we call every patient within 48 hours of discharge by a nurse. We make sure that that patient understands their diagnosis, knows when their follow up appointment is, and we do med reconciliation and depression screening, and we measure all of those things.

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

My answer's a little bit complicated. The original extension center part of OCHIN supports five different vendor products. But the Health Center Controlled Network side supports primarily one, and 65% of all of the hospitals and major practices in the state of Oregon are already on this one system, and 85% of all of the community health centers in the state of Oregon are on this one system. The reason that's relevant is that we use Epic, and Epic to Epic is an automatic, there's no interface. You actually have direct access, the patient has to sign permission, of course, but you have direct access into their version of Epic and you actually see it within your workflow. So instead of having five different med lists to look at, when you're looking at your med list in your organization you would suddenly see that they had a med list in these other organizations and you would be able to see them all simultaneously.

Then there is Epic to non-Epic, which is an interface. We're currently working on those in the We're also a health information exchange with more than 250 interfaces. The whole crux of it is working towards sharing of information so you have the right information at the right time on the right patient, and that you can make the decisions that you need to make without having to be fragmented and then your patient gets better care. Does that answer your question?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

David?

David Lansky – Pacific Business Group on Health – President & CEO

Thanks, Jim. From a different tack, all of you talked about how the clinicians perceive the measures and the burden, for example, Jerry, you talked about the exclusions and being sensitive to those exclusions, ... of care ... documentation, and I'm wondering about the role responsibilities of the vendor versus the clinical team in capturing the data and manipulating the data. I think in an idealized world there's routine delivery of care with the accompanying documentation, which is not conscious about the specifications of the measures, and then the technology engine extracts the relevant data, does the computations and transmits it as appropriate. And we're not there obviously. The vendor product's not yet ready to properly capture and process the data, so where in this pipeline of roles, where should we give our attention? Obviously there are opportunities, you've all mentioned the harmonized standards, the LOINC code example, for example, Susan. There's an opportunity for the vendor products to capture data, perhaps in a different way. Is there an opportunity to reduce the mental burden on the clinicians because the vendor products become more capable, what would you ask of the vendors, I guess is my question, to make the quality measurement piece more efficient?

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

I think you just hit the nail on the head. I think that what's happened is that most of the EHR vendors have replicated technologically what there really was on paper and they tried to make it an elegant solution but it was still a replication nonetheless. I think this group is in a fantastic position to really help push vendors, I guess you do that indirectly. I know that as consumers we've been pushing because I think that to the extent that the EHRs are smarter and anticipate and can make it easy for clinicians to do the right thing, the data can absolutely be captured. We've got to get a couple of things ironed out. One is free text. We're actually involved in two research studies looking at free text ... natural language processing and actually creating data table overlays to the existing data fields and basically taking free text and turning it into additional data fields and testing that notion with asthma, care quality, and obesity. So far the evidence is pretty good. But that's an emerging field that I think has a long way to go. Once you can start taking free text and turning it into the data that you need, I think it's going to be a lot easier to meet measures. But I think that getting the vendors to really catch the vision of what really... to be available in the future, to help with the anticipatory needs of clinicians and care teams, is exactly where we need to go. I don't have the answer about how to get there, but replicating paper is not going to do it.

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

David, that's a perfect question. It's almost like a cycle. We need the vendor to accurately report these measures so that the results that get publicly reported or that we use for internal quality purposes are as accurate as they can be. But then it's that cycle of taking those, if you will, noncompliant or the patients that don't meet the measure, feeding that back into the point of care tools so that at the point of care if that patient happens to come in, then you don't miss those gaps in care. That's why the reporting has to

be 100% accurate, so that at the point of care that information is timely and accurate for the physician who's practicing. The vendor not only needs to report, but we need those actionable lists for two reasons. One is point of care and two, for the patients who don't come in, outreach.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Norma, you've been ..., we'll go to you next.

Norma Lang – University of Wisconsin and American Nurses Association

While I was waiting David addressed several of the questions, so you're really right on target and this is really great. Part of the question that I have is, we point to the vendors and the vendors point to us, where does that stop, because vendors are dependent on actionable data elements that are standardized and interoperable, so to speak, and they need to come from the field, not from the vendors. We don't want the vendors, I think, telling us what that content should be or what those ... should be. So do you have suggestions of how we can, and I think that's part of our responsibility here as we develop the measures, to also have the standardized data and then to be able to say to the vendors this is the standardized data. Can you help say how you could speed that process along? Otherwise we have people calling different things with an incredible amount of mapping required, and I was going to ask you whether the HIE work has helped move that along, because in order to have an exchange that really works you have to have standardized interoperable data. Otherwise you're just sharing data that still has to be interpreted or mapped.

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

For the HIE we've been using the continuity of care reference standard data elements, so that has helped. But to your question, I don't know the answer but I can tell you that what we're doing is we actually have access to Epic's code, that one vendor, and there are limits to developing your product but we pushed them. We actually have access to their code and we actually are creating more and more documents and ... tools and forms and things that are supposed to make it easier. But the kind of pushing that I think needs to happen is actually more transformational than that. I think that technology needs to be much more forward-thinking. I think that it actually needs to be voice activated. I think it actually needs to somehow allow voice activated orders.

I'm not a technology visionary, but I think that you have to have practicing clinicians working side by side with the vendors, and I can tell you that for Epic in particular and the other vendors increasingly they're coming to our organization. I have quarterly meetings, for example, with all the medical directors, they're pretty rigorous meetings, we meet for two and a half days every quarter, and no one ever misses. We make clinical content decisions and we meet with the vendor to say this is what you need to have. This is why this doesn't work. This is what we need. Here's why. Furthermore, if you really want to be forward-thinking this is what we want in the future. The vendor increasingly brings more and more people to our organization at these quarterly meetings and they soak it up and they come back the next time and say, is this what you're thinking of?

So I think that there are vendors that are interested in pushing the envelope, but it takes practicing clinicians that need to see patients away from, and actually increasingly not just physicians but care team members, case managers, care managers, people doing outreach, they're actually spending more time with those team members creating tools for them. But I think you just need to have vendors that are listening embedded with practicing clinicians to get there.

Norma Lang – University of Wisconsin and American Nurses Association

Can I ask just one follow up question, because that may solve it for you, but how does that solve it for Jerry, and what makes us think his clinicians are going to accept that same thing that you've settled on as we try to move towards interoperability, even across states or nation?

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

Boy, that's a great question. Yes, try to get my physicians to agree to things.

Norma Lang – University of Wisconsin and American Nurses Association

But then you go to the next set of physicians and the next and then you go to the nurses and then you go to the others and you say we need to have a common—

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

There's that old joke: what's a 99:1 vote in the medical staff? Tie. What I would stress—I guess when I was thinking about the question, I would stress that there are critical data elements that we need to manage as a population, smoking status is a good example, that we need to have that if we're going to manage this population and do interventions, blood pressure. Then we, as a group, have accepted the idea that we will standardize where it is put in the electronic healthcare record and we mandate it, and that's the end of the story. So we need to know as clearly as possible, what are those things that we're going to need to do and we will mandate and do it.

Norma Lang – University of Wisconsin and American Nurses Association

Just one more question, if you do that then and you put it in a special spot, what if you have it standardized and coded, does it matter where you put it in the record? If you put it in this little square and you put it in this little square it shouldn't really matter.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Let me suggest that we fold that one as a technical question that we can probably do off line. So we're down to four minutes, five minutes, and my apologies, I don't know who put their card up first. So I'm going to start off with—I think for the people that we're clearly not going to get to in four minutes, let's try to be succinct. But for the others if we can impose on you just a little bit more, if we could record questions and send them to you, we'd be very grateful if you'd give us your responses. We will absolutely get them into the mix.

M

.... Susan triggered a question for me in your discussion around the paper version and the replication in the electronic health record. I'm wondering if you could address, from your perspective has there been an evolution on the population health part of it. Because I still hear mainly the replication of the paper medical record for individual healthcare, but I'm not really sure what your perspective is on the evolution of the EHR and measures aspect for the population health piece in the mechanics, the registry systems, and the stuff we were doing in the health disparity And to what extent has that been absorbed for reporting realities by the EHR vendors and

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

Fantastic question, and it illustrates the reality that electronic health records are outstanding at the individual patient level. That's the way they're built, patient by patient. What we have found is that there's a lot of population health data available and we're leaving it that way, but it requires separate reporting. The vendors that we're working with are hearing loud and clear that this is great. We still want to push the envelope on individual patient levels and get more forward-thinking, but ultimately you need to be able to look at panels of care, entire clinic, if you've got multiple panels, and organization, and across, for example, in ours, a network of care, and we have had to create a separate reporting tool to do that. Electronic health records have not gotten there yet, but that is what's needed.

M

And the corollary, is that true for Sharp Rees-Stealy and the medical group perspective on their ability to deliver population health outcomes, not just individual good outcomes?

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

Even before the electronic health record had a very robust data warehouse, and our data warehouse, if you will, serves as the function for the registries and for population management. What we've done with the electronic health record is taken critical data elements and then put them into the data warehouse to match with the other data elements to do population management. But the EHR by itself, no, has not served that function.

Doug Spotts – Family Practice

For us it becomes a real problem in terms of the mechanics of figuring out which measures work for the individual level, the clinic panel level and the public health level, and the local, state and national level.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Patrice, you have two minutes to respond.

Patrice Soltz – CMS

It might take a long answer, though. I think you mentioned earlier the difficulty in identifying exclusions for the clinical quality measures. What is your experience with clinical decision support, and do you believe that that would assist you in identifying those exclusions?

Jerry Penso – Sharp Rees-Stealy Medical Group – Medical Director, Continuum of Care

Interesting. I've never thought of clinical decision support in that capacity. We use clinical decision support more for gaps in care, so the patient is a 38-year-old woman who comes in who hasn't had a Pap smear in three years and the clinical decision support tells the practitioner she's here for the toe injury, but by the way remind her that she needs her Pap. And because of open access we'd like to do it today if she wouldn't mind, and she maybe needs an LDL cholesterol and things like that. Or her LDL is 180 and she has diabetes, things like that, we almost use it more for action. I don't have a good answer for you on the exclusions, because we haven't used it in that way.

Doug Spotts – Family Practice

Our system doesn't support that yet. It's moving in that direction. It's an interesting take on that. I'd love to also provide that service the same day, however, under the current system I would be paid not for both things but for one thing only.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you very much. Susan, go ahead.

Susan Chauvie – OCHIN – Vice President of Quality and Practice Transformation

I just want to say, we have health maintenance alerts and best practice alerts. The best practice alerts actually can have enough logic factored in to include exclusions.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, again, all three of you. This has been, I think, really remarkably useful to us. I want to make the follow up two-way. When you get on the plane and you remember what you wish you had said to us, please send that to us and we will get that into the database also. Thank you very much.

... come up, we'll turn our attention to the vendor perspective. As is often the case in these meetings, we're just going to keep working and people who need to take breaks of course should do so as they need to. I'll remind people on the phone it's sometimes hard to know if you'd like to get in a question, so when we do get to the open question and answer discussion please give a loud signal so we make sure we know you're out there if you'd like to get in.

Alas, we now have four witnesses, so we're going to offer you five minutes for your verbal testimony, but I'm sure you'll be able to give us the highlights in that time. So we thank you all for coming and joining us today. It's really a pleasure to have you.

As you heard in the last panel, a lot of this is about the interaction with the vendors and the provider system to generate the quality measures and the data for this, so we really value your perspective. We have four presenters today: Connie Moser from McKesson; Sarah Corley from NextGen; Michael Barr from ACP; and Mark Stewart from the Heart Association. Thanks very much for joining us and for your wonderful written testimony. We'll just go in order, I think, starting with Connie. Thank you.

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

Thank you for the opportunity to provide testimony today. My name is Connie Moser and I'm the Vice President of McKesson Provider Technologies, a division of McKesson Corporation. I'm testifying today

on behalf of McKesson Corporation, a Fortune 15 company with decades of experience leading the health IT industry. In my current role I'm responsible for developing, implementing, and supporting data analytics and quality measurement solutions. In response to questions you have raised, we will share with the panel the lessons we have learned in three key areas: alignment of measures, maturity of standards, and clarity of methodology.

On measure alignment, McKesson recommends these components. First, common EHR data elements are needed to address similar concepts and facilitate efficient and safe clinical workflows. For example, CMS, the Joint Commission, and meaningful use measures include information on tobacco use. But each measure defines the data elements differently. This requires a provider to ask a patient multiple questions about smoking and tobacco use instead of focusing on patient care.

Second, standard calculations and definitions must be used to ensure integrity and comparability. For example, while the stage one ambulatory measures calculate a patient's age prior to the start of the measure period, the stage one hospital measures calculate patient age at admission. These different approaches to computation require unique age calculations. A common method would simplify the work involved in implementation, and alleviate confusion and inaccuracies. This will become a greater challenge as we adopt measures that cross care settings.

Third, we recommend the adoption and use of the NQF format for measure specifications across all programs. Because of the compressed timeline and priority to implement clinical quality measures for stage one, CMS has adopted measures from multiple sources. For example, in stage one we had a mix of NQF and HITSP specifications with different definitions, formats, and approaches. We recommend that all quality measures move to the NQF format, including any relevant manual measures.

The second area of focus is in maturity of standards. Before adopting new measures we asked the panel to consider the maturity of both the measure specifications themselves and the data standards referenced by those measures. When enhancing or introducing new standards we asked the committee to review and validate implementation to ensure support of clinical practice. For example, RxNorm does not support partial doses, even though it is a common clinical practice to administer only half a tablet. In the CMS audit the care provider is then expected to explain the discrepancy between what was administered and what was used in calculating the measure. The documentation and associated computational logic should be aligned to clinical practice. We also ask that you provide implementation guidance around handling missing, duplicative, or conflicting data.

Lastly, we ask that you develop and deploy standards that support the evolution of eMeasure data capture. For example, a new stage two objective focuses on the longitudinal care plan. However, no current standard for longitudinal care plan, the data elements to be included, or how providers would manage the care plan across care settings exists. Therefore, we urge this panel to evaluate and determine whether the prerequisite data standards are in place before adopting new measures, which depend upon this foundation.

Measure scope and methodology is our last area of focus. Many of the new measures being considered require information from multiple settings and providers. Without specific guidance it is not evident who is responsible for the calculation and submission of these measures or how claims and EHR data should be combined and used in measure calculations. As we move through stage one we are learning that time pressures can lead to substantial challenges and data integrity issues for eMeasure specifications. For stage two we urge the committee to focus on solidifying the current infrastructure before introducing new quality measures. Building this foundation should incorporate time for establishing the necessary data standards, completing adequate field testing, and developing implementation guidelines to ensure data quality and consistent, efficient clinical workflows.

In conclusion, align measures and focus on common EHR data elements, standard calculations, and adoption of NQF formats for measure specifications. Evaluate the maturity of existing health IT standards, and clarify the scope and methodology of measures that need to be established, and solidify

the current infrastructure for measurement before new quality measures are introduced. On behalf of McKesson, thank you for the opportunity to testify.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks very much.

Sarah Corley – NextGen Healthcare – Chief Medical Officer

Good morning. I'm Sarah Corley. I'm the Chief Medical Officer for NextGen Healthcare. I wear both a clinician hat and a vendor hat today. I thank you for the opportunity to testify on quality reporting using electronic health records. My written testimony addresses each of the questions you asked of us, however, because of the limitations on time I'm going to focus on a few areas. Specifications for quality measures need to be harmonized. When measures have different specifications for the same clinical guideline it creates additional work on the part of both the vendors as well as the providers to complete that information and it does not result in an improvement in clinical outcomes. Measures need to be consistent across the different programs and it's very important that clinical decision support facilitate the guideline-based care. If you do not have consistent specifications we're unable to include clinical decision support that includes both the exclusions and the inclusions so that it matches the measure.

Requiring measure developers to produce clinical quality measures in both human readable and HQMF format should be imperative for meaningful use stage two. All measure developers should also reference value sets for every required data element and the reference set should be freely available in a format that can be downloaded or a Web-based service. Until we have a single standard for the information collected and that single standard is widely used, measures need to include all possible code sets. So producing measure specification with just RxNorm requires translation on the part of vendors. It has the potential to introduce error in the translation.

Using data that is already collected as part of routine care would speed the process of rolling out measures. These changes can save development time by vendors and the need for clinicians and health systems to upgrade their software. One area that has been particularly problematic has been exclusions. This was mentioned earlier. If the exclusions are clinically relevant and are collected as part of care, that is not an issue. But if the exclusion is not clinically relevant, it may not be completed by the provider even if a structured data field is entered, and that can result in disparity in the accuracy of comparing performance across providers. Measures should be meaningful and not just created so that every specialty has a set of quality measures to report on.

Refinement of QRDA and its adoption would reduce pressure to reinvent the wheel. While there are some concerns about the scalability and flexibility of the standard, those concerns suggest that revision may be appropriate rather than abandonment of the standard altogether. There may be merit to a standard set of data quality queries for quality measure reporting. This would allow for the creation of standard queries based on HQMF defined quality measures to request reports of an EHR rather than requesting data sets or require submission of granular data. The HL7 HQMF standard has not yet been helpful, as quality measures were not published in this format. We are hopeful that CMS and NQF can collaborate to enable all quality measures to be published in this format. This would cause much of the ambiguity of prose measures to be eliminated.

The current eSpecified clinical quality measures for stage one were not sufficiently adjusted from the prose versions to qualify as truly being called eMeasures. We applaud the recent retooling work that NQF, AMA, PCPI, NCQA, and the Joint Commission have undertaken to address this. As they stand today there is room for interpretation in many of the measures. I'm pleased at the attention being paid to this important benefit of the use of electronic health records, and the potential to improve care that we provide to all citizens. Only by improving the care that we provide in an evidence-based fashion can we hope to stem the cost of providing healthcare in this country. Thank you.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you. Dr. Barr?

Michael Barr – American College of Physicians – Vice President, PA&I

Good morning. I'm Michael Barr. I'm an internist and the Senior Vice President for Medical Practice Professionals and Equality at the American College of Physicians. On behalf of our 130,000 members, thank you for the opportunity to offer comments this morning. It's important to be clear that ACP doesn't develop clinical measures, we develop guidelines, although in 2010 our performance measurement committee reviewed over 340 measures and over 8,000 pages of material from NQF and the PCPI. So it's important to us about the translation of these clinical practice guidelines into eMeasures. Translating with high fidelity clinical guidelines and statements into validated, tested, and NQF endorsed EHR-based quality measures for improvement in public reporting is essential to achieve meaningful use of health IT and the attainment of higher quality more cost effective healthcare delivery. However, clinical processes are complex and current measures generally target what can be measured now rather than what should be measured based on clinical relevance. As Albert Einstein once said, "Not everything that can be counted counts; and not everything that counts can be counted."

Patients move through various healthcare settings so we tend to measure something in each location, but not across settings in a patient-centered manner. While an outcome may be attributed to a particular clinician or setting, that result is a consequence of the patient's trek through the healthcare system, affected by multiple different factors along the way. We rely predominantly on activities that generate claims or orders and depend on coding systems that are not clinician friendly or specific enough to assess particular elements of the care delivery process. Further, few, if any, measures assist the accuracy of diagnosis, clinical judgment, appropriateness, cost, coordination of care, or engagements of patients and their families in decision making. Optimally, the same measures of quality, efficiency, care coordination outcomes with both guide improvements to care delivery processes internally at the practice and group level, and provide evidence of the extent of those improvements externally as part of a well-designed public reporting process.

So with these points as background let me outline ten recommendations from the American College of Physicians for your consideration and direct you to additional details in the written testimony. One, ACP encourages full transparency in the conversion of NQF endorsed measures to eMeasures. Two, ACP recommends field testing of each eMeasure through simulation with a known data set to identify any possible misclassifications or miscalculations prior to implementation.

Three, ACP recommends the development of an online reference implementation, an actual working demonstration about eMeasures and automated measure reporting would work, and this system would help facilitate and speed vendor implementation. Four, ACP suggest that vendors be urged to adopt immediate functionality to support eMeasures as rapidly as possible, but that additional certification criteria should not be instituted until the vendors have had sufficient time to field test and implement the new measures.

Five, data to support EHR-based quality measurement and reporting should rely upon information routinely collected during the course of providing clinical care and measure developers should consider whether required data for measures are routinely captured in order to minimize unwarranted complexity and additional work at the point of care. Six, future measures should include relevant data supplied by patients.

Seven, EHR-based quality measurement should begin with the goal of facilitating the real time collection of data that supports the effective use of point of care clinical decision support algorithms. Actions of physicians in the clinical team in response to recommendations provided by clinical decision support systems could form the basis of future assessments of quality delivered and potentially become part of ongoing maintenance of certification and achievement of continuous lifelong learning objectives. Eight, data elements that comprise quality measurement data sets should be defined in a standard way to enable health IT developers to implement them effectively.

Nine, measurement developers should recognize that information systems other than electronic health records have important data that could either pre-populate reports or be reported directly on behalf of physicians and institutions. This could dramatically reduce the reporting burden for clinical teams.

Finally, ten, certification criteria should recognize that data required for reporting is scattered across multiple systems and multiple organizational entities. EHRs may not have to, and perhaps should not, collect aggregate analyzed report quality data to multiple target agencies. EHRs should more appropriately focus on delivering important information at the point of care.

In conclusion, until and unless we have far more standardization for capturing, organizing, and reporting information from EHRs, as well as exchanging information between healthcare systems, it will be challenging to generate robust indicators of meaningful use of health IT or to inform healthcare delivery and patient care. We are hopeful that the work of the ... application partnership to identify relevant measures, the NQF quality data model to specify measures, and the recommendations of this workgroup will help accelerate the meaningful use of health IT and help the United States move past the limitations of currently used performance measures. Thank you.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks very much. And Mark, please.

Mark Stewart – American Heart Association – Science and Medical Adviser

Thank you for the opportunity to be here on behalf of the American Heart Association and its subsidiary, the American Stroke Association. I'll represent today the perspective of a guideline and measure developer. I have the good fortune of serving as a Science and Medicine Adviser for the American Heart Association with the Quality portfolio here in Washington, D.C. on behalf of our more than 20 million supporters and volunteers, both professional and lay, we're considered a trusted and credible source for science and quality improvement. Along with Partners, we've been developing clinical practice guidelines for more than 20 years and have developed a rigorous methodology that was recently highlighted in Appendix D of the IOM report on developing trustworthy clinical practice guidelines. These guidelines form the foundation for development of our performance measure sets, which, as appropriate, are developed in conjunction with AMA PCPI, and most recently we collaborated on the development of key data elements and definitions for base cardiovascular vocabulary for EHRs, which will be published next month in our journal.

In addition to these efforts, AHA has developed, implemented, and manages five national registries known as Get with the Guidelines, which aims to ensure that patients with cardiovascular disease and stroke are consistently treated according to the most recent evidence-based guidelines. Our recently launched re-branded Get with the Guidelines outpatient, now known as the Guideline Advantage, will work directly through participating practices for established EHRs or health technology platforms, to receive data to generate measures and reports in an ambulatory environment. We have noticed that a number of EHRs and EHR modules have begun to capture data for the eMeasures specified in meaningful use as a result of the code sets specified. Within the Guideline Advantage we have incorporated 34 of the 45 eMeasures into our data specifications. Not all eMeasures are relevant to this program, such as those that target pediatric populations.

One of the questions was around challenges and data mapping, and we found that the different code sets being updated at different times throughout the year, both by the code set developer, such as SNOMED or CPT, and then having to be updated by developers such as us is a primary challenge. There was a question on what we can do to improve existing standards to optimize clinical quality measurement and reporting. Data elements that compromise the quality measure data sets should be defined in a standard way to enable health IT developers to implement them effectively. We also believe it will be important to cross-check the eMeasures manually with abstracted measures, at least initially, to determine if there are any potential inconsistencies with the eMeasure. This will be important to ensure that the numerators and denominators are correctly crafted.

There has been discussion today around the care continuum and we recognize that measures that are longitudinal as well as cross-cutting are important to really further patient care. Many patients who have these chronic conditions are seen by multiple physicians and it's important to provide the ability for the information to be shared seamlessly across providers and care settings. While there are concerns, we

acknowledge using a unique and constant patient identifier, and systems will need to be developed to assure patients' progress be evaluated longitudinally.

With regard to patient reported outcomes, we do believe that these may hold value, especially if they include assessment of symptoms using well-defined terms. Also, the ability to improve quality of care is dependent of course on the adherence of the patient to the recommendations made by provider in consultation with the patient. There was a question around adapting the product end users and quality improvement, and the Get with the Guideline modules mentioned previously contained in our suite of registries, collect a number of critical measures and provide hospitals and physician groups with quarterly reports that allow them to continually assess their performance compared with national benchmark data.

Another question highlighted the role that can be played in informing future products. I would like to mention that the guideline advantage that we've re-branded is being done in conjunction with the American Cancer Society and the American Diabetes Association. We feel that there's an opportunity there through this joint venture between the three major organizations that represent four major disease states to partner and create a data set that's less burdensome than collecting measures for all four disease states separately. I should say that the American Heart Association will be pleased to collaborate with ONC to help facilitate the consensus of alignment of current measures and development of future measures. HHS should encourage the ... sharing of data between EHR developers and vendors and measure developers, and this data is needed in order for measure developers to be able to test the reliability and validity of measures as they proceed from being included as a reporting measure to being elevated to a quality or endorsed as a performance measure. I thank you again for this opportunity.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you. Thank you all for a very enlightening, informative testimony. I'll use my prerogative to ask the first question. We're encouraged, it's very positive that all of you, both as developers and as implementers of products, have taken the meaningful use program so seriously. It's obviously influenced a lot of what you're doing and that is a signal that what we're doing here is still important. We're very conscious in all of our meetings that what we're doing is linked to the larger goals of healthcare reform and health system improvement. For that reason the kinds of measures that we look to in quality measurement will probably keep evolving in the years to come, and even in the stage two measure concepts we've all seen there's some new and fairly challenging ideas about measurement that are embedded there.

I have a two-part question for you all that I'll ask you to react to. One is, what can the vendors be doing, or should they be doing, or are they doing to engineer their products for flexibility? So there's a tension between the desire for high standardization and specification and precision and the flexibility we'll need to accommodate new concepts, new measures, new methodologies, new computational approaches going forward. That's really primarily a vendor question. Then I think a larger frustration that some of us feel is that you've all rightly said, almost each of you has said that there's an important role for testing and validation of each new measurement concept of the terminologies that are used and the computations that are used and so on. We heard that from the first panel, but when you take the entire pipeline for measure development through implementation in a doctor's office for a testing period or a reporting period of meaningful use, there's no way we're going to get a new measure developed in time for the life cycle of meaningful use program by 2016. What can we do to compress the cycle, either parallel paths or some new kind of synergy or agreement up front about approvals, so that each process of testing, validation, endorsement, consensus making, certification, vendor specification, installation, that whole cycle can somehow be shortened. Any suggestions you have for us on how to ensure that new measures can be available for use in a more timely way?

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

I guess I'll start. I'll jump right in. There are a couple of things. I think we are trying to define flexibility in our processes because we have clearly heard from physicians and clinicians, as Susan and Jerry spoke about in the last panel, where they want flexibility of workflow. So if we clearly define measures and we understand the interpretation in a uniform manner, that will absolutely decrease cycle time. It will allow us to get faster to the development of what is missing in our solutions, in our vendor solutions, and it will

allow us to get to the testing and validation of workflow. I believe, again, back to my three key statements, if we have measure alignment and standardization we can get more quickly to the process of let's develop, let's get after it, because we absolutely support these measures.

Sarah Corley – NextGen Healthcare – Chief Medical Officer

Certainly it speeds the process if you're using data that's already being collected as part of the normal workflow. If we have certification requirements that require that we as vendors put in language that says current same day, every day smoker, current some days smoker, that requires development work that doesn't improve the outcome, because we're already collecting tobacco information, not just smoking but tobacco use. So if you make these measures use fields that are already commonly collected, then it is a lot easier to adapt them and take that data. Certainly we put tools in to facilitate practices to create their own protocols because every payer may have their own performance program. But when you're talking about reporting on them, the more complicated the measure, the more exclusions it has, the harder it is, in a nimble fashion, to create those reports. If the reports are simpler with fewer exclusions, fewer this many visits in this period of time, when you're looking at set data that's already entered, it's going to be a lot faster to do that. Now, we put in dashboards so that our practices can see how they're doing across their panel of patients, across their enterprise and that helps them, but again those dashboards have to be set up with the information and the more complicated the measure the more time it's going to take to test it and validate it.

Michael Barr – American College of Physicians – Vice President, PA&I

I'm going to take a slightly different tack and speak from a ... perspective, and the life cycle issue. Right now you're in a lock-step issue because you're developing the criteria, the meaningful use stages. These guys have to develop and at the same time we're asking the clinical teams around the country to implement, and I think therein lies the challenge because it's additional pressure. If it was somewhat relaxed where it was asynchronous, you're developing the measures, you're testing them, the functionality's making its way into the products. We're starting to get teams to use them and not rush it out there, and that's sort of what we're concerned about, and I don't know if there's some flexibility, but the flexibility that I'm asking about is whether we can create an asynchronous process. So development is not actually at the same time as implementation in the field with the clinical teams.

Mark Stewart – American Heart Association – Science and Medical Adviser

I would mention, it's already been discussed today, the issues around harmonization, which I know NQF is putting a focus on both retrospectively for currently endorsed measures, and prospectively that we bring all the parties who need to be at the table to the table in development of the measure. I think that will go a long way. As part of Get with the Guidelines we do provide you quarterly reports, but I think it's really important that they see at a minimum, at least quarterly, where their performance may be low and have access to tools that can help improve their performance on a timely basis through small sets of change.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks. We'll start going around, I think, clockwise. Tom, do you want to go first?

Tom Tsang – ONC – Medical Director

Thank you very much for participating in this morning's panel. I have a two part question. The first one, and we've heard from the first panel that it's important to have measures that are available for improvement and actionable. I like to think that what we did with stage one, to have the ability to have the measures calculated at the EHR, at the point of service and available for providers empowers the providers and entities and delivery providers to have the capacity to actually do quality improvement efforts at the local level. My question is, to Sarah's point when she's recommending ... or expanding ..., how does that fit in the context of allowing providers to actually have calculated quality measures at the points of service? Then my second question is, how can we link calculated measures with CDS or guidelines at the local level for quality improvement purposes?

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

Practices and clinicians are always going to be interested in seeing how their performance is on quality measures that they feel are meaningful to them and their practice. So there will always be a role for having dashboards and quality reporting available at the local level. But when you talk about an expansion of measures and measures that may not be particularly relevant to the focus of a practice but they need to be collected because of regulatory requirements or payer requirements, you really don't want to clutter up their dashboard with those. A practice can only focus on improving quality in a few areas at a time. To try and say that you're going to, and Tripp knows this because I was a researcher on a project he participated in, if you present someone with 75 measures and say, try and improve all of them, they'll get nowhere. They have to pick a few to focus on. But when you're talking about getting the data out of the system for multiple reporting requirements, really we need a standard way to do that.

As far as the clinical decision support and harmonizing that with the guidelines from the quality reporting, we work very hard as vendors to try and make sure that we do that. We try and put the exclusions in there in the appropriate workflows so that it can be documented by the right person at the right time. But the more exclusions you have or the conflicting exclusions are very problematic because you want one set of clinical decision support in your software. You don't want to be presenting clinical decision support if the patient has this payer and a different set for someone else. So we really need that harmonization that we talked about in order to continue down that road of making sure that our CDS supports the guidelines.

Tom Tsang – ONC – Medical Director

Can I follow up? So you're suggesting to use ... as an export file so that the measures can be calculated elsewhere?

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

Yes, and continue to allow the vendors and the practices to display the quality measures they care about in their dashboard functionality or there other quality reporting mechanisms so that they can see what's relevant to them at the local level, but not have to deal with trying to calculate those things that they're not working on.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks. Karen?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Thank you very much, all of you. It was extremely helpful. I want to follow up on a point, Connie, you made about wanting to make sure we have the prerequisite, I believe you called it, of the data standards in place before we ask for a collection on more measures, and that's something I know our subcommittee has been thinking a lot about. So my question, all of you, is how would we manage that? Let's say we know we want to do measures XYZ in stage three, say, and to get there we need these four data standards in place. Do we announce that? Then do we quarterly, yearly do a random survey to see, are there in place, are they being used consistently? When will we feel confident enough that we've got success on the prerequisites that we can then say, okay, we want everyone to collect on these measures?

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

Let me take a step back. Prerequisites, we need to define the standards, like the longitudinal care plan and the definitions surrounding it. How we do that with McKesson, we have our clinical workflow and then we have an analytic solution that's integrated with that clinical workflow but the data is offloaded and we identify and calculate the measures separately and then deliver, just like Sarah, back in dashboards and scorecards so they can actually get to meaningful use. They understand exactly down to the patient level where they are not providing optimal outcomes, correct.

So two years ago we started on the readmission analysis, because we knew it was coming, we knew there were penalties for our customers, so we formed the workgroup. We formed a workgroup from our customer base and we discussed with them what readmission analysis required, based on all the definitions out in the industry, and then we started working through workflows. So understanding where

the information, the sources of data would come from, or did they exist, because we find that many measures that come out, the measures, the data doesn't even exist in a common workflow, so does the data exist? Where does it exist? If it doesn't exist where would we put it that would complement the workflow? How do we standardize the measure to allow them to have flexibility in their workflow and then we go and implement testing using either the EHR system or the HIS system and work through the implementation and then publish the end result. But we use it as a guideline and we start, like you said, as a byproduct of care.

That's what we want meaningful use to be, is a byproduct of care. We start with the clinicians, for example, in a clinical standard, and we work it all the way through. But we have clinicians and analytic experts at the table, because the way clinicians view data is very different than the measure specifications that are defined, and you need those two experts at the table to work through it. That's just how we work through it at McKesson to come up with these standards and implementers through customer specific workgroups and analytics and clinical experts at the table. So I'm not sure if that helps or answers your question.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

As a follow up then, so would you say that you want time to do that, or is there anything from a national perspective that we can do to make sure everyone's taking those kinds of steps? It's how do we get this confidence of readiness?

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

Obviously we all love more time as vendors, because it helps make sure the product's higher quality, so that's almost like saying "nevertheless," so I'll say yes on that one. But as we relate to the national forum, I would want the national forum to have workgroups with analytics experts and clinicians performing basically the same process that we went through. We'd be more than welcome to assist and participate in those workgroups because we have hundreds of clinicians and analytics experts in our company that have over 30 years of experience in defining measures. So I believe you need to bring the right experts together at the national level, create these workgroups, which you all do all of the time, but having the right set and working through implementation to determine that it is in fact a byproduct of care or whatever the standard is that we support.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks. Rosemary, ...?

Rosemary

Thank you for your well thought out testimony. You alluded to the complexity related to workflow, and the first panel identified that complexity as well, the need for alignment between quality measures, the data standards, and then the workflow. So I have two questions. Workflow, there's individual workflow and then there's the complexity of all the members of the clinical team, nurses, doctors, pharmacists, that are entering the information that's needed for quality measurement. What are some of the challenges, what do you think your role should be as a vendor, and what are some of the gaps? At a national level, what can we do nationally to facilitate the process, because I think vendors sometimes get caught in that squeeze?

Sarah Corley – NextGen Healthcare – Chief Medical Officer

Every process is different in who is going to take on a task, so we as vendors need to provide flexibility in allowing for different workflows and for different people accomplishing that task. It is important to try and support practices working as a team so that the lowest paid person who is capable and legally allowed to perform the service can perform that service. That means that you're presenting your clinical decision support to different people depending upon the practice, the specialty, the workflow, and that becomes complex to do but it's very important for the use of the software. Where we have problems, we certainly have a lot of our users who say that regulators, and that's their own internal auditors say, oh, the doctor has to document everything themselves and therefore the doctor is doing a lot more administrative work than they have.

I think that it would be very helpful to have clearer outlines that, yes, the physician must take a history of present illness, but the physician does not need to be the one to check every check box if a medical assistant has gathered preliminary information ahead of time on those guidelines. I think there are good guidelines, standing orders available for immunization orders, so that you can have team-based completion of those immunizations. So more of those examples of standing orders for small practices so that they do not have to figure them out and write them up themselves for non-immunization type orders would be helpful as well to support that team-based care approach.

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

I'm just going to do it from the perspective of how we help our customers, because I think that's probably the most relevant and where I'm probably the most knowledgeable. We look at best practice implementation guidelines and we create those for our customers based on the meaningful use stage one measures. We then work with them on workflow redesign. So we have nurse consultants go in and based on their current construct of their clinical workflow, we say this is how it's best for you to implement these guidelines. Here's some opportunity. Here are some ideas. Then we work with them and get feedback on yes/no that's going to work and why. So we have a collaborative discussion.

We also help them understand the measures, because these are clinicians, Sarah is wonderfully versed on both sides of the coin, but we have clinicians that are really focused on providing care and their understanding of the numerator and denominator is very limited. So we have got to get in front of them and help them understand the importance of those measures. Then we give them education on interpretation, so once we get through the clinical workflow and then into the measure calculation and we're doing root cause analysis on meaningful use, we help educate them. They've never had access to this data before in their careers and now they need help understanding hot spots and then best practices on behavior change. We also have another two solutions, a visibility product and a quality monitor product, that takes the root cause analysis of meaningful use and put icons that will help out on big screens across our organizations and help clinicians support staff, both of them case managers, understand alerts and messages so they can change their behavior. Because the only way we in this country are going to get sustainable meaningful use is to hit the behavior change aspects. And it's not just documenting, it's not just a byproduct of workflow, it's understanding the root cause analysis and it's putting the behavior change at the point of the clinician and the support staff that's in the healthcare organization.

Michael Barr – American College of Physicians – Vice President, PA&I

I might just explain it a bit differently. Our vendors covered it very well but from a professional society perspective we own some of that responsibility too in terms of helping clinical teams work as teams. It's not something a lot of physicians, especially trained in a certain era, are really comfortable with. So whereas they might be EHR specific or product specific influences on the workflow, we really need to train clinical teams to work better and not just think about the teams in the four walls of the organization, but virtual teams and connections. Especially as we try to help small and medium size practices actually have the facility and the infrastructure by tapping into external support folks. So it is a cultural thing and something that the professional societies have to own a bit too, and thinking opportunity for collaboration with the vendor community.

Mark Stewart – American Heart Association – Science and Medical Adviser

I'd like to make two brief points, one around the ... clinical practice guidelines and the other an experience so far with our Guideline Advantage. On the former, we have a strong evidence base in cardiology. We're fortunate in guideline recommendations they're based on the best available evidence, preferably of course randomized placebo controlled trials. Right now evaluation of quality measures and practice does not drive guideline development, but it's possible that after ... peer review publications some aspects of performance measurement could then better inform our guidelines. Regarding the Guideline Advantage, I mention we have incorporated some eMeasures, but the early program adopters are not yet submitting complete data in order to enable us to calculate those eMeasures, so we're working with the participants to help them understand what data needs to be captured in order to make that possible. It's labor intensive, it goes without saying.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

We have about half a dozen more questioners and only 15 minutes, so I'll ask everyone to try to keep it as brief and focused as we can. John?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

Thanks. I have one question for you in 27 parts. No. I have one question for you. Lots of good discussion but one I want to focus on, so you all talked about the need for harmonization across different groups, Connie, you mentioned Joint Commission and HHS and lots of different folks, so there's different ways to do that. If you say, all right, there's always going to be one set of measures, that's not going to happen, and alternate ways to look across measures and say when we talk about smoking, what does that mean? What is that data element? Folks up here know that we ... support a metadata registry called USHIK, U.S. Health Information Knowledgebase, but I don't know if that's useful to you. I guess what I need to know on the vendor side of the table is what do you need from us to be able to harmonize across those measures, and then from the guideline developer, measure developer side of the table what are you going to do to help make that happen?

Sarah Corley – NextGen Healthcare – Chief Medical Officer

To harmonize the measures, well, it's difficult if one guideline says a diabetic should have a blood pressure of less than 130/80 and another measure is looking at a blood pressure of 135/85. So that is very difficult when you're trying to harmonize your clinical decision support with your guidelines. Certainly on the tobacco issue, and I'll say tobacco and not smoking because as a clinician I care about all tobacco use and not smoking alone, allowing vendors to report using the language that they already use on the measure of tobacco would certainly be helpful. It requires perhaps more mapping or just the use of code set, so 305.1, tobacco use disorder could certainly be one way to make it easier to capture that data without requiring different fields, different workflows, etc. That's something that could be automated in the back end by a vendor if they're collecting it in one way to add that diagnosis. So that's one way. Connie, did you want to add anything?

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

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Michael Barr – American College of Physicians – Vice President, PA&I

I think the key is obviously the developers need to work on standard definitions and use them again in agreement that we're going to use them. Repurpose them for measures where that's applicable and agree to use them consistently, and to find reporting periods, basically making the measures as consistent as possible so that the interpretation and implementation is easier. It will come back to the clinicians if it's, just as people said, if there are all these different definitions and not usable. Also, ... record, these things are supposed to be housed, so ... when they try and pull the clinical decision support. Looking at a diagnosis in a family history is very different than looking at it in the problem list, and so making sure that that information is accurate and relevant.

Mark Stewart – American Heart Association – Science and Medical Adviser

Yes, I don't think I have much enlightening to add. We're working through the report from NQF on what harmonization means and trying to apply that prospectively to future development of measures. We hope that these key data elements for cardiovascular disease can help with the vendor efforts.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Gene?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

A question about EHRs and PHRs, when Dartmouth was getting ready to go to a new EHR system across the continuum we studied about five health systems that were doing a great job on clinical and population measurement and management. What we noticed was that the best systems were taking the electronic health records and the personal health records in an analog database and really bringing these together so that the patient reported information on health status and on their experience, etc., is actually

part of that information environment. So the question is, what are the vendors doing to bring together the clinician's electronic health record and the personal health record that follows a person over time?

Sarah Corley – NextGen Healthcare – Chief Medical Officer

I'd say certainly in our proprietary portals and personal health records they're integrated and so patient completed data is included and can be part of that analysis. But if you're talking about a patient with Google Health or Health Vault or another one, unless we have one standard then that information is not going to be populated. Certainly looking towards standards for data collection from devices would be very helpful. I know that we used to have an interface to one of the major blood glucose devices so that that data could be downloaded and populated directly into the EHR. Then the device manufacturer stopped supporting that API because they now have their own software where the patient can do it, but that doesn't help us integrate it into the record. So that's an area where there's a lot of room for improvement is in that device interoperability to pull in that patient data.

But as far as the patient completed information themselves on a PHR, right now I think what you're going to see is only the proprietary products are going to have it as we see standards, and certainly if a PHR is capable of continuity of care document, then that information can be pulled in. But I think there's a rich amount of other data that you would want to pull in that isn't currently included because there aren't standards for that.

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

I agree with everything that Sarah said. The only follow up I would have from a McKesson perspective is we have a solution that is source system neutral that has a healthcare data model that continues to extend its database from originally the acute care. Very financially focused, to clinical financial and operational integration, to physician based integration so you can do referral analysis, physician practice analysis, and we are also looking at population management. Somebody asked a question in the last panel, and also the PHR, how can we include that data effectively to get to the business of health and understand where we can provide more meaningful guides to a healthcare organization overall. So hopefully that answers

Mark Stewart – American Heart Association – Science and Medical Adviser

The only thing I'd add from the clinical point of view is that the combination of integrated EHR/PHR is really probably the only way we're going to get clinical teams to use that information. If they have to go outside their system and get personal health records that are standalone and not integrated and the information is disparate or doesn't line up, then it's really going to undermine the whole idea of patient reported information and sharing that information with them.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Peter?

Peter Basch – MedStar Health – Medical Director

Thank you guys for your testimonies. It's been very helpful and informative. One of the questions that I've had, and I think, Mark, you highlighted this and it's an elegant way of stating it, is we certainly know that we have difficulty in defining our guidelines and of course specifying them well enough so that you guys can put them into EHRs and we can actually operationalize them. From our perspective on our workgroup many of us have an idea of what our next few years are about, we have a picture of what meaningful use stage one, stage two, and stage three is. So in a sense we have a map of the world, correct or incorrect, but we think we know what it is and where we're directing our quality measures and where there are gaps and so forth, and that's based on what we know now.

Mark, you raised the point of we have these great guidelines in cardiology, but of course we're moving into a new world now and maybe in a couple of years we will have clinical data on hundreds of millions of people, or maybe perhaps less than that, where we have data sources that we never imagined we would have before. We also will have learning back from stage one, and as we move into writing our measures from stage two to stage three from stage two. So questions for you guys first about what words of wisdom would you give us about going forward with our mission of writing our stage two quality metrics

and we're already planning our stage three without necessarily taking into account what are we learning from stage one or stage two, or the oh, my God the guideline that we thought was so wonderful is now being challenged by this influx of clinical data? Then of course to the vendors how might we be able to incorporate new learnings without making your life more miserable than we've already made it.

Mark Stewart – American Heart Association – Science and Medical Adviser

One of the things I didn't mention, the comments I beg your forgiveness for having submitted it this morning right before the meeting, but references are in there on both the guideline methodology and the performance measure methodology. And heretofore we have required a Class 1 level of evidence ... in the development of performance measures, so this is things that should be done and have RCT evidence-based, and that's, obviously, as you mentioned, a challenge as we move forward. We're currently considering a new methodology which will be a third paper in order to allow for development of performance measures outside of that rigor, because as we can see the fields are rapidly evolving, especially around cardiac imaging. We're trying to, with this joint ... cardiology taskforce on performance measures, come up with an accepted methodology for drafting performance measures where there may be less of an evidence base. I think it's something that we're having to tackle, and obviously it's currently constantly evolving.

Michael Barr – American College of Physicians – Vice President, PA&I

Peter, thanks. I think, just to be a little bit more specific, I think new measures that you might entertain really should be a menu set if you're contemplating that, because some of the proposed measures require further definition and testing. And also we need to put out there what the expected impact and value of new measures might be, the risks, both on the clinical and the administrative side, evidence of efficacy, which it should have based on practice guideline, and what the administrative burden might be by putting those out there. The other part I'd say is that the performance thresholds sometimes have not been defined in what you would expect from a clinical practice guideline, so putting those out there for meaningful use at this point seems somewhat premature.

Then the final thing is, from the clinician's perspective there's pretty stiff reaction to the idea of placing clinicians at risk for behavior by other parties. Obviously we want to encourage patients to be self-engaged in their care, but to put the clinical teams at risk for usage of, let's say, a portal or a personal health record seems to undermine some of their interest in that whole endeavor.

Sarah Corley – NextGen Healthcare – Chief Medical Officer

I think that a lot of value can come from the data that we're going to get because this is going to be our opportunity to see where our performance is in this country, because we really don't know. We have metrics on a few things based on claims data, but we don't know what the, to use the term "triple," be familiar with the achievable benchmark of care of what you can really expect that providers can accomplish with the realities of patients not exercising and following their diets. So what we need to do from stage one, I think is take that data, see what the achievable benchmarks of care are, and based on that use that for thresholds for improvement. But we need outcomes data as well, and the outcomes data are going to inform us and see if the guidelines are correct.

Remember, once upon a time we were looking at providing estrogen replacement therapy was a good thing for women postmenopausally and suddenly we got a big study that says it's not. Well, I understand that the measures may change based on outcomes, so I would certainly hope that we can move towards incorporating outcomes in what we're looking at once we have more providers giving that data. The measures are not that hard to change. If you find that one drug really is not associated with an improved outcome even though it lowers your cholesterol by 100 points, that's not very hard to change. What's hard is when you have to put in new fields that are not part of the normal workflow. So if you say that now we're seeing the target hemoglobin A1C is not 6, it's 6.5, or it's 7, or it's 7.5, it's not hard to change those reports. I don't have a problem with that. It's adding new fields that aren't going to be meaningful to our clinicians and doing them in such a fashion that we don't have enough time to develop them, put them in a logical workflow, safely develop the software, roll it out to our users, test it, etc. The problem we had with stage one was the rushed specifications, the vague specifications and the short timeline for getting it out to our clients.

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

I think Sarah answered it very concisely. The only other thing that I would suggest is bring us to the table. We do support meaningful use. We support moving forward and we support it for improved health in our country. As a patient and as a vendor we support that, so bring us to the table. The other very tactical thing that I would be remiss, because my team that does read all of the measures and calculates them for me, when you send out alerts if you could make it more organized so we don't have to comb through reams of data on Thursday, just a very big little nit, but it would save us voluminous amounts of time. And then give us a heads up for the ED exclusion, for example, that came out. We didn't have a great deal of time to react to that because it came out as an alert, and we had to actually cover that, we put it in a workflow process, we handled it, and it was fine. But if there's a way we can get even more proactive communication, we'd more than welcome that type of communication in an organized fashion.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Let's see, Floyd and Paul if you're still wanting to—no, okay.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

Like others, I really appreciate the contributions that you've made to this discussion. At the Substance Abuse and ... Services Administration, we're concerned about behavioral health and integration of behavioral health with primary care. Since this panel is composed of both vendors and clinicians, how do you address the issue of a missed opportunity and the potential to influence practice if we simply defer to the status quo in practice and code for that with static EHR products, allowing the status quo concept of meaningful clinical practice to govern what it is that we do?

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

I think that a lot of the clinical guidelines on the behavioral health end of things, certainly the depression screening for chronic disease, we put that in our clinical decision support so that that information can be collected. I'm not sure, though, what you're asking as far as other behavioral health measures of quality.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

Incorporating the actual meaningful use quality standards in the software, there are some certified software packages that actually don't screen for alcohol use. They don't have alcohol use even though it is an option, and alcohol use is a major issue for cardiology, it's a major issue for diabetes, and there are certain certified packages that I've looked at that don't even have that, and they screen for depression but not for alcohol use. So there are certain substances that people pick and choose, but in other words, we maintain the status quo and we don't really change anything and therefore we don't actually change clinical practice.

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

I think certainly the clinical decision support related to hypertension and alcohol, I think that our product has alcohol questions and drug questions relative to the conditions where you see an impact from it, it's part of our social history template. It tends to be routinely collected by our practices, although I would not say that most practices are doing ... questionnaires. And that brings us to the use of copy written screening questionnaires, which is problematic if we cannot get copyright release to include them we have to then vary the wording so that we're trying to collect the same thing, ... being one that is under copyright protection. But certainly I have no problems with that being part of the certification process, to have those fields in your software. But if you're not making those part of the quality measures, then your level of commitment by the physician to do that—I mean, that was one of the research projects I did was looking at alcohol screening and hypertension and users of electronic health records. It was pretty low to start with, although once we raised the level by it being a research project we certainly got more data collected.

Michael Barr – American College of Physicians – Vice President, PA&I

The only thing I'd add, because Sarah kind of covered what I was going to say, is it is still a cultural issue to get primary care practices in particular to use the tools even if they're embedded. The other issue is it's an opportunity again to move away from coding and ICD codes and actually pull clinical data to help

decide when there's an appropriate time to ask the kind of questions and screening tools. ACP's very supportive of primary care, integrated behavioral health, mental health, and working with the ... right now in terms of the proceedings of a meeting that happened in October calling for exactly what you're describing.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think our last question ... if people on the phone want to jump in after Floyd's question, and then we'll wrap up.

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

I want to follow up a bit on what Jon White had asked. I did hear the comment, first of all, thank you all for very good presentations and very helpful answers to questions. The concept of the value sets that are being used and to make them freely available, I think I heard that in Connie's comment, and to make them around all terminologies or all vocabularies, I heard from Sarah. One question is around the vocabulary capabilities and if there were a central source that had mapping capabilities from one terminology to another and that were available, would that be helpful? And at what frequency would you be able to take updates into your system in order to deal with new versions of those value sets?

Connie Moser – McKesson Provider Technologies – Vice President, Performance Management

The current mapping tools that we have are woefully inadequate, so I know that our team trying to map the RxNorm codes to what we used with our first data bank software missed all the combination drugs, so Caduet was not showing up as a lipid lowering drug, even though it includes the atorvastatin. So if there are good mapping tools, that would be extremely helpful to do that. A lot of the processing of the quality measures is done through a registry tool that we use, not done at the practice level, although it feeds back to the practice data. So updates could be taken, well, I'd be killed if I said on a daily basis, but certainly on a more regular basis than we could accept it if we're incorporating it into a software release, which typically would come out twice a year and would have about an 18 month lead time. But medications are updated in our system on a monthly basis, so certainly for the tool that we're using for reporting it if the mappings were updated and were accurate and comprehensive, we certainly would appreciate that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Does anyone on the phone have any questions, if we missed you? Okay. Well, thank you. It's been a wonderful panel, very enlightening for all of us. Thank you for your time in coming and educating us.

We'll welcome our last group. Thank you all for coming. Again, we have a very inspiring and challenging panel, I think, coming up based on the written testimony I'll enjoy hearing your perspective. We have Art Levin from the Center for Medical Consumers, based in New York; Paul Wallace, who's formerly a California colleague of mine and now a local, I guess, now with the Lewin Group; and Rob Greene from United Healthcare. Thank you all for coming. I think we'll just go in that sequence, if that's okay. Art?

Art Levin – Center for Medical Consumers – Director

Good morning and thank you for the opportunity to be here this morning. I had the privilege to be a member of the IOM's committee on the quality of healthcare in America, which issued, as you all know, two landmark reports: “To Err is Human” in 1999, and “Crossing the Quality Chasm” in 2001. The chasm report envisioned a transformed 21st century health system that was safe, effective, efficient, equitable, timely, and patient-centered. This last thing was radical for its time. In a trajectory all too familiar in the world of healthcare policy, patient-centered and patient engagement are now terms commonly and liberally scattered throughout most of today's healthcare transformation and reform conversations. The different actors in healthcare have different notions of what is meant by these terms, at least when it comes to implementing transformative policy into practice that effectively changes the locus of power.

As background, you should have received copies of the consumers' platform for health IT, which was released by the Consumer Partnership for eHealth earlier this month. This document starts by laying out what many consumer and patient advocates mean when they use the term “patient-centered.” Certainly, one foundational element is that the free bidirectional flow of information from and to patients, families,

caregivers and providers is critical to ensure safe, high quality clinical care, to maintain and improve the optimal health of individuals and populations, and to honor the well-established ethical doctrine of informed consent. The integration of the public into the hard work of healthcare transformation and reform seems to be agreed upon by all as a necessity for its success.

The translation of this principle of patient centeredness into practice, the engagement of the public in the complex business of moving from a high bound, perversely incentivized, low performing and opaque status quo to a system which is rational, sustainable, high performing, learning and transparent, has a long way to go. The consumer platform describes four domains of desirable public engagement: first is agents of change; second is integrators of health and healthcare into the broader context of everyday life. Third, as sources of contextual information essential for shaping care to individual needs and preferences and for verifying the accuracy of provider perception and understanding; and four, as informed decision makers, and this is where the ethical and legal doctrines of informed consent and self-autonomy are actualized.

I am a longtime advocate for publicly accessible performance measures as a tool for informing decisions, but we've gone in a decade or so from very few publicly reported performance measures to an ever-expanding set. Unfortunately, among this growing set of measures few are useful in supporting the public's engagement as actors in the four roles previously described. Current efforts to concretize stage two meaningful use measures offer us an opportunity to do better, but we must act before the mortar sets. The prioritization of measures that have meaning and relevance to patients, families and caregivers must be front and center now. Such measures include those falling under the rubric of patient reported outcomes, and include experiences of care, quality of life and functional status measures, and decision quality measures. Obviously, aggregating a new set of patient reported outcome measures on top of the ever-expanding measurement set has the potential to create enormous burden on reporters. But if we're serious when we invoke patient centeredness and engagement as job one, then we should be focusing right now on measures that have relevance and meaning to patients and caregivers and their families in the context of their everyday lives.

This in turn of course requires that certain EHR functionalities be in place to support the development and implementation of these measures. We need to recognize that it's very tempting to measure that which is easiest to measure, but informing public engagement requires that we resist that temptation and set about to do the hard work now. At the very least it should be an immutable keystone of HIT Policy that the flow of information be bidirectional and the goal should be to make such functionality ubiquitous throughout systems and populations sooner rather than later. Some health plans seem to have figured out the utility of such functionality for themselves and it's now time for everybody else to catch up.

I also worry that an ever-expanding portfolio of performance measures risks creating a tower of measure babble for the public that is cognitively baffling and lacks relevance. So I would suggest that the ongoing development of metrics and the means to collect the data for metrics should be guided by almost a laser focus on things that matter to the public and be parsimonious to mitigate both reporter and reporting overload. As I say in my written testimony, there seems often to be a field of dreams mentality at play in much of the current HIT activity. Build it and they, the public, will come. But it would seem more likely, I would suggest that the public will quickly lose interest in supporting the development of information systems and performance metrics that are seen as not equitable, not meaningful, and not actionable. Expending energy in converting the existing set of mostly consumer unfriendly measures to e-SPECS is in one sense akin to running in place. I think it pays to constantly remind ourselves that the chasm report did not recommend the move from a paper information system to an electronic one as an end in itself. The invocation of the information technology imperative envisioned it as an essential enabler to support system transformation from the unsustainable and indefensible present to a better future guided by the report's six aims. Thank you.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer
Paul?

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

Thanks very much for the opportunity to offer my testimony today. I will come to the material that's in the printed materials, but I just had a couple of additional observations too. This is a reminder to me that I was part of conceptualizing and building a business case for an electronic medical record related to the oncoming health reform, although that was actually the Clinton health reform. At a time that we created the business case within Kaiser Permanente because we thought that would be a critical business need in order for us to operate in that environment. We'll also take a little bit of caution about thinking about projections about what's going to happen. But at the same time, I think there are a lot of learnings from that experience from the 18 years that actually have intervened since that time until now in the experience.

I also have had the experience of being a physician delivering care with an EMR over an extended period of time, but I'd also add that as a patient I am totally intolerant of seeing a physician who doesn't have a practice supported by an EMR. I honestly don't understand why anybody would tolerate that. So that's an additional component that you need to know. In thinking about participation and this panel reminded me that I'm probably an "other." I was trying to figure out whether I'm a consumer or a patient or a private payer or another stakeholder. I'm pretty sure I am an "other," but I'm an "other" because I've had the opportunity to actually straddle many of these camps. Again I have been a provider, I have been a patient, but I also have worked a lot with employers in the last few years and I've also had the chance to be quite sensitized to the perspective of patients working in a couple of settings and thinking about how we can better share information with patients.

I wanted to really draw on that whole experience. What I particularly wanted to do was to reflect a little bit that much of our discussion today has appropriately and necessarily been very operational and very tactical. But I think it's also important for us to think about the overall strategic needs that are associated with meaningful use and how it supports longer term goals, and not the least of those goals is thinking about how we actually acquire a health system that meets a broad set of needs. So I think we also need to be thoughtful about whether the things that we're talking about are just going to cement in what's been the characteristics of our past health system and make it even harder to change going forward. Or is this actually the opportunity where we are disrupting workflows and where we are changing the way that people are thinking about ... to really be sure that we think strategically so that we bring in opportunities that may be very difficult to do if we basically cement in the current practice patterns and the current attitudes. This is the opportunity for us, and it's actually the time for us and the requirement for us to think highly strategically.

The other part about this too is the opportunity that's related to bringing forward a portfolio of measures that clearly allows us to create accountabilities around performance. I have often thought of performance measurement as being more of a communication tool than a performance measurement tool, and it communicates priorities, and it communicates intent, and it communicates strategy. So I think that the portfolio that we bring forward will be a strong statement of what we think the strategy should be over a period of years, and it will, again, establish that. I think it's important for us to be really careful and think that we're inclusive about all of the needs we want to include, again, not just carrying forward current momentum.

As I mentioned before, implementation is disruptive. If I've learned nothing else in 20 years of doing that within Kaiser Permanente, it's extraordinarily disruptive. But disruption is also an opportunity, and that's what we don't want to miss. I think it would also be important for us to think about if we're trying to meet the needs of the various stakeholders, what are their perspectives? Particularly the way the questions were posed, where we've been asked about if different perspectives would find what we're doing valuable it's important for us to be really thoughtful about what's the value framework of the different perspectives. We had an experience like this in Kaiser Permanente, which I described in the paper, and basically, this was about ten years ago, and we wondered why doesn't the consumer, why doesn't the payer get quality? We're measuring all this wonderful stuff. We're putting it out there. They keep beating up on us so we're not meeting their expectations around quality.

We thought maybe we should understand what their perspective of quality is. And so when we actually sat down and talked to different perspectives, clinicians, payers, patients, and asked them, when you

think about quality what do you think about. Well, when we talked to clinicians they did think about the quality we've been talking about here. When we talked to payers, when we talked to large self-funded employers, their perspective of quality was heavily flavored by financial metrics, not that they would trade off quality to achieve financial metrics, but it was also to recognize where is there waste? Where are there opportunities for efficiency? Where are the workflow issues that we haven't fully harvested? The biggest surprise, though, and it shouldn't have been a surprise but it was, was when we talked to patients their perspective of quality had very little to do with anything that we had talked about previously, and it had to do with relationships, it had to do with respect, it had to do with access. So when we're going to ask whether these measures meet the expectations of patients in the delivery system I think we need to be really thoughtful about how does this align with the patient perspective of value. Does this actually support their participation?

The final component would be for us to be really thoughtful also in thinking about a strategic framework of what do we expect of the patient going forward? So historically in our medical model the patient has been very passive. We've talked about the workflow of the care team. We've talked about the workflow of the physician, but do we care about the workflow of the patient? What are the implications for the workflow of the patient? How are we accommodating that? Are there places here where we're creating messaging and signals that we need to stretch our thinking about workflow to be inclusive of the workflow of the patients? I would maybe just jump ahead and say yes, I think we are. I think that there are concepts and domains in Part 2 and Part 3 that begin to do that. It helps us recognize that the patient participation going forward, the 21st century patient will look to the health system to do a lot of things for them, and that's basically what we measured in stage one, what the health system does for the patient. But we're also going to increasingly expect the patient to do things with us, shared decision making, continuity of care, care transitions, and we're also going to increasingly expect the patient to become accountable for aspects of their own care.

I personally think as a physician it's a physician's obligation to position themselves in a system that will support patients to be autonomous. I think that we need to consider whether that's part of the tension that we want to build into meaningful use. I think as we catalog, and I've done that again in my testimony, there are measures that begin to stretch our thinking, to communicate that the strategy here is broader than the workflow of the physician office. It includes patient workflow, it includes a signal that says that if we're going to support shared decision making there's a lot of work that we've got to do to understand decision quality. I guess what my final comment would be is that I would urge us to be aggressive in sustaining, maintaining, and promoting the concepts that are a little bit out of the well-worn path of physician workflows and physician office visit and historical quality the way we thought about it, so thanks very much.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you, Paul. Bob?

Robert Greene – United Healthcare – Vice President for Clinical Analytics

Chairs Lansky, Walker, and Kmetik, and members of the workgroups, thank you for the opportunity to testify today. I'm Dr. Robert Greene, the National Vice President for Clinical Analytics at UnitedHealthcare. UnitedHealthcare is an insurance benefits business of UnitedHealth Group. UnitedHealth Group serves the healthcare needs of more than 75 million individuals. After reviewing the three stages of meaningful use measures we conclude that while these are necessary and laudable efforts, they suffer from a conspicuous, consistent and striking omission: they do not provide high value measures that address the urgent need to evaluate the safe and efficient use of healthcare assets. At this moment in our nation's history both of these concerns are essential and the proposed measure sets and framework are inadequate to meet this critical task. We suggest the workgroups refine the measure sets and the framework to add high value measures that will assist in improving care while reducing cost. I believe the committee should take immediate and specific short term actions to improve the proposed quality measure sets, and I will suggest a longer term strategy for future measure development.

As background, allow me to review briefly the measure taxonomy proposed by Dr. Mark Kasem and which measures address underuse, misuse, and over use of interventions. As you know, underuse

measures encompass the interventions where we'd like to see more and they include the well-known measures related to cancer screening, yearly tests for diabetes control, and the like. These are well represented in the meaningful use measures. Overuse measures, on the other hand, represent interventions where there's evidence against use, where fewer is desirable. Classic examples are overuse of antibiotics, overuse of magnetic resonance imaging, and Addressing overuse and related clinically appropriate care measures would increase quality while decreasing cost. However, among several commonly used measurement sets, most commonly used measurement sets, I would dare say, fewer than 10% measures address overuse or appropriate use, and not giving details on the written testimony. For example, of the 113 proposed eMeasures, only 10, or 9%, address overuse or appropriate use.

UnitedHealthcare is committed to filling gaps in underuse of key medical interventions and has implemented several large scale programs to help physicians do so. However, such measures are not sufficient to address the crisis of rising healthcare costs. Therefore, I'd suggest a couple of short term improvements. First, to make sure to address any lost opportunities, for example, meaningful use to include an all condition, all cause readmission measure. Second, we should use ... NQF endorsed measures, for example, coupling the all condition readmission measure with the NQF adjusted inpatient length of stay measure, the unnecessary hospital days increased patients' exposure to hospital acquired conditions and infections. Third, I think we should focus on our effort. We should spend less time and effort on measures of low impact, for example, many measures which seem to represent a minimal standard of care.

In terms of the past and future measure development, I'd say that while our existing quality measures are consistent with well understood responsibilities of physicians and health professionals, we're falling short on the related responsibility to address affordable access to healthcare for our nation's citizens and patients. The widespread adoption of the Charter on Professionalism provides eloquent support for this dual accountability. Therefore, the current approach to quality measurement should be refrained. Our existing quality measures don't correlate well with costs, but in other industries increasing quality means decreasing defects with resultant decrease in cost. This suggests a need to develop and utilize measures that reflect true quality deficits. We believe, therefore, that the next step in measure development should be prioritization by severity and type of quality defect in relation to patient outcomes. For example, at the top would be defects in outcomes of measures of medical care, for example, readmissions and length of stay, as I mentioned. Then, hospital acquired conditions and infections, although using a broader set of definitions than CMS, and in addition, for example, outpatient facility acquired complications and infections.

The next level of priority would be inappropriate diagnostic or therapeutic interventions where each instance actually exposes the patients to harm. So, for example, inappropriate CT scans expose patients to unnecessary radiation. A third level would be overuse issues, as I described, which are inappropriate interventions with the potential to cause harm. For example, antibiotics potentially cause adverse effects each time you get them, even MRIs that might not be clinically indicated to have dye exposure or false positive results generate anxiety and exposure to further procedures. Now, for any given measure analogous versions are needed across multiple levels of care, such as physician groups, patient centered medical homes, accountable care organizations, and therefore a critical piece of the puzzle is alignment across the programs.

In conclusion, with the costs escalating unsustainably and patient safety threatened on a daily basis, not acting is simply not an option. We're not on track through the meaningful use measures to achieve the goals of a high value health system, and we must address quality defects and cost to AFAP. The problems we have are largely understood. Some good measures aren't used and we have known gaps that are not filled. UnitedHealthcare is committed to applying and developing additional quality overuse and appropriateness measures, and we're committed to leadership where we can influence the outcomes. But we need your help and ONC's help to step up, take charge, and demand the measurement tools necessary to transform healthcare services into better and more efficient outcomes for patients. The question I have for you, will we continue down an incremental path to a few more

measures, or will the workgroups lead us? I appreciate the opportunity to testify today and I welcome any questions you may have.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks, Rob, and thank you all for very candid, challenging testimony that holds us accountable for meeting the goals that are ... and in our charge. I'm going to ask an opening question, which is essentially the same question I asked the last panel. We will probably get strong endorsement of many of the views you've expressed today from our panel, and then we of course have to bring this to fruition through the mechanisms of the meaningful use program and the resources and limitations of CMS and ONC and everybody else. The timeline that seems to be imposed by various steps in the process certification, NQF endorsement and so on, for measures that are not already—Rob suggested some that have been endorsed, but there are many other concepts that we've all talked about that haven't yet made it through that pipeline. What would you recommend to us to expedite the successful adoption of the kinds of measures that all of you talked about in the pragmatic environment that we're operating in today. I'll just let each of you respond.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I think the key is to pick one, to be honest; pick one but don't pick none, I guess. There's the tyranny of the urgent, which could easily contract this back to a pragmatic approach where we decide that these ought to be in phase seven. I think that would be a huge mistake. I think the bargaining needs to be over how can we retain a placeholder, a toe hold for this within there. I think it probably means that pick one or two, and I think we need to do some really thoughtful prioritization to be sure that at least some measures stretch our perspective and directly bring in the patient perspective ... in the final set. I think it's almost important for us to think about if there's some aspect of this that we can actually bring in to phase two and is this all about development or are there some things that we can get out there. I think there is some wiggle room in this. There is the wiggle room around collection, validation, and non-public reporting, which I think is another degree of freedom. For instance, it's been used with other things that are controversial. You can look at how many years it has taken NCQA to make available the relative resource use measure, and a lot of that was to recognize their importance on one level, to engage people in their evolution, but also be really thoughtful about as we create accountability if there are ways to do that too.

Art Levin – Center for Medical Consumers – Director

I would just say amen, but I think there's a lot of work that's gone on. We have CAHPS surveys. We have a new module that's just been put out for public comment by NCQA and it's going to be voluntary, and I think we should think about how we make those decisions about what's voluntary and what's required as part of the certification program. I think we have some good science around the decision quality and full disclosure. I'm a board member of the foundation for medical decision making and I think there's a body of work there that looks at the quality of decision making. In terms of quality of life and activities of daily living, we've been collecting information about that for decades, in the old style, in the paper world, and I don't know why it would be so difficult to translate that to electronic

Robert Greene – United Healthcare – Vice President for Clinical Analytics

I agree with many of those comments, especially the prioritization, of course. UnitedHealthcare is ready to help and we can contribute and synergize with many of the groups around the table. We do data mining. We have extensive analytic capabilities and we would rather our internally developed measures become publicly endorsed and widely used and just have them internally. I agree with the idea of private use first, and we're going to do quality improvement programs in-house using these. But I think eventually we will look for a national endorsement and anything that we can do to streamline that process as well would be excellent. Thanks.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

We'll start around with Ahmed and come back to Gene, Eva and Karen.

Ahmed Calvo – DHHS/HRSA – Senior Medical Officer

Thank you for your presentations. They were really spectacular. You triggered in me thinking about a formula that goes value equals quality divided by cost. Could you please comment on whether you believe that there are measures of value in approaches such as composite indexes that combine measures of quality and measures of cost so that we can truly get to this question that you guys are bringing up around value and prioritization.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

I think one of the conceptual difficulties, I agree with you with the need for ... of value, is the dimensions and the points of view so that which quality and how much cost, so are we getting so many hospitalizations for so many dollars with appropriate outcomes and such. I think we need to have a better handle on the quality measures. We can certainly analyze the cost very well and the quality measures for value or efficiency, the non-perspective version, if you will, at the outcome measures. So as we get to better outcome measures I think we'll have better efficiency and value measures.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I think it's a great question and I think it's the creative tension that we feel when we're trying to implement the triple aim. It's sort of that dilemma that you've got to hold three somewhat competing ideas in your head at the same time and then try and move forward and not get stuck. I think the other part about it is that the defective simplicity of that formula is it makes us think that we can come down to a "V" that everyone will endorse, when in reality it's a big "V." So I think that part of it is to realize that the discussion is part of the solution, of continuing to figure out how do we tactically and strategically make the trade-off so that we can move forward. But it's also important to make sure if you're going to do the triple aim it's pretty hard to say that we've addressed the care experience if we don't have the patient perspective included. It's messy necessarily, but I think that it's approachable through processing.

Art Levin – Center for Medical Consumers – Director

It just struck me, as you asked the question of the rock/hard place of this because you're damned if you do bring in cost and you're damned if you don't. In the political arena it's such a loaded issue that I worry that we won't be able really to resolve the tension because of the politics that surround it.

M

But we have to.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I guess the other part that would be too when we get stuck is to look at who might have experience that can help us. I think we have to realize that as patients we're making, as people we're making value-based decisions sort of like, how many times a day. I think part of the opportunity around things like shared decision making is to unburden the clinician from having to figure all this out when it's really some of this actually isn't their turf to figure out. It's figuring out how do you actually engage and outsource the decision to the patient. There are some other parts around actual behavior change where it's not the physician. There are some aspects of implementing an EMR, which are about behavior change for physicians and teams, but there's an awful lot about improving health which is about behavior change for the patient. So I think we have to think about it in that way too.

M

If I could follow up on Dr. Wallace's comment. I like that idea very much, and it then implies the need for transparency on the quality and cost so that patients can in fact make those decisions.

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

Really powerful and provocative remarks, thank you. The number of quality measures that we have today is large, over 600 NQF endorsed measures today, and it could become thousands with all of the conditions and illnesses and evidence-based practices that are out there. Yet we want to try to take this opportunity to step back and say how do we get parsimony on the measurement of value, health outcomes, ... experiences, cost of care. So what's your guidance on how to get the balance of measures that really matter and parsimonious sets of measures that could be useful for improvement and for payment reform, things like ACOs and primary care medical homes?

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I can share my bias, and there are other people around the table who are more expert than I at assembling measures and doing all of that. But I can see from my experience at Kaiser Permanente that part of the way we dealt with this was to think about the dashboard metaphor on one hand, thinking about what are the big buckets or the big dots that you care about. So you care about quality, you care about cost, you care about patient experience, and then think about what are the derivative things that you can measure that contribute to those larger areas, and then think about how you can actually construct indices that are useful in decision making at different levels of the organization.

I think that the other opportunity is to also create, part of transparency in building an index is allow people to dive down in and look at the components so they can find the level of the index that resonates with their accountability. So you can have a prevention index that you can look at as a health system if you're actually the person who's scheduling mammograms you might be very interested in as a component of that. So I think that's ... to figure out ... for a long time to think about what are the big dots. What are the areas that you want to have indices for that are really critical that you've built into your dashboard. So that's really the metaphor that I would think about it. I think there's an opportunity here for us also to think about what's the indexing potential and what are the other indexing efforts that are going on at NQF and elsewhere to think about how these things can actually roll out and make sure that we can complement and extend that and not compete with that.

Art Levin – Center for Medical Consumers – Director

It's a great question, Gene. I think it's governed by what the enterprise is about, what's the foundational principle here why we're measuring, and we just again, all too typical in healthcare, sort of created a sub-industry around measurement that's off and running and has really nothing to do with the ultimate goal here, which is I think, again, articulated in the chasm report. How we pull the cord on the production line of measures I'm not quite sure, and sort of shift backwards in a sense to really measuring what we think is important. At the end of the day, what to me is important is what the public perceives as important, because not only are all of us the recipients, we're also the payers. So we're paying for this, we're receiving it, and it really should be governed by what we think is valuable for us as a collective public.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

I'm glad you asked this question. I think it's a key question. First, I think there should be a bias towards outcome measures, and that's related to the first question about value, so that we can actually start talking about value. Second is I discussed outcomes that are defects or potential defects and patient safety are extremely important. So there's a prioritization of the measures and I think we do have to pare down the NQF measure list. It was 600 a few months ago, and in preparing my testimony I downloaded the most recent one and it's up to 730. So we're great doing measures, but to some of our other panelists' comments why are we doing them, with all due respect to measure developers. So for example, I mentioned low bar measurements, one of the NQF endorsed measures and the eMeasures set, I think I looked through this morning, number 13 is did you measure blood pressure once a year in a patient with high blood pressure? I took care of blood pressure patients for 20 years and it's hard to imagine not measuring a blood pressure once a year. That type of measure is far removed from the outcome that blood pressure patients have a stroke or that they have controlled blood pressure, or that they have the right medicine. So you can work backwards. I think that there is an opportunity to pare these down and prioritize.

Now, having said that, unfortunately I think there is also a need for some condition level granularity. So if I'm a patient looking for a hip replacement, it's important for me to find a doctor who has good outcomes for hip replacements. And I'm trying to move our measuring system towards that, although we're not quite there, so we measure orthopedists but sometimes it's hard to tell if we're measuring the quality of their shoulder or their hip replacement or their knee replacement. I think we need some granularity by condition. Perhaps there are some that can be coalesced, so rather than dividing a patient up into diabetes and heart failure and CAD and hypertension, there are six or eight common important things for those patients, are they smoking, is their blood pressure controlled, is their sugar and lipids controlled.

So again there's some tension, but I think the combination of prioritization, focusing, and appropriate granularity, perhaps that's the best way to put it, and then grouping the high yield measures within that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thank you.

W

Thank you and I would like to say amen to everything you said. It warms the cockles of my heart. But I would like to focus a little bit on what Dr. Wallace talked about, because I think it has particular relevance to the roles articulated by the Consumer Partnership for eHealth that Art talked about with respect to implications for the workflow of the patient, as well as how might we signal necessary supports from the practice environment to patients. I'm just wondering, I'm just throwing this out there not having thought it through completely because it just came to me today in listening to your testimony, what's the viability of an approach that focuses on clinical outcomes, if you think of the three areas that Dr. Wallace outlined, clinical quality, affordability, and experience? Considering the fact that meaningful use measures are at this point not publicly reported and there's no obligation to actually perform on these measures, it's just simple reporting on it. Would it be a viable approach to use the quality measure reporting piece of meaningful use to, in essence, be a test bed for these areas that are so clearly lacking and that can help us focus efforts that then help providers not feel so overwhelmed by the numerous measures that don't really provide much benefit to anyone?

So would it be a viable approach to take the first area of clinical quality where most of our measures focus today, and simply focus on outcomes, no other measures other than outcome measures. As Dr. Wallace has said, let's pick a couple, let's pick a place to focus, and focus there, and then put all the rest of our efforts into the other two areas that are so sorely lacking, as we've heard from your testimony, and really hone in on some of these things that I think are very well aligned together. In other words, the affordability, that has huge implications in some areas for the patient workflow when you talk about readmissions, duplication of tests, inaccurate diagnoses, all of those from the payer perspective obviously equal dollar signs. But from the patient perspective they also equal some dollar signs, but they also equal time lost away from work, they equal pain and heartache and dealing with this crazy system that we have, and so that also feeds into the patient experience. I think there's a way to get some synergy there, but this is a radically different way of going about this approach. So I'm curious just to hear your thoughts on that.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

That's a really interesting way to look at things, and having some personal experience with family members who have been extensively using the healthcare system I sympathize exactly with the patient point of view. I think that outcomes actually is a more patient-centered way of looking at many of our process measures. In addition, if you have poor outcomes and you wind up, just as you said, not only spending more healthcare dollars but the patient has to return for the readmission, they have to return for complications. They had 20 sessions of physical therapy recommended but they got better after 3 and they stopped going and then they're marked down as a noncompliant patient, so I totally agree. I think there's a lot of synergy there. I think the patient-centeredness is extremely important.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I'll answer with the doctor part of my brain that still works a little bit. It's hard. I draw the analogy to managing the multi-morbid patient, so the patient who comes in who has heart failure, diabetes, probably has arthritis, depressed, and maybe one other thing, and so you can look at the measures and there are 27 measures that apply to that patient. So you're going to say to the patient, okay, these are the 27 things you need to do. Well, no physician does that and the physician job is to think about what's appropriate for the patient in front of you. I would actually argue that probably a good physician is probably the one that can figure out the 4 or 5 things that that patient can actually be successful with instead of creating some structure that holds that patient accountable for That's like trying to be compliant with 27 things.

I think that's exactly the same problem we have with the physician, where we want them to be accountable for doing 27 things I think that we're signaling chaos. I think the trick here is that if we want the clinician to manage a portfolio, if we want the clinician to participate in managing the triple aim, we've got to think about how do we actually create capacity so that they can focus. I think it's a portfolio management problem, and part of it is also one of the opportunities for the committee is to think about how do you ramp these things up. In phase two and in phase three what is the portfolio of measures that you want a clinician to be responsible for and if someone's willing to take on something that has to relate to patient workflow, where are you going to give them a little relief and something else so that they can actually do that. It comes back, again, to measures being as important as signaling ... as it is to hold people accountable for what they did. That's an additional part that people can differentiate. I think the first part is actually just saying it's important. I would think that one of the other opportunities ... is to think about what's the portfolio you want to present to people and are you going to give people credit or give people a little relief to take on some of this other stuff by lessening the load for some of the other expectations. That would be another strategy in which to keep this within the doable realm.

Art Levin – Center for Medical Consumers – Director

That takes me back. There was an IOM report that came out about two years after chasm report that I was also involved in learning from experience, which was in response to Congress asked IOM to take a look at the federal programs as related to quality and safety. One of the things we suggested in there, which disappeared, is that in terms of relieving burden that there would be a credit system, that really the high performers should get some benefit from being high performers. It doesn't have to be money. It can be that you're really looking at trends and saying these folks know what they're doing and they're doing a good job. The quid pro quo for that is you won't have to do as much as somebody who we don't have evidence about that's doing as good a job. So it's another currency that isn't dollars that could be used.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

Just to add to my earlier point, one of the exciting parts in the meaningful use and the HITECH opportunities, in general, is that with all the contacts we're talking about right. And the way of tying many of these together so it occurs to me that tying the clinical decision support to which things to use and to when would help the patients. So for example, to prioritize the 27 things, the clinical decision support might say, "Of all these things the most important thing today is blood pressure and the stop smoking and worry about the Hemoglobin A1C of 8.5 today." So things like that I think are an opportunity. Then also, the tie to help information exchange so if the patient has already had the test across the street you can save the patient time and money by getting that results here and not repeating the test.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, I've got six more people and, again, 17 minutes so I'll ask you all too kind of be very focused, okay? I've got in sequence, Karen, Jim, Tom, Norma, Peter, Helen. Karen, you're first.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Thank you. On the overuse topic I'd like some more feedback from all of you about how we can pursue that agenda arm in arm with the consumer and patient alongside it and also leveraging the EHR. What I mean by that is—Rob, I think if you came back here in six months you'd see those percentages go up pretty significantly in terms of the numbers of measures that address overuse. Thanks to the encouragement from you and the NPPs I think you'll see that coming. What I worry about though is whether those types of measures will fall flat without everybody locking arms.

For example, you'll be seeing some measures about inappropriate imaging around sinusitis and inappropriate antibiotics around sinusitis, work that you've done in the past, Rob, and you'll be seeing measures that talk about radiation dose optimization, so who's tracking how many CT scans I've had and what the doses of those have been? Those kinds of measures though are going to require some good communication between the clinician and the patients because this is something that is not going to be done. Also, we have to figure out how to leverage the EHR data and functionality to get that kind of information into a registry or somewhere where we can track things like doses of CT scans.

My questions are what thoughts do you have in terms of when these measures come out now they're not going to have the impact we want, I don't think, unless we all rally around the education piece. But also, Rob, to your point what can private health plans do because it's not just mining the wonderful data that you have but now leveraging EHR data going somewhere where it can be looked at from an overuse perspective?

Robert Greene – United Healthcare – Vice President for Clinical Analytics

This is excellent and I'm glad to hear those measures coming. So in the projects that I did that Karen Kmetik was referring to about decreasing antibiotic and sinus imaging we actually created with our physicians—and this was before I came to United—an integrated package including patient handouts in Spanish and English. The patient education materials, and so with some publicity in the newspapers and things like that, so I think that's extremely important. The health plans do have patient outreach disease management/case management programs. I think they can be more tailored and more efficient but I think each of the five of the pairs has some capabilities there, which we could enlist and align with us. Patient education is incredibly important, and I think another opportunity is to work with the public health, so for example, the CDC has had for many years a program on antibiotic overuse, which we were able to leverage as a credibility for our program because of course patient come in and say, "I want an antibiotic for my sinusitis." The stuff we're talking about in population health perhaps we can also bring in those elements.

Art Levin – Center for Medical Consumers – Director

That's a good question and a tough issue. I think in my more than three decades as an advocate focused on overuse, getting that message across has been the most difficult. Certainly, underuse is an easy sale politically and sort of to the general public but overuse is a tough one. I think it speaks to shared decision making. I mean I think it takes a really intensive effort because unless we reverse the Supreme Court decision on commercial free speech the promotion, the socializing that more is better and new is better, is the environment in which you are asking people to sort of reject that automatic acceptance of that promotion. So right now it really means intensive shared decision making. Decision aids and an intensive effort to explain the benefits and risks of alternatives and the fact that the old stuff may be the better stuff and that more isn't always better but we can't do that without a really intensive effort at shared decision making.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I would agree. I think the other component I'd throw in is to help support physicians in the clinician/patient relationship with information from a trusted source, which may be repurposed from that physician himself. Make sure that it's accurate and evidence based but that doesn't mean that it's brought forward in evidence ease, so somebody's got to write these things in a way that actually resonates with a patient not necessarily even in doctor's fee. Then the final part would be don't underestimate the ability of the patient in this decade to understand resource stewardship. I think it's not inappropriate for us to point out where choices do have a resource waste. There's an element of waste and what the opportunity cost is of waste. I think all of those are credible parts and I think it also can help to educate the clinician how to talk to the patient about issues that involve restored stewardship.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So I have a simple and concrete question in service of a large strategic aim. I think many people in this discussion want to create eMeasures that address issues that have large public health impact but it isn't clear that there is a validated credible listing of healthcare conditions in rank order of remedial burden of illness or potential quality adjusted life saved or whatever. Are any of you aware of such resource? Rob, I thought you might—

Robert Greene – United Healthcare – Vice President for Clinical Analytics

Sure. We can go back to some of the materials that supported the work of the national partnership, the NPC National ..., thank you, sir. I'm suffering from a bit of a head cold so—so that's one area. We can certainly go to public health and CDC. Medicare, I think, has done some research on its priority measures which is a little slightly different list from the commercial age population, which I have the most experience with although United Healthcare does have both Medicaid and Medicare data so we regularly

generate lists of numbers of patients and costs by condition. I think a hard part is what percent is remediable within that although it seems like there are opportunities everywhere you look so starting at the top is probably a pretty good place to start.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

The other reflux I've heard to develop to that question is ...say tobacco, and I think that we shouldn't forget that that's still probably the greatest accessible health impact that we can make.

M

As we talk about innovative measures such as patient reported outcomes and these value measures we're also talking about perhaps new infrastructures and capabilities of EHRs to collect the information as well as different data sources, so for example, Rob, you mentioned re-admissions measures and like the state measures. Many of those measures right now are strictly claims based. And I'm trying to, in my mind, grapple how we can actually turn them to eMeasures and use electronic health records to actually look at re-admissions measures, measurers that look at pharmaceutical adherence may use data from pharmacy benefit managing plans. So besides having a multi-payer or payer database how would you—can you recommend strategies on actually moving forward with incorporating patient reported data, functional status information as well as how to incorporate claims based measures?

Robert Greene – United Healthcare – Vice President for Clinical Analytics

Let me just think for a moment. So part of that, to stay in the claim based zone for a moment, is optimizing what we're already doing. So for example, the CMS hospital quality conditions and infections, that list gets maybe 0.5% to 1% of discharges but if you bring that we can double that. Now, that gets us 2% and the Office of the Inspector General said there is 13.5% that we have so there's a big gap in there. I think some of that one would hope would come from more detailed information that was in the hospital electronic records. That could help us get some of that information.

I think patient reported outcomes are extremely important and there are a number of tools for that. I'm not sure there as well standardized, so for example, there are well validated tools like the FS12 and 36, which by disclosure are not part of the Ingenix UnitedHealth Group suite of products, but those tend to be somewhat general. They're not outcome after my knee surgery or aftermath of my CABG, they're how are you doing in general. So but then there are some patient reported outcome measures, for example knee surgery, but there are a number of them, so I think we have to go back to standardizing those and working with the specialty societies and the patients to get at that, but it seems that there are many electronic methods for collecting patient information. There are many Web based tools for people who have access. I've heard of offices, which have kiosks as people come in the door. So I think we can use technology to help us but we have to like all the other things we have to standardize the data and the formats so that the results of the patient reported outcomes are comparable and standardized to measurement tools.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

To me one key component is I think it's appropriate if we want patient generated data to outsource the work to the patient, so you can think of HRA from the employer context where basically the patient is doing the work. I mean I think one reason why I'm a clinician, I'm afraid of this is that I don't want to sit there and record all this stuff. Well, why should they? I mean I think it's appropriate for us to think about the patient workflow and how do we actually inter-relate with that? I think there is an accruing experience, certainly the employer environment, about how to gain a lot of this information. I think we want to look at sort of those ... experiences but they're pretty rich in terms of how to begin blending within the big databases.

M

I just want to remind everybody of Gene's comment in the last session about how do we integrate PHR/EHR? That's not the way it's done now. They're seen as sort of two separate markets and two sort of firewall and we have to change that attitude.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

A few places have done that.

M

It will go nameless.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

My sequence now is Norma, Peter and Helen unless we have any additional adds.

Norma Lang – University of Wisconsin and American Nurses Association

Okay, thank you. Can I be a consumer or patient for a moment? So much of our assumptions are based on sort of the employer contract with an insurance and kind of the standardized way in which you do business today and our data then is formed around those units of measurements, but as a consumer, I'm getting forced more and more to make choices. Maybe I don't want to buy these measures. Maybe I don't want to pay those that we're thinking are so great, and so how as we go forward, and I'm a major user right now of United Healthcare for some major events. So one of the first questions is, "Well, what's covered in your contract and what did you pay for and what did you buy and what didn't you buy?" in terms of getting some of this. Maybe in the past there was a lot of primary care not covered and now on the contracts they are. So how do we account for my choices and what I'm willing to pay for, and then I guess I just want they put that on the table. There's a big part of my choices that will influence this. It's not only the physician and not only the insurance companies, and it seems to me the current policy makers are much more moving in this direction of your choices, you buy, you look a menu of things, so how does that work?

Art Levin – Center for Medical Consumers – Director

It seems to me it relates to the value ... and where you have that conversation as Paul said. I mean the most appropriate—

Norma Lang – University of Wisconsin and American Nurses Association

I don't even have a physician. I'm buying this from—I've got to make some choices off of these sheets or maybe not at all, not at all. I don't want to spend any money. I'm young I got to pay gas—

Art Levin – Center for Medical Consumers – Director

So you're talking about choosing a plan rather than choosing services?

Norma Lang – University of Wisconsin and American Nurses Association

Correct, and part of this dilemma if I have even that option ... to plan.

Art Levin – Center for Medical Consumers – Director

Well, I think we have to support the consumer decision making in all aspects. It's almost impossible for the average person looking at a menu of health plans to figure out what the appropriate choice is. We sort of believe in the market and we throw stuff out but we don't recognize the complexity and that people really need help and support in trying to figure out what is best for them.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

And to that extent transparency so not only applying to others but transparency to what the insurance companies cover, and writing in language that people can understand to an earlier comment.

Norma Lang – University of Wisconsin and American Nurses Association

So these measures could be used as help for the decision-making, I guess, if they're so important so that they should be there then that should be something that I would be inclined to want to be sure I pay for or I bought into for my plan.

Art Levin – Center for Medical Consumers – Director

Just to add one thing, I mean I realize this sort of one not terribly robust and somewhat unique example of trying to standardize benefit or insurance options. That's Medigap policies where we have a letter system that categorizes and it's universal so every A policy, B policy, C policy, D policy has the same set of

benefits. So when you sit down and you're making that choice at 65 if you're going to get a Medigap policy it's much simpler. You decide on the level of benefits you want and whoever offers the A or B policy it's pretty much a done deal.

Norma Lang – University of Wisconsin and American Nurses Association

So the measures, is OM trying to connect to that, so I guess the best investment—

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I think there's another body of research that they complete that—but it's about delving for the participating physician what the value for you in presenting your services to the community and being a meaningful user. I alluded to that before but I mean I think that we need part of the mission of this group, frankly, is to make people intolerant of seeing people who aren't meaningful users. So I think that is partly to see that what you're describing is a symptom of the absence of meaningful use.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

... add one comment, two things both the ACO regs that would expect certain levels of meaningful users to be among the ACO participants is another pull through but the discussion about the quality reporting in the insurance exchange is beginning to talk about using these same kinds of measures for the plan to be required to report on their provider performance using these measures. I think there's an integration beginning to happen where this will be pulled through to the plan decisions and the exchange context, much like our point on the MedSup program. Peter and Helen?

Peter Basch – MedStar Health – Medical Director

Thank you. I very much enjoyed and was informed by your testimony and, Dr. Greene, very much interested in the overuse measures and would love to see more of those incorporated. Dr. Wallace you made a comment about focusing on what's important and clearly this is something we need to do. I'm a practicing primary care physician as well and one of the things we've already done is change the nature of an office visit from a what did you schedule for or what is the first thing on your list to the shared agenda.

So one of the challenges we've noted in doing that is that some people figure this out quickly, other people are socially awkward in making that happen and said, "Well, here's what needs to get done this visit. I don't care what you came in with, which obviously hasn't worked very well" but there are challenges in moving to this model of dealing with what's important from a traditional model of medical training, medical history taking, medical documentation, the payment model. In other words, what needs to be documented and how we document it. So curious to hear from the three of you as to how we can move forward in an elegant way that engages patients and lets them know that we do care why they came in and what's important to them. But also what may be important for their health that they were not aware of, and also, what its impact on our documentation and payment model so that we don't have barriers in the way of people moving towards this direction that they otherwise would readily move toward. Any of you?

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

Well, I think a lot of it is, and where I see a great deal of hope is that clinicians are increasingly being creative in how to offer patients options. So shared decision making has a lot of different forms but one reminder I always remember is just think about what's the average time for a primary care visit. We'll all say 15 minutes or eight minutes or whatever our context give of care deliver is, but from the patient perspective the time for a primary care visit is however long it takes you to drop your kids off, drive into town, park your car, walk into the office and blah, blah, blah, so it's three or four hours. From the employers perspective it's three or four hours.

So a lot of this in thinking about how we serve different perspectives is to be mindful and respectful of how they spend their time too, and so part of what we're communicating in these new models is actually respect for the patient's time, not making you wait or doing a variety of other things. I think we want to also build on where we're learning that those messages resonate with patients and also make sure that we're not trading off, and quality measures give us a good floor to make sure that we're not putting

anybody at risk by doing that but that we're creating new capability. I think it's really just to create a flow that's reinforced by figuring out what things they are testing, making sure we're not compromising quality but realizing that it's actually the patient's time, the patient's money and that we ought to be there to serve them.

Art Levin – Center for Medical Consumers – Director

Maybe I'm off the wall with this but I mean I think some of this is responsibility of the professions. I mean that competency in these things really is just like any other competency, and so part of this is looking to change how we train professionals. We're not really changing anything so we're just simply going to—we like to think that we've got people who are adapt at keyboards and screens because they've been playing games but it doesn't address the issues you bring up. So we're going to continue to make the same mistake unless we learn and really address how we educate health professionals.

I think the professional societies that are making progress in looking at continued competency issues really need to build this in. That should become sooner rather than later. A quality of being professional is respect for your patients, your clients, and the ability to listen more than the ability to talk. All of those things should be competency issues. We did say in the ... report something about the role of licensing and certification in changing behavior. That fell off the table very quickly and I think it's time to bring it back.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

So ultimately I think the two shared agenda is the patient's health and respect for the patient's, and that's where I come back to the outcomes issue. So if we can have a discussion that focuses on what the patients want to happen and what we can offer and how safely we can provide it and at what reasonable cost we can provide it, I think that's a pretty good discussion. I agree that there are barriers in terms of communication that has to be approved on all sides and payment reform is important. United Healthcare is a big supporter of the patient center medical home. We have five going on seven projects on that going on around the country, but I think, again, centering on the patient and the patient's health and outcomes gives you the basis for the shared agenda.

Helen Burstin – NQF – Senior VP, Performance Measures

Thanks. I'll be brief. I just want to comment this is a great panel, as were the preceding ones, lots of food for thought. There's clearly an inherent tension we've heard between the panels, and I think I just want to put it on the table, which is I think we heard from Jerry in the earlier clinician panel that we really want measures that are parsimonious from their perspective at the clinician level to allow them to satisfy multiple federal programs, multiple needs. They don't want to do measures for different programs at the same time, and yet at the same time we also want to move to some of the measures we think matter.

Some of which are incredibly important, care plan, the kind of things Gene and I have been talking a lot about over the last few months as part of the ... group effort. We don't know a lot about how those measures perform as accountability measures, which are the measures that are used in these other programs, so I think at some level we need to kind of come to terms with that, and we now as part of the ..., and you're right it is now over 700 measurers. Some of that is because there's a need to satisfy the different—your perspective on your big dot depends on where you sit I think, Paul, to a certain extent. So there are measures that satisfy lots of different providers, types of settings, etc. but I think part of what we need to do as we really reined in our criteria on the tougher requirements this year a good number of those measures on the 2011 list will not maintain endorsement because exactly for the points that were just raised. I think we're kind of in this environment of kind of flying the plane while building it.

I think we need to acknowledge that inherent tension is saying we know we want the better measures but we also need to recognize we want measures that also allow parsimony from the sake of those who are being measured while getting the measures that matter out there for the sake of patients. I have no doubt that those better measures are coming, and yet in fact a third of our portfolios now are outcome measures; very few of those were selected from the initial program. We didn't even think through how difficult it will be for the vendors and others to actually pull in some of those more meaningful measures and put them into EHR, building those additional requirements that we just heard from the EHR vendor

panel saying it's so difficult for them to do. A question perhaps but it's, I think, more just a philosophical thought, I think, for many of us as we grapple with this afternoon.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

If I could just link that back to Art's comment before to, I think that one message for clinicians and for all of us really, is that this is about not creating a change implementing an EMR, it's creating a mindset of managing change. To me part of the accountability here is that each year at the end of the year you ought to be doing 10% difference on what you were doing the year before. Part of what we're trying to do is give people guidance and signal what are the critical things that you ought to be delving in for next year's 10%. And if next year's 10% is more of just what you do this year you're not going to get there. Part of it is what are you doing in that 10% to bring in the patient perspective and what are you doing to bring in accountability, and I think that's the way you creep up on the triple aim over a period of time.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

I think part of the answer is internalizing best practices and evidenced based medicine so that people don't feel like it's an external imposition so that after ... earlier to the point that it's oh we got you on this measure or you have to check this box to meet some regulatory thing. It's totally external forces on changing physician's behavior. On the other hand, good measures, I think, can make things easier, so I'll use my sinusitis example. We came up with four simple things, it's mostly viral, educate the patient, if you've tried a few antibiotics refer to a specialist, don't use CT scans right away, and that made it a lot easier for me as a practicing physician. When I saw somebody with sinusitis I kept those four things in mind, keep it simple, those were the key things, and then I had time for talking with the patient and the art of medicine and the other things. I don't think necessarily the measures can interfere, we have to be careful on the different uses and on the parsimony and on the key measures, and getting to this ultimately is to internalize the best practices, I think, is the hard part and then the measures will reflect that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Rosemary, one last question.

Rosemary

Thank you for the panel and very insightful, I think in many respects it forces us to kind of change our thinking about care delivery and how it occurs when you look at it through the eyes of the patient. You reference the eight to ten minute office visit where a physician has time to spend with the patient, has to prioritize and a lot to go over but if you think broadly about the healthcare system, I'm just interested in your perspective. Many times they leave the office and they go to homecare, they spend time with the homecare nurse, they spend time with the physical therapist, OT. I'm just thinking about my mother and all the stakeholders, so many times that eight to ten minutes has some impact but it's these other care providers that they interact with along the chain as they're thinking about it and making decisions and then assuming responsibility so it's a shared accountability model. I was just interested in hearing your perspectives on that.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I think a common characteristic that I've heard across all the panels is that we're moving our thinking from these sort of slices in time to things that happen much more longitudinally, and it's on sort of a micro scale, the office visit. I mean the successful office visit is a point forward is the one that you've actually prepared for, and so we used to sort of be in shock and awe when the patient came in with a list but actually now we kind of like to see the patient with a list. So there's that element but there's also thinking that so many care processes now or the things that drive cost are only influencable by incremental activity over time as opposed to the way that so many of the strains that you just come in, we fix you and then I'll see you back in a year. So I think there's a growing recognition really just about what the nature of healthcare is and the nature of the pursuit of health. To your point, I think we just need to continue to move our measurement frame to be less sensitive to just those immediate moments and more integrative of things over time.

Robert Greene – United Healthcare – Vice President for Clinical Analytics

I think the caregiver's perspective is extremely important. People will recall in the ... clinic disease model that's one of the things up in the cloud affecting the activation and sequential healthcare outcomes, and we're starting to look at that more formally and finding some very interesting things the caregivers are patient to. They're affected by the illness of the person they're giving care to, and I think it's an area that's very fertile. It may not necessarily be a measure development although certainly there have been some materials about the need to give information to caregivers as well as patients but I think this is a very important topic.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Well, we thank everyone for the long morning session and the great testimony this panel and the ones before it, really inspiring. We know have our hands full. We'll have a lunch break, and we'll come back and we will figure out what to do with all of this input and begin to chart the stage two and stage three course ahead. So we'll have a meeting jointly of our two committees this afternoon, and we'll have public comment towards the end of that, and I think our meeting this afternoon continues to be public, Judy? So those on the phone, you'll be joining us, I guess, at 1:30 Eastern time and we will all be back here then. Thanks, everybody, for a great morning.

(Lunch Break)

Judy Sparrow – Office of the National Coordinator – Executive Director

I'll turn it over to Dr. Walker.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

So I think the first question we're going to address is core and menu—

M

We're going to summarize the morning first.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Oh, we're going to summarize the morning first. Okay, thank you. That's what you get for giving it to me. So do we have those slides, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director

.... David, do you have the clicker?

David Lansky – Pacific Business Group on Health – President & CEO

Okay, so this is our summarization of what we heard from the various panels. We tried to focus it down. I think maybe the first order of business would be to just sort of check this with the committee, make sure this matches reasonably well with what people heard, see if there are any really core things that we heard that aren't on here, if we need to state any of these a little more crisply. I'm sorry, ...?

M

I agree with the summation with the caveat that the word harmonization means something differently to different people, so that we have to be as rigorous about what that might mean as the question of being rigorous about numerator and denominator. That's part one and the second, I didn't really hear the message need to be clinically relevant only. I mean I heard they have to be relevant to patients and they have to be relevant to the population. It may be that we can't address that because most of the measures are from the mindset of a clinical level. That's why I always talk about those three levels, the patient, the clinic and the population. I guess I would be more comfortable if we're clear that it may be only practical right this second to talk about clinically relevant measures but that's not what the panelist themselves actually said. I thought that they also were intimating that there had to be person relevant and population relevant also.

David Lansky – Pacific Business Group on Health – President & CEO

Maybe if we said relevant to patients, clinicians and populations?

M

I would be much happier if we could say that—

David Lansky – Pacific Business Group on Health – President & CEO

Does that sound right?

M

Yes, I'd like to support that because there was some tension between the third panel and consumer patients and private payers versus the care providers and the vendors. Because the third panel saw that this dynamic process changed things whereas the first two panels seem to be more focused on the clinical relevance and so clinical relevance here in terms of consumer choice, consumer—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I should say that we summarized each panel, this is the first panel and then we tried to do a summarization of all three panels together. So this is an attempt to represent, but I still think it probably wouldn't be an injustice to the first panel to say, "Relevant to patient's, clinicians and population."

David Lansky – Pacific Business Group on Health – President & CEO

And the other thoughts, Paul?

Paul

... compared the harmonization bullet on each slide that reflects the difference in how the perspectives thought about harmonization. I mean part of the disharmony, if you will, is that we haven't come up with a definition for harmonization.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

I heard, I think, in all three panels, certainly at least in a couple, about the need for outcome measures and a focus on that and that's not reflected here.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, thank you.

M

....

David Lansky – Pacific Business Group on Health – President & CEO

Right and I think we want to make a note that outcomes need to be defined carefully also because different communities use it in radically different ways. Okay, next slide Technology and Measure Developers, so we got harmonization—

M

... slightly different

M

I don't understand the flexible approach to measure calculation specifically because it seems that that's a little bit hard for my own brain to hold with the other thing of being more rigorous about the measure specification. So maybe I'm not reading this correctly but that's hard for me to—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think what we heard them saying was that if NextGen has one way of recording smoking status and McKesson has another and Cerner has another at least in the first phase—that's my read—let each one of those count as documentation of smoking status. And wait until we have a standard way of representing smoking status that is evidence based that has been tested for usability before we dictate a specific standard. Whereas your right for some things standards are very clear and they don't require that sort of intermediate phase, so Hemoglobin A1C is just Hemoglobin A1C. Other—

Karen Kmetik – AMA – Director Clinical Performance Evaluation

... qualify that, Jim, I heard something slightly different, which is I think what she was really trying to capture and I agree with completely, was the idea that the measures have to allow for flexibility in the clinician workflow and the location within the EHR, but I think we heard pretty clearly the idea of that. So the measure calculation part is the part that bothers me. People really do want the standards so the actual nominator is the denominator in way of calculated with allowing the flexibility for the actual implementation of workflow, etc.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

She's not here anymore is she? I heard that also but ... any other responses? I thought that Ms. Moser did say that like for smoking cessation we should just let them capture the way they capture it, at least for the interim.

M

... would actually be flexible data capture ...—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes, that's a reasonable—Yes, let's say that. Is that—Did you hear that?

W

....

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, all right. Yes, very good. Yes, Westley?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

Moser also stressed the need for collaboration between the clinicians and the measure developers, and all of what you've got there is great but I think there are still issues of collaboration that's important to them because that helps. So I don't know if it fits but I think they want to be at the table.

M

That makes sense.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think body language is saying that's one that probably was an important point. Thank you.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

... just a concept of having the intent of the measurement be accurately and clearly communicated, and I heard that both in the first panel and in this panel but that goes along with that point. That part of that is getting this collaboration—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

And that's particularly important to remember because that's our work. Good, thank you. Yes?

Helen Burstin – NQF – Senior VP, Performance Measures

I head one additional thing related to collaboration. It was collaboration across all providers of care across different facilities, so a broader level of collaboration amongst all clinicians going across different facilities, care deliveries, menus—

David Lansky – Pacific Business Group on Health – President & CEO

Right, thank you, and just on that note just as a language thing I think it would be helpful if we just thought of the healthcare team as including all of the providers and the patient and the caregiver first as working together, and we can just sort of take that as a given and continue on that basis. Yes?

M

I would caveat that understanding the point is what I'm thinking. We've got individuals—the financial incentives are being paid at individual levels to professionals based on their own reported quality measures. We haven't really found a way yet to either attribute or articulate how care team—We're beginning in the meaningful use criteria to talk about capturing the care team and having some measures of information flow across the care team. But we haven't really talked about quality measures that reflect coordination or that— How do we say does the cardiologist quality measures and the PCPs quality measures reflect this kind of coordination in this next round as a clinical quality measure? I don't know but I'm not sure we heard that that was encouraged by these panels.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Maybe team is our aspiration even though we can't execute it all the way across the board yet or even at all yet.

M

I just didn't hear that this panel described a solution to quality measures using the measurement development and the technology approaches they have that would address where we're trying to go yet.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Okay, fair enough.

Helen Burstin – NQF – Senior VP, Performance Measures

No, I didn't hear that at a team level either.

M

No, I was talking about our discussions. I just think we very often leave out one member of the team. I think we often don't mean to it's just the way we talk. I—

Helen Burstin – NQF – Senior VP, Performance Measures

... specifically speaking to various members of the team and they're practicing including to their scope of practice and individually they make up the team so it's multiple providers across settings but not the team as one singular group or unit but just respecting all professionals and their scope of practice.

David Lansky – Pacific Business Group on Health – President & CEO

Ahmed?

Ahmed Calvo – DHHS/HRSA – Senior Medical Officer

We really are talking about the expanded care team and it's like purposely saying it that way because for me it no longer can be just a team in the sense of say a nurse and a referral staff, front office, back office staff as a microsystem. In many ways we have to really just broaden the whole dialog, the HIT staff, the data entry person, the public health department might be related to having some data of vaccinations. That whole expanded care team concept is much more critical to the ability to actually getting real outcomes in the long run because by definition just like the single doctor five minutes out of the four, 15 minute visits for the year making a difference is not going to happen. You're going to have to have that health educator and all the others, right but we know this already but we have to use the phrase to capture that or we're making assumptions about what we mean by a team when in reality we have to really get out to the expansive consensus of it.

David Lansky – Pacific Business Group on Health – President & CEO

Right, thanks. So any other thoughts about this set of— Paul, I'm sorry, yes of course.

Paul

I thought of one thing that I heard that is actually quite helpful is the attentiveness and the awareness of workflow, and I know we talked about that here but I don't think we captured it explicitly up there. I think that also and I heard them saying those from partly the clinician side but also from the developers side and the technology side is that is a degree of freedom that allows you to minimize variability in other dimensions. So people will tradeoff the major specification if it doesn't screw up their workflow. Also I

think it gets to the—part of what I think David was talking about is there is—if we want to create accountabilities for the team—If how we grant credit doesn't necessarily have to be exactly the same as how the team does their work.

So there's also the leadership piece of the team where a lot of this is going to flow through whoever the index is for the team and it's probably going to be the clinician. How they work out credit is a local workflow issue. It's how you manage your team. I think that workflow is a really critical characteristic, and to me it's one of the things that's really changed from particularly the vendor side is there's sort of, if you will, anthropologic competency is now more approaching their technologic competency and thinking about how people actually go about doing their work. That's a huge step forward for people to actually use these things in a rational way.

David Lansky – Pacific Business Group on Health – President & CEO

Thank you, yes. Ben?

Ben Hanlon – NCQA

Yes, I'd just like to add one to the limited issue with your last bullet as a measure developer but primarily I didn't hear that from this group. I think what I heard was more given that we have these high level of expectations for feasibility and usability I think we're changing the dynamic. We're looking at the team based approach. What I heard was we need to really think about the parallel implementation so development testing while we're thinking about how these get used for attribution or for accountability or things like that. So to really shorten that cycle because I don't think it's possible to shorten the measure development testing and endorsement cycle at all. I mean I don't think there's really a way to do that but I think there are ways to create synergies in doing these things in parallel and eventually getting to where we're going in a shorter period of time than the six to eight years it could take theoretically from beginning to finish.

David Lansky – Pacific Business Group on Health – President & CEO

Would it represent the sense of the panel to say, "Shorten the cycle by using parallel processing?"

M

I think I heard parallel being mentioned a couple times in trying to understand that we're trying to move forward. We're still waiting for agreement on which standard definitions to use so therefore we can't test something until we have—so there's limitations so I think by doing these things in parallel as we've done we created eMeasures specifications while the standards are being developed. While we're thinking about these new modes of measurement, and we're doing this all parallel now and so I think it's the shortest way we can do it. I think if we make a recommendation to shorten the measure development cycle we would get into some dangerous territory there.

David Lansky – Pacific Business Group on Health – President & CEO

In sense of the committees on that?

M

In parallel, it can always work faster than series so actually that's a really great pickup and recommendation I think for ... word wise.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, does that make sense to you, Ben? Okay.

Helen Burstin – NQF – Senior VP, Performance Measures

In addition to parallel, I heard alignment, so alignment of the technology standards through quality measures and the workflow.

David Lansky – Pacific Business Group on Health – President & CEO

Great, so this is the third panel.

Helen Burstin – NQF – Senior VP, Performance Measures

If I could say something about the second before you go. Is there anything needed there for standardized terminology or interoperable terminology or is that implied in there?

David Lansky – Pacific Business Group on Health – President & CEO

It's certainly implied. I don't know if they said it—

Helen Burstin – NQF – Senior VP, Performance Measures

Well, people are talking a lot about mapping as the answer, and I hope sometime we will continue to work towards standardized terminology. I know that's very hard but I think we should and I've never heard things like SNOMED mentioned or anything like that this morning or at least I missed it if I did. Is there any move towards that, which means when we develop the measures we will try to use the standardized terminology or do you do harmonization by just mapping?

David Lansky – Pacific Business Group on Health – President & CEO

Karen, did you want to—?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Just a comment because I keyed in on that to and I think it was Sarah from NextGen who said—or maybe the woman from McKesson. That for example for drug on the one hand we heard, look you have to put the specifications out now in multiple code sets because we're not all using the same code sets, so that says RxNorm and NDC but then we heard someone say well I'd like to use RxNorm but that doesn't support half doses. Not sure that that's relevant to the quality measure but that's relevant in practice. I think what we're hearing again is sort of the stresses of where there is a national vocabulary, and that's one thing our group is going to be working on with NQF where there is a national vocabulary for an aspect of care. We should all be moving in that direction but because all the vendors aren't necessarily using that yet we keep offering multiple sets of specifications. I don't know how to get around that.

Helen Burstin – NQF – Senior VP, Performance Measures

Well, I mean you sort of stopped my conversation this morning when I was asking them if we would get to that point would the vendors use it. We point to the vendors and the vendors point to us. In some place that has to—I mean we have to keep working that. I know it's difficult. ... where they're trying to put in all of the standardized terminology or vocabulary that everybody uses. I know we're going to have a hard time getting there but I just don't want to see it left out in terms of harmonization only through mapping.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Just to edit what I think you're saying is movement toward the standard vocabulary, in the meantime better mapping.

Helen Burstin – NQF – Senior VP, Performance Measures

Okay, I could live with that.

David Lansky – Pacific Business Group on Health – President & CEO

But I think that's our read, not their statement but I think that's—

Helen Burstin – NQF – Senior VP, Performance Measures

Okay, probably—

M

It sounds like they recognize the need for better mapping tools. I mean they—

Helen Burstin – NQF – Senior VP, Performance Measures

That part they did.

M

And my guess is that they were assuming that we've all got to get SNOMED and RxNorm and all of those things sooner rather than later but it wasn't said. I think you're right.

Helen Burstin – NQF – Senior VP, Performance Measures

So can we—

David Lansky – Pacific Business Group on Health – President & CEO

I think we need to keep it clear, absolutely, if that's an okay. I mean right now what we're trying to do is just get a representation of what we heard them say, and clearly they couldn't say everything in seven minutes ... you know how that is when you're presenting.

Helen Burstin – NQF – Senior VP, Performance Measures

Well, that's when you stopped me from asking the question. That's what— So I just didn't want to hear ... this afternoon too.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, third panel. Oh, I'm sorry, Tom?

Tom Tsang – ONC – Medical Director

Just going back to the discussion five minutes ago, I think what I'm hearing really is a lack of standardized value sets for specific data elements that we want. I think it's going to be incumbent upon us to really have this repository of value sets and code sets for those specific data elements so that they can do their work. I think the work that this group is doing is going to be critical moving forward.

David Lansky – Pacific Business Group on Health – President & CEO

I assume we have that half dose in RxNorm on our vocabulary—

Tom Tsang – ONC – Medical Director

We can engage the FCO to think about that.

David Lansky – Pacific Business Group on Health – President & CEO

Because they will be critical. Okay, third panel, so Paul can tell us what he meant.

Paul

I just wanted to make one comment that I actually agree with bullet number four and the appropriateness to drive value but it's kind of a chicken and egg. Appropriateness measures really only work with a really good electronic health record and administrative integrated data structure, so an appropriateness measure would be the use of an electronic decision support tool for whether a patient meets certain criteria and it's not a yes or no it's a one through fifteen or one through ten decision support. So the measure looks at that and we love to develop appropriateness measures but we need to wait for the chicken or the egg. I don't know which one you're looking for so it's kind of a—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

But one of the ones that Rob suggested in conversation afterwards is for instance did you document why you started a patient on a net ARB instead of an ACE inhibitor. I think at least in ... mind there are some like that that would be fairly crisp and fairly early in addition to the ones that—

Paul

I think it's going to be hard ... association between the cost and the value side using fairly—I don't want to say simplistic but fairly low proportion tools that don't address the huge proportion of the population that you're looking at. So—

M

I think I might have heard that point around appropriateness a little broader or at least I sort of thought about it that way. And that is that I think what we particularly heard from Rob Greene is this notion of focusing on measures that matter in the sense of either have a high clinical payoff or are associated with

saving costs even in the short-term or in the long-term, which would include measures of appropriateness that would match it.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, so you'd restate that to say, "Implement quality and appropriate measures?"

M

Let me see if I can find a quick monitor for that. Yes, I don't know how to say it any shorter than measures that impact quality and costs together, something like that.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, great. Thank you. Other—Rosemary?

Rosemary

.... And I also heard the workflow of the patients, so engaging them in data collection, improving health, and that we need to take into consideration their workflow processes not just the clinicians.

David Lansky – Pacific Business Group on Health – President & CEO

Yes, thank you.

M

... harmonization bullet on this one? I think it would reflect the disconnect now between the patient workflow and the clinical workflow, and so it's a different dimension of harmonization but it's disengaging now.

David Lansky – Pacific Business Group on Health – President & CEO

Yes, I thought that was a very powerful observation. Will take us some work to execute. Yes, Gene?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

One of the things we heard from this group was that the performance measurement that are mandated communicate strategy and actually should be disruptive if we take as a given what we're currently measuring isn't what we need.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, could you state that again?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

I think I was quoting from Paul, performance measurements should communicate strategy and they actually need to be disruptive.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, and disruptive of what specifically, Paul?

Paul

Yes but the intent was two things. One, that implementing EMR is disruptive so there's an opportunity while you've got things torn up to think about what you want to build in their place. Also that performance measurement is as much a communication tool as it is an accountability tool so a good way to signal what you ought to be building for are the portfolio of measures and since you want to end up with something different than what you had before they're necessarily disruptive.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, thank you. Great. Thanks, Gene. By the way if you introduce yourselves it helps the people on the phone and the transcript each time you talk. Yes?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

... Gene pointed that shared decision-making is a concept that belongs under shared decision making as well as value-based decision. I think shared decision making captures that and shared decision making is different from patient engagement, so I think that belongs up in the summary because it involves the consumers and patients and ultimately in relationships between PHI and EHR. That empowers and in the mental health community and behavioral health community shared decision making is also very important.

David Lansky – Pacific Business Group on Health – President & CEO

Absolutely, thank you. Great. Any other either refinements or anything that we missed? All right, I think we can try the common themes slides, so this is our attempt to distill from all three panels top-level themes and I guess on that first one we could just, again, put in patients, clinicians and populations. Is there anyone on the phone who wanted to comment on this at all? Well, all right people feel like— Gene?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

I feel like this is a great summary and looking at the second to the last bullet point now and the second to the last bullet point says, “Including patient generated data,” very important. The last one, measurements and team based. We also think of the team as not including the patients or the family, and in monitoring of care delivery it really makes fundamental use of self-management and family and self-care, and so the term team may convey the wrong image there. It may be the professionals, the paid members of the team, and not the ones that are doing it pro bono for themselves or for the family.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, so maybe we including the patient—

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

... families.

David Lansky – Pacific Business Group on Health – President & CEO

Yes, great, absolutely. I think we just need to keep reminding ourselves that that’s what it means. Other things that we missed with this? Always a little dismaying to just have silence but all right we’ll regard this as a reasonable summary of the day. Great, thank you.

All right, so now we have to do some more work. This is actually pretty powerful. This last slide, I think, takes us down the road now. How do we take what’s on this slide and turn it into the stage two and stage three measurement proposals in support of standards work is the question at hand. I want to call out and thank ONC and Lanre, in particular, for giving us a couple hundred pages of measures here, so we’re going to spend the next three days doing. You’ll see on number 1103, what’s in here is a couple slides that we’re going to look at that are visualizations of some approaches to the menu, a few slides that we’ll come to in a minute about methodology issues that we want to come back to. Then the appendices of this six pack that we have in the room at least—Sorry, those of you on the phone I presume don’t have access to it—is one version of a measure inventory grouped by condition, which is about twelve/fifteen pages worth and then it starts over again. The last thirty or forty pages by field, by ... is another long list of all the measurers grouped by specialty. So you’ll see core, alternate core, and then adolescent, medicine, anesthesia, cardiology, and so on.

We are not going to try to reorganize this entire inventory today. I think it’s here to sort of give you a flavor for what’s in the library of measures that we can contemplate deploying for stage two or stage three. It is also not the definitive inventory; it is what we have in hand today that’s to be considered. It’s worth reminding ourselves that there’s a parallel process based on the measure concepts that we’ve all looked at in the last few months in which ONC will be looking to partner with measure developers to take those measure concepts and turn them into measures, which could be added to this list. Those, especially, address the domains we just talked about where we have not as many measures in care coordination, patient engagement and so on. However, the question really to Tom whether we are likely to have access to new measures in these that are not in this packet in those domains in time for inclusion in the stage two measurement approach or whether we really are now thinking that’s going to be a stage three body of work.

Tom Tsang – ONC – Medical Director

I think it's going to be highly dependent on the certain measure concepts and the complexity and the infrastructure that's needed. I think all the things that were said this morning in terms of creating standards, in terms of having the technological capacity to capture, including patient reported outcomes. Having ... make overlays and the ability to do all this wonderful stuff and robust stuff that we're talking in these innovative measures, and then the field testing is a big concern of mine. What Ben is saying—that what he just said six years or— so is it going to be ready in twelve months? I don't know but I hope we can get maybe some of this list, at least a few, into stage two and the rest, the more complex measures, we can shoot for stage three.

David Lansky – Pacific Business Group on Health – President & CEO

Tom or Dave or David or whoever do we have a defined set deadline by which something would have to be ready say for manufacturers for it to get into stage two?

M

I would say we need the measure specification, meaning we need at least the numerator and denominator by roughly December of this year, and we need to have them tested by April of 2012.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, thank you. Pat?

Patrick Gordon – Colorado Beacon Consortium – Executive Director

... out the one clarification looking at this list many of these measures have already been specified and tested not as eMeasures, so I think we need to be very clear when we're talking about testing as eSpecifications and eMeasures versus a tested and utilized measure, and that's the one area where none of these eMeasures have really been tested yet, and so I think that there are some of these that could easily be defined, specified, and converted to a eMeasure specification but we need to be where you're following on that whole testing and feasibility in the different vendor environments or whatever we're talking about. So there's some speediness that couldn't happen but there's also some questions about what well what do you mean by testing.

Josh Seidman – ONC

I would say that we would have expectations of a similar process and timeline to the stage one processes, which was that when we release the NPRM we had measures and non-eSpecified specs, so we would want numerators and denominators, and then by the time we release the final rule we had the full XML eSpecified measures. So that would be similar framework for this group to be thinking about.

W

Inaudible

Josh Seidman – ONC

... middle of 2012.

Patrick Gordon – Colorado Beacon Consortium – Executive Director

So just to kind of ... all that we expect there to be a final rule that would incorporate stage two measures in next summer of 2012, a notice of proposed rulemaking in December or January coming up this year, to include the numerators and denominators at least with the detailed concept in the NPRM by December. Then realizing that over the next several months there will be time for final specification then testing. So our job really is to get to a proposal that hopefully the other powers that be can endorse. One step prior then, in order for something to make it to the NPRM, let's say by December, that's when they're able to do it, I know the process by which final decisions are made within the agencies, when is our last chance to submit recommendations to ONC and CMS?

Josh Seidman – ONC

Well, I think that we need to have a good sense of what these measures are so that they can work their way through clearance within really the next—by the obvious September timeframe. That doesn't mean that they have to be as fully specified by that timeframe but we have to be able to do, in a sense, have that vetting process going on about what these measures are that are being considered.

David Lansky – Pacific Business Group on Health – President & CEO

Well if we can maybe give ourselves or maybe in the next short couple of weeks can you give us something like a deadline that says September 15th or September 30th is our working deadline for a final discussion among ourselves for what we want to recommend? ... process? Eva?

Eva Powell – National Partnership for Women & Families – Director IT

Thanks, just a question about what impact, if any, the conversation about timing of meaningful use stage two going on in the meaningful use workgroup has on the ... NPRM? That is what it is but knowing there's not a decision about timing of meaningful use but understanding there could be a decision to delay it would that then give us also more time for the quality measures? I don't know, that's the question.

David Lansky – Pacific Business Group on Health – President & CEO

Josh, could you just update everybody on what the status of that decision is?

Josh Seidman – ONC

Right, so the Policy Committee is going to be discussing its final recommendations to HHS at its June 8th meeting. Now, it would be good at that meeting if there was some sense given to the Policy Committee of the potential measures that the Policy Committee would like to be included in the NPRM so that they could sort of include that as additional recommendations to HHS.

David Lansky – Pacific Business Group on Health – President & CEO

Eva, does that answer the question now?

Eva Powell – National Partnership for Women & Families – Director IT

Not really, that's helpful though. I guess what I'm asking is if there is a decision, which there isn't yet, but if there is a decision to recommend that the timing of stage two be delayed by a year then does that also give us, as the quality measures support group, a year additional planning? I know the NPRM is a set date but we need, I guess thinking along the same lines.

Josh Seidman – ONC

The primary reason that it's been expressed for the need to delay the stage two implementation is to give vendors and providers more time to take what they need to do and do all that programming so if we were to delay the release of the XML specs from that mid-2012 timeframe that would get in the way of that. I think that—Let me just give maybe a little more specificity to what I was describing. I think one example there have been a lot of discussion today about patient reported measures. That's a pretty different kind of functionality from a quality measurement perspective and from a meaningful use perspective. I think that it would be a good thing to if that is something that this committee believes is important or these two workgroups think are important it would be good to bring those recommendations to both the Policy Committee and the Standards Committee in June so that those recommendations are well understood, and then can be communicated to HHS.

David Lansky – Pacific Business Group on Health – President & CEO

Thank you, good. All right so our tasks now we have an hour or so left to solve all these problems, so we thought we would break it up into a few subtasks each of which obviously deserves a lot more than an hour but we'll see what we can do. The first is to come back and consider the structure of the quality measurement recording process as a whole. This is a very high-level question. Do we retain the CORE/... menu model that we have used in stage one or not, and we have some ideas to toss out on that. That's the first task for the afternoon. We have another sub-proposal that's affiliated with that around specialists and how they might report into this program, which has been a subject of continuing hearings and discussions in the Policy Committee. Then, there are some methodology issues. I think,

Tom, you'd like us to respond to, and is there one other topic for today? I'm trying to manage our time here.

Tom Tsang – ONC – Medical Director

I think the methodological issues is just really highlighting the issues so that we bring them on the table and perhaps Jim's group can focus on it and also bring it up to the attention to the Standards Committee. The third issue is just highlighting the course that we're going to take in terms of giving some assistance to NQF on the taxonomy and vocabulary advice that they need and how we're going to go about bringing some of the FDOs into the process.

David Lansky – Pacific Business Group on Health – President & CEO

All right. Yes, and this is sort of the request of the Standards Committee work I think that comes out of all the discussion we've had today. So let's start with this, to refresh your memory in recurrent stage one proposal there is a small number of core measures that are all eligible professionals are expected to report and you have that in various versions on your handout today. The three core measures, hypertension, blood pressure measurement, preventive care and screening for tobacco use, and then tobacco cessation intervention. I can't really see what's in the bullet of the core there. For those providers who were not appropriate to respond to those three cores they could choose the alternate core, weight assessment and calcium for children and adolescents, child immunization and preventative care influenza immunization for older patients. Then, there's the menu, which allowed different specialties to select a number of measures from short lists of available measures in their specialty area. The vast majority of which were clinical processes measures as we heard some about this morning.

The core that we're actually using came out of a long discussion about a year, year and a half ago, in which we once had a longer list of core measures we thought would appropriately apply to a number of ... specialties, and the more we worked it the shorter and shorter the core got. So while there was a philosophical desire to have a core set of measures that applied to everybody it was hard to actually execute so we ended up with this menu approach.

Let me toss out one proposal for discussion. Maybe I'll put both parts of the proposal on the table for discussion. Part one is though we conceptualize the next generation of quality measures as just menu, so to add this is a hybrid version of what I'm going to propose. This is still retaining the core. This picture, this slide, if you're on the phone hopefully you can see it, has the core in a brown color in the middle and then surrounded by five domains, which are the same domains that we have taken up from the tiger teams last fall when we realized there were some measure gaps we wanted to address. This model says, "Yes, there's still a core but then each eligible professional would be drawing their measures from menus in these five categories," and the theory here would be to say that everybody just ... meaningful use program has to be doing something in each of these five areas. So you can't just satisfy the criteria for the menu by pulling three clinical process measures out of the quality bucket, which would have worked in stage one.

Instead, you now have to have, to be determined, at least one or at least two whatever it is in each of these five categories. Then, our job would be somehow to populate a reasonable set of measures in each of these categories for each specialty area. Now, ideally we'd still have a virtual core. We'd still have some measures like tobacco screening might apply to 90% of specialties and we still want them to appear almost everywhere. Maybe there's still some true core that apply to every specialty. Maybe in some domains like care coordination or patient engagement we have a measure which applies to everybody because of the way it's specified ... but conceptually this would be a way to say to the specialty society, the radiologist or the orthopedist or the dermatologist, you have a place in here. You also need to be addressing each of these five domains that we've decided are important.

So conceptually let me just put that on the table for discussion and see how people feel about that. Now, we could either keep the core as it's described in this picture or just get rid of the core and have the core elements be populated virtually everywhere. Let me just let that be open for discussion for a moment. Yes, Danny?

Daniel Rosenthal – National Quality Forum – Senior Advisor, HIT

So I think it really depends on what the purpose of the clinical quality measures are within meaningful use. If the purpose of the measures is to drive quality improvement then the current model, I think, works well. If the purpose of the clinical quality measures within meaningful use are to specifically drive additional functionality or drive additional kinds of information that we think would be useful that can also be used for quality improvement. Then this second model over here I think would work well provided that those within each of these menu areas the functionality and data requirements were all sort of similar within each there. So for example, care coordination, if the purpose of care coordination is to talk about are you able to interoperate and send information between point A and point B then you can have different flavors for the different field of medicine but provided that everything within that area is sort of addressing the similar functionality and data requirements.

M

Nicely said by the way. My comment was going to be similar that I thought this conceptually feels better to me, seems better and drives us to change in other areas than just the clinical piece. But I'm wondering whether we have the ability to be systematically rigorous about populating those new fields, categories, buckets or whatever you want to call them and because of the timeframe aspects. That's the question I had but I like this a lot better than the previous.

David Lansky – Pacific Business Group on Health – President & CEO

Very good point, thank you. Karen?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

As we said on the phone since I think Eva put forward this idea, I think it's a nice idea. It sends messages and Ahmed, to your point we're probably not going to fill this with the perfect measure for every discipline so we'll be back to people saying, "I don't have anything that fits me" but if we could live with that I think it sends a nice message. The one thing I wanted to ask is where would we put measures such as blood pressure control? So outcome measure we all think it's important to track where would that go in this scheme? I want to make sure we're not being so prescriptive in the wording here that we're missing a category of something we still want as part of this dashboard.

M

In my own listings I have kept a sixth category, which was crudely called clinical quality, which is where a lot of the clinical process measures live, and I would be fine adding a sixth category or maybe we can re-engineer these to accommodate.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

We just might need something to pick up some things we want.

M

... clinical appropriateness.

M

....

M

... recommendations from the earlier slides was to create standardization around definitions of measures. Could we do the same thing for this because we're all obviously putting things in different buckets at this point so—?

M

Yes, we'd have to do that. I think conceptually if we want to go down this path we'll have some work to do to—

W

....

M

... can you do that, so if we can do that it makes sense but because you can have a standard ... for all of the specialties unless it's absolutely inappropriate question is can you do that? So—

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

... specifically blood pressure control. One of the things that many people have been working on is the health risk index that could apply to a patient or a population, and if you look at avoidable risks of death in the U.S. as mentioned this morning number one is smoking, number two is high blood pressure. So it's not much of a stretch to also consider blood pressure control as a primary risk factor for a population and it could reside there as part of a good health risk index.

David Lansky – Pacific Business Group on Health – President & CEO

That's very true. ... Helen?

Helen Burstin – NQF – Senior VP, Performance Measures

One more thought and I love the word appropriateness. I think it's really important but at the same time I think a lot of the discussion we had this morning, and in fact was listed here, some could argue it's actually effectiveness. I almost wonder if we want for that whole discussion this morning of quality and cost and getting add value is it really clinical effectiveness and efficiency with appropriateness really being an element of that? I don't want to water it down but I just think it allows a lot of those specialty oriented clinical measures to have a home.

David Lansky – Pacific Business Group on Health – President & CEO

I think the challenge in deciding where to put these different groupings, coming to Rob's testimony this morning, not losing the visibility that we're addressing. A number of our panelists this morning I think alerted us to it's important that we do address measures that address overuse on these issues, and if we remove the word appropriateness I would feel like we were losing something. I know it's a little bit of a volatile word in this community but one we should come back to making sure there is some visibility around value issues in this discussion. Paul?

Paul

I liked it for several reasons. One, I think it's recognizable as having continuity from what was done in phase one and I think that's important to carry forward certain messages, and I think it is appropriate to retain certain things as core that are basically community health issues that everybody has a stake in. The other part is consistent with what we talked about this morning to that I think part of where we're going to end up with is having people make tradeoffs particularly of even thinking about phase three. We need to get some folks who are willing to be innovators and take some risks but how we're going to tradeoff among the categories. So I think that this could set that up in reasonably good form, and there also is sort of an implied degree of difficulty for these. The further you get to the outside the more difficult it is and you probably don't want to burden the illustration with that but the ones that we want people to stretch a little bit on are probably the ones that are going to be towards the outside. It would be important to see and to be thinking about that as we move to where we want to figure out who are the people who are willing to take a little risk but how are we going to reward them and figure out how we work out the trade out?

David Lansky – Pacific Business Group on Health – President & CEO

I wanted to comment this morning but that wasn't the scope of the discussion about that sort of giving people credit for doing something hard and then you don't have to do something easy. I don't think that's maybe the best way to think of that. I think that there are enough organizations that are already doing the hard or a tenth of the way through doing the hard that—... is one of the ones that's trying to do the hard. I don't think it would be appropriate for us to say you don't have to do blood pressure because you're doing care coordination or something. I think we need to think of another sort of mental frame and then incentives that would fit in that but in a way we shouldn't make it reimbursable meaningful use if it isn't something that pretty soon we'd be embarrassed not to be doing.

Paul

I agree strongly but where I was going is it also doesn't make a whole lot of sense to me to keep giving people credit for something that they're already have plastered at the top of the—I mean there's something. But also there's that dilemma that we tend to only retire majors when everybody's there but the point here would be to figure out who are the people that actually have capacity to move forward because they've already achieved a high-level on a major. I hear what you're saying but I think we want to accommodate both of those concepts in there.

David Lansky – Pacific Business Group on Health – President & CEO

So let me make a proposal for this particular piece with one— First let's ask the question again that Paul just raised, whether to keep the core as it is for continuity with stage one purposes or others or to have the core dispersed into the menus essentially and disappear here. Let's see if we have any sense of how we want to go on that issue. Then depending either way would we have time to end with—I'll ask Tom and Lanre—to do sort of a story board of two or three specialties using this framework in the next week or so just to populate some of what's in here into this framework. And so that we can ask ourselves the question several people have asked of is this workable realizing it's not going to apply to 100% of all the EPs out there but give us a sense for a couple specialties that works and internal medicine, general practice. Then do we have time to look at that as a group either on the phone or by eBallot before the June 8th meeting so that we'd be able to communicate to the Policy Committee a sense, even if it's only directional, that yes, we think this works or no, this is not going to be valuable. Is that a workable plan of action?

M

Yes, we'll do a ... focus group.

M

So then the question to come back to is do people want to do that in a focus group keeping this core as is or dispersing it to the domains?

M

I think dispersing it to the domains makes sense maybe thinking in terms of a virtualized core so that there's some things maybe that apply all the way across— We push everything as far across the board as we can and so it's a core in that sense. It actually ends up being a spectrum of some things that may apply to absolutely everyone versus some things that apply to only one specialty and just sort of work out for each one of those how far across we can push it. So it's a virtualized core or something. We haven't gotten rid of the idea of—

M

Are there opinions about the core?

Tom Tsang – ONC – Medical Director

Reemphasize in a couple of phone calls that we talked about supporting and augmenting such priority initiatives like the national quality strategy. There's actually a shout out for looking at cardiovascular issues. I think having the core and retaining blood pressure control is one that it gives you some—as Danny said, some fundamental data elements that could be applied to other measures that would—If you're looking at composite measures that take into account blood pressure then you have at least one core measure that you'd be doing that could serve as a foundation for other measures.

M

Tom, that's what I was trying to say about not so much getting rid of the core as virtualizing it and blood pressure's a good example. Maybe that's irrelevant to somebody.

M

... radiologist said that last week.

M

Okay, radiology. Some radiologist that would be irrelevant to and so maybe it only runs 95% of the way across the EPs but we'd still preserve—that's the idea that would push it all the way as far as it could go so that we'd have that kind of building block. Just so the patients would get the right things so it wouldn't be some kind of arbitrary thing that you're just allowed to say that's not core for me.

M

I'm not hearing strong opinions one way or the other about this retention of the core. Conceptually it sounds like we don't have a lot to put in the core wherever we put it and we have a couple of perspectives on how to handle it. We may want to look at the storyboard and then call the question the next time we meet.

W

... this is the area that you identified adding? Could you just repeat that?

M

Un-named clinical quality measures. Essentially where a lot of the current process measures are now. If that—

W

... if we change the wording as Helen suggested but you wanted to keep the—

M

That was another discussion—

David Lansky – Pacific Business Group on Health – President & CEO

Ben, do you have a comment?

Ben Hanlon – NCQA

I mean me being a newbie and not being part of the earlier discussions is there a set of defined elements such as tobacco, blood pressure, weight, that you think this group would agree on? It could be a virtual core or would that open up a whole another set of discussions? So that would sort of be the base for any visit or any type of quality measurement strategy.

M

A series of core element pieces that would be virtualizable across all these different things, I mean I just think—

M

Well, I just think it's a level of certification at the product level and at the functional data collection level we have some of that addressed whether it turns into a quality measure, reportable—

Ben Hanlon – NCQA

... another risk assessment for things other than the three you have there now. I mean were those eliminated—

M

....

Ben Hanlon – NCQA

... the population that you're looking at health risk assessments and for other risks as well as just those sort of three—

David Lansky – Pacific Business Group on Health – President & CEO

So, again, it became a matter of which specialties felt it was appropriate to be accountable for measuring and approving performance against those indicators. All right, let's move on to the next part of— Sorry, Eva?

Eva Powell – National Partnership for Women & Families – Director IT

Just a recommendation as we look at this framework with the areas, patient safety, care coordination, population, public health etc. combined with the testimony that we heard today could we take a broader perspective on the story boards and look at it from a patient centric perspective and not specifically medical specialties and their goals?

David Lansky – Pacific Business Group on Health – President & CEO

Is there a way you picture having that come back to us that would help you—?

Eva Powell – National Partnership for Women & Families – Director IT

I'm just thinking there are certain ... that are important to patients related to safety that are outcome driven and they may not specifically fall under one medical specialty but they're very critical and to patient safety as we look across the board in terms of all care that's provided to patients.

David Lansky – Pacific Business Group on Health – President & CEO

Well, I think the time in the storyboard or whatever we call it taking the measure concepts, which we have out for review would be a way of addressing them. There was a number of those things that were reflected in that list of concepts.

Eva Powell – National Partnership for Women & Families – Director IT

A number of adverse events and different things that don't specifically fall under specialties but nonetheless we don't want them to happen to patients such as pressure ulcers and other things that are not tied to one specialty or even one domain of practice but yet are very important to take into consideration as we move forward.

M

....

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

One of the reasons I like the menu approach is that in talking with a number of health systems and providers there's the idea that different health systems are at different places in their quality journey, so one place might be great on safety actually but not so good on care coordination. So by having a menu like approach you're better able to match what you're working on with what you actually need to work on, and that allows the self-assessment and tailoring. It's actually helpful because health systems do have different strengths.

David Lansky – Pacific Business Group on Health – President & CEO

So this becomes a dashboard in that respect. The flip side of this is it's a reporting dashboard. Paul?

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I'm sensitive to the fact that this may just reflect a mindset in a place like Kaiser but we thought of sort of the center of this there are things like tobacco use or blood pressure as really being more about the patient with the condition than the condition the patient has. And the method that we wanted to convey was that anybody you touch if that patient has a stake in their health even if you're a radiologist. The other part about that that I think is at least semi-empiric is that the boost that we get out of involving everybody is that additional 3% to 5% that move you to the top of the ranks and you don't get it if you don't engage the full group. All that's indirect but that's why I would advocate retaining it and keeping certain measures in there that are really everybody's responsibility.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, thank you. So Part B of the proposal I'm going to flow today for the discussion, this may be much more controversial and difficult to address today but we'll just put it out there. We heard specialty societies testify last week about their interest in being properly represented in this model and one platform that exists that would address some other goals we have that we heard about this morning are the clinical registries that exist in a number of specialty areas where you've already got a professional society

endorsing a data set. There's an infrastructure of some kind in place to capture data. It could be extracted from the HRs. The task that we in CMS have given ourselves of enumerating hundreds of measures that seem relevant for each specialty and putting ourselves in the position of judging this that are handled by professional society that's closure to the practice issues in their area.

So one notion is could we allow there to be a set of qualified registries which capture these one or more or all of these domains and an orthopedic surgeon for example or cardiovascular surgeon by reporting to their authorized certified registry is thereby supplying the quality measures for meaningful use? If the registry in turn is required to do something with that data that we would have to give some thought to. So part of the reason for doing this is to create a partnership with the professions and with the infrastructure that they are building to manage populations, capture data, feed it back, do improvement, potentially generate public reportable quality indicators. Part of the reason is we address the problem we've all had in not knowing how to deal with those longitudinal data integrations. What do we do with patients that move across facilities, across time?

Right now in effect we're expecting each individual eligible professional in their own local EHR to somehow be the locust of longitudinal data capture and management. If we're ever going to do longitudinal measures or patient based outcome measures or re-admission measures we're somehow saying to each EPA charter you have to capture that, which isn't like to be sustainable. So by empowering some intermediate layer of pilot registries that would be a place to begin to do some of that kind of measurement and feedback and improvement and learning system support, so that's a notion. But there are a lot of unanswered questions if we even want to consider this path but we just wanted to float this for discussion today and if it's viable do more work on it and if it's not we can move it and move on. Gene ...?

Gene Nelson – Dartmouth – Prof., Community & Family Medicine & TDI

The idea may have a lot of merit but one red flag comes up very quickly for me and I mentioned this morning that when we look at some of the health systems that seem to be best at having a very rich information environment to include patient and population health they all had registries. Then the next common denominator was that all their registries started out being condition specific and they were all moving to a patient based registry because people may have cancer and blood pressure etc. So the red flag is the need perhaps is for a patient level/person level registry rather than cutting it up into the different specialties and clinical populations. So it may be a good place to start but it might take us down the wrong path.

David Lansky – Pacific Business Group on Health – President & CEO

Very interesting. Karen?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Just to follow up I think it speaks to maybe thinking about national platforms just like we want our EHRs to be interoperable we want our registries to somehow represent that patient. The thing that's attractive to me about what David's saying is I always wonder about your meaningful use in the quality measures, which I fully support. What is it saying back to the patient and in a registry kind of environment you might start to be able to say if your physician is a meaningful user and they're submitting your data to a registry that physician should get back data about other patients like you. It gives something else more rich perhaps to further that dialog about patient decision support and everything else until you're part of a collaboratory. We can build towards all patient and all physicians in this country being part of the big collaboratory and maybe that's a little Pollyanna but I think it's worth pursuing.

David Lansky – Pacific Business Group on Health – President & CEO

Thanks. Danny?

Daniel Rosenthal – National Quality Forum – Senior Advisor, HIT

I think it really depends on the relationship between the EHR and the care provider and the registry, and it's that interface that is going to be crucial. Registries in and of themselves I think are a wonderful idea; however, it depends on what kind of functionality you're trying to drive at the point of care. If the purpose

of it is just to get back quality information in a rapid standardized fashion the registries can serve the purpose. However, if you're trying to encourage data capturing not just for registry, not just for ... condition but across all diagnoses, all labs, all medications then the behavior that you're trying to modify is at the point of care before it gets to the registry. As long as that's sort of protected at the communication between the EHH and the registry and data capture then I think it's definitely viable.

David Lansky – Pacific Business Group on Health – President & CEO

Okay. Tim?

Timothy Ferris – Massachusetts General – Medical Director

I'd like to say the idea—the basis on which the registry idea makes sense to me is that we would regard simple participation and registry as phase one of ten or 15 phases, so that phase two is that the registry has to provide—Well, registries may already provide information back to providers about their performance. Maybe that's part of phase one also, and then maybe phase two is that there's a concept of registry certification so that registries have to provide information in patient meaningful form either through the physician to media to patient or maybe straight to the patient. Maybe it doesn't matter which, and then maybe registries have to meet national data standards so that what we're doing is creating a bridge to—You're exactly right. What we need in the end game is sort of all the patient's needs and conditions in one database not in 12 different ones. But I guess the thought was this would be a way to get people started in a relatively painless way that might be acceptable for MU2 with clear indications that this is the first step on a journey toward what the patient really needs.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

... that may be a very good path to what a specific place—I think it's okay to mention it's a Kaiser organization, Kaiser Colorado. They about ten years ago started out with ten registries and at the time over 45 different ones, but they still have those separate registries. But in fact they've standardized the data elements and variables so that you might be on the high blood pressure registry but the way smoking is asked is the same and so that can— They create a virtual super registry through the standardization of the variables whenever it comes to cross registries. So in affect they've created a registry of registries through standardization of data elements, and enable specialty specific or population specific functionality, and yet in the data warehouse there's a super registry function.

M

That's exactly what happened in RM to help disparity collaborative and we have a registry for the diabetes. Basically all the health centers and all their patients that were in the diabetes collaborative, similarly with the cardiovascular, similar with the depression, and then ultimately evolved to patient care ... being multi-condition registry system based on individual but was really across board of all the registries as a super registry. The beauty of that, by the way, from our perspective was when the diabetic hypertension control quality changed from having a blood pressure 140/90 to 130/80. We could systematically push that all at once by just simply changing the algorithm in the multi-condition registry and overnight changed it in all the places all over. The scary part is how you message this to the patients because it does have the sector of big brother sort of tracking on everybody in one platform and so you need to think about that upfront and how it comes across.

David Lansky – Pacific Business Group on Health – President & CEO

Right, very good. Helen?

Helen Burstin – NQF – Senior VP, Performance Measures

I think the registries offer an incredible opportunity for us to get at some of those clinical outcomes and appropriate ... that we couldn't get our hands on. I think as you look as this wheel though we're going to heavily focus registry based measures in the part of the wheel so I think the last thing is we want, again, this harmonization moving towards parsimony speech here. The last thing we want is every registry to cough up care coordination measures and safety measures and pop health measures, and so the danger there is you wind up— So it's got to be a hybrid. I think there's a real emphasis you can bring phenomenally good measures forward but they're going to be primarily clinically oriented and I think we

don't want to get into, as we've seen, care credential measures for every condition, pop health measures for every condition. I think a hybrid model would work very nicely actually.

Paul Wallace – The Lewin Group – SVP & Director, Center for Comparative Effectiveness Research

I think the other place that there's a lot of wrestling with this concept are just basically where data resides. I mean there's a lot of thinking around is it the cloud or is it a federated model. In a sense what you're describing and even within an organizational like KP Colorado is that there are stakeholders for cardiovascular who want to hold on to their data but they want to be able to talk to the asthma guys, and so they really worked out both the technology and the sociology of having a federated model. I think it's really important to think how you move down the stream because otherwise it's like having the old days in the academic medical center where every clinical department has their own record and God forbid that you want to know what happened when they went to see the neurosurgeon. I mean this could really compartmentalize this. I think it's really important to think about the both and acknowledging data ownership, acknowledging control but maybe even thinking about what are the critical elements that any register ought to include. Then maybe cardiovascular disease and diabetes and stuff like that, but it'd be worth thinking about what are the cross walks to make sure that you can use it.

David Lansky – Pacific Business Group on Health – President & CEO

That's a great discussion.

Helen Burstin – NQF – Senior VP, Performance Measures

Just one more point of connection, I'm told CMS is actively working on this big registry of registries so I would hope we connect the dots here to make sure these get aligned.

David Lansky – Pacific Business Group on Health – President & CEO

So what I'm hearing—what Helen said about a hybrid is really interesting and part of what I think we have to also do is imagine the status quo world where we've got specialist reporting a set of clinical quality measures to sort of a black hole at CMS or attesting to the fact that they have them. Is this registry idea or hybrid idea an intermediate transitional platform towards the kind of things Gene was describing, and we don't know. We haven't figured this out yet but is it too ambitious to try and pencil this out as a possible vehicle for conformity for stage two or even stage three? It sounds like there's enough interest in some aspects of it to take it a little further but I don't know if we have time to even just flush it out to maybe a short concept paper or something in the next few weeks to take it further. I don't know what people think about that.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

I think it's ready for prime time. I think it's something that we really need to talk about across the hall aspects of healthcare. And I would hate for us to have that being done in CMS to allow submission from registries to PTRS and, again, I think so much of this is so important is the alignment from a perspective of the doc and having to do two different things at some levels just starts to feel wrong.

David Lansky – Pacific Business Group on Health – President & CEO

Yes that burden issue's worth reminding ourselves that if, for example, the cardiologists who are already in the cath lab registry and the PCI registry, you'd like to be able to say to them, "Thank you, that's great that you already do all this. That reflects the fact that you're participating in a meaningful use of electronic information." Rather than saying, "No you've got these other six measures over here we're going to make you conform to." So there is a burden reduction opportunity here as well if we can figure this out. I'll take so far the nods, unless I hear some other objections, as a reason to do a little more planning work around this and see where it takes us. Pete?

Peter Basch – MedStar Health – Medical Director

One consideration in this is the role of the primary care practice and all, and internally when ... became part of the CMS PGP program we started building registries. Then once, again, we started building internally that in the primary care context you really needed the registry to be let's say chronic disease plus registry to get at evidence based prevention as well as the basics of chronic disease. So in thinking

about this we wanted to make sure that the registry development didn't disenfranchise to some extent the primary care practice that's trying to cover all of the basis around prevention and chronic disease care.

David Lansky – Pacific Business Group on Health – President & CEO

Another challenge for this All right, so I think with that why don't we turn to Tom. Do you want to talk some about the methodology questions?

Tom Tsang – ONC – Medical Director

It's actually in the package here where we list the five domains and while we're having these entire team discussions last year Helen and John White actually took us through some of the methodological issues and challenges for some of the innovative measure's that we're thinking about within the five domains. So in the five that said clinical appropriateness particularly some of the value measures such as re-admissions measures that's incorporating claims and administrative data I think one of the methodological challenges is how do we incorporate other data streams and other data sources? The second point is using ... dashboards that use multiple data sources across settings of care, so I think we were talking about pharmaceutical looking at measures that look at pharmaceutical adherence data from pharmaceutical benefit plans. I think that's one set of challenges that we're going to have to face as we talk about some of the new measures in thinking about how we can incorporate some of this in either in a standards discussions or in the infrastructure discussions.

Within the population and public health domain we talked about some of the health equity data that may not be well aligned with EHR and so the standard data entry convention's not identified for measures. I wasn't part of this discussion with this entire team so, Helen, do you recollect some of the methodological challenges in this domain?

Helen Burstin – NQF – Senior VP, Performance Measures

In the equity one in particular you mean? Is that what you're asking?

Tom Tsang – ONC – Medical Director

Yes.

Helen Burstin – NQF – Senior VP, Performance Measures

Yes, so I think the equity data issue is the fact that there's usually little to no connectivity between where the data is stored on ... and languages that are within the EHR and a need to align those if we ever want to be able to stratify and be able to look for disparity.

Tom Tsang – ONC – Medical Director

I think there's also some issues, some challenges with standards regarding race, ethnicity and language. I think early on this year the Policy Committee had hearings about waiting for the ION standards. There are some discussions on health disparity community as well talking about adopting from the ION standards, so I think that there's some standards work that needs to be done regarding this topic.

On the patient and family engagement issue I think we've had multiple conversations about this about incorporating patient reported data and what type of format we can do particularly, also using validated instruments whether they can be converted in the electronic environment, the work I think Kaiser's doing with the PHQ-9 and PHqQ-2. I also stuff that I think Gene if doing with some of the patient reported outcome surveys, is it the BR12 and 36? So other standardized instruments and how to convert that into an acceptable portal or how do we engage patients.

The last point, sampling versus the census approach to data collection, David, you were part of that group. Do you want to expand on that?

David Lansky – Pacific Business Group on Health – President & CEO

Yes, the whole part of it is that the issue of patients willingness to supply data represents a kind of convenience sample. So for the purposes of measurement it introduces another level of bias if we're going to be having comparable quality measures. There's also just an infrastructure question of which

patients have access to the technology to supply patient supplied data in this model versus having—if we have connectivity's in the patient or we have patients coming in the clinic, for example, and capture data there that will change the nature of the population that's being included in the measure. I think there's a lot to be sorted out as to what is the ... sample frame or research method you're using to capture data from patients when it's not going to represent the entire population typically unless you capture it in the clinic. In which case you may get everyone who's being served for a ... condition or need but introducing the bias and data collection from the patient with the provider sitting there, kind of white coat data collection.

Tom Tsang – ONC – Medical Director

So moving on to the care coordination domain, I think in this domain there's the issue of—I think one of the panelists actually talked about standardization of the longitudinal care records. Right now that's still to be decided. There are a lot of discussions about this. There are issues about exchange of data, whether we have the necessary infrastructure to allow for the exchange. Do we have the correct CDA record that has the necessary components to actually measure care coordination that's going on, and then the difficulty of measuring clinical summaries across various settings of care. So a lot of challenges in this domain.

The last domain in terms of patient safety, I think here the issues of standards, again, come into play in terms of capturing data. Particularly events that may have never have happened or even defining what is an adverse event if we're looking at drug interactions and drug allergy interactions and we have patient reporting what they think could be adverse events but may just be part of the side effects of the drugs. So looking at that and then actually having the technology or capacity to measure things that may have never happened.

In terms of crosscutting events, measures of adverse regiments and falls relevant to both hospital and ambulatory settings, I think it's coming up with these measures that would happen against ... parsimonious set of measures that is relevant in both types of settings, and there are challenges in that aspect. I think in all of these five domains we see a series of challenges and infrastructure issues, some standard issues, and I think that we want the committee measure members to actually prioritize in thinking about what kind of measures we could include for stage two and stage three relevant in relationship to these types of methodological challenges. Then we could use your expertise to actually tell us what may be feasible, what could be overcome, what can we do in terms of developing the infrastructure and the exchange capacity over the next two or three years.

David Lansky – Pacific Business Group on Health – President & CEO

No problem. Are you looking today for any kind of input or just putting us on notice to some of what you'd like—

Tom Tsang – ONC – Medical Director

I'm putting you on notice, David.

David Lansky – Pacific Business Group on Health – President & CEO

All right, do you have in mind kind of a process by which these two workgroups can work on these issues in the next few months?

Tom Tsang – ONC – Medical Director

I'm going to turn that to maybe Helen and Helen has been the lead on the methodological tiger team, maybe she could shed some words of wisdom.

Helen Burstin – NQF – Senior VP, Performance Measures

He was looking at me let's—I mean it might be reasonable to just see if the way these two groups come together if there's a subset of both groups to want to just kind of sit down. And go over these one more time before the next meeting just to see if there are some that are logically being taken care of elsewhere, ones that are kind of taking care of themselves. And ones that are on a pretty long trajectory, things that require feedback, the standards of the organization, things like that.

Tom Tsang – ONC – Medical Director

So perhaps maybe the ONC staff can provide a crosswalk and a list of activities that maybe we're doing. I mean I think there's some of the stuff we're actually working on so for example the standards for health disparities I think there's been discussions within the Policy Committee and the need for use Policy Committee actually looking to ... standards for stage two. There have been a lot of discussions about the longitudinal care record standards. There's been some work SNI framework about care transition pilot going on. There's also a pilot on exchange of lab data related to care transitions, so there's a number of new activities that have been going on since these slides were put together about six or eight months ago. Maybe we can start off with that doing a crosswalk and an inventory of all the activities that are going on and then we can bring it to a smaller ... group.

David Lansky – Pacific Business Group on Health – President & CEO

Helen, maybe the question is to you. Each of these slides suggest the possibility that we might try to identify measures, and perhaps someone already has, that get around these methodological limitations. Rob Greene suggested on clinical appropriateness just chatting but because it's cardiovascular it fits in that way, if patients on an ... did they document a contraindication to an ACE inhibitor. I mean you can have strong ... at least that you could say, "Okay, here is the potential measure that would start to get at this domain and gets around these methodological issues." Has that been done? Would that be worth trying to do, and then the other question I have is in terms of the issues you could say, "Well, this one is incredibly difficult and we're not going to even try to address that for MU2 or MU3, either one. "This one we think could be addressed in time for MU3." Any effort or thought about sort of stratifying the different issues in terms of which ones we ought to try to knock off first?

Helen Burstin – NQF – Senior VP, Performance Measures

I think that's a reasonable discussion for our group to have, sit down and look at this and see that. That was part of what we tried to do on that call last week. That we knock off some of them we thought had some potential approaches but some of these are kind of big issues. The reality is some of these things are claims based measures. We don't have interoperable systems yet, like re-admissions as an example, so we could lay out the issues but the path towards fixing them is—I don't think is in this room easily.

David Lansky – Pacific Business Group on Health – President & CEO

Well, right but maybe we could just say, "Well, look we're going to put those at the end of the line because they're so hard or—"

Helen Burstin – NQF – Senior VP, Performance Measures

Or we use the term ... cases but we could pull a couple of examples of measures that ... has gotten around it and look to see what was done and what worked. Especially if, again, we want to go back to some of those measures we had looked at before and that work we had done over the summer, potential measures for 2013 and 2015, looking what some of the leading institutions have done where they have made some of these measures work in the MU environment.

David Lansky – Pacific Business Group on Health – President & CEO

I think it's also our role to recommend to ONC, through either of the two parent committees, standards or policy, that these are priority problems. They may be longer term but now is the time to start developing solutions so that if health system improvement depends upon some of these measures, like a longitudinal care record. We should encourage the powers that be to invest and support that kind of development work starting now, and we have the right role to be that voice of advocacy, I think. Norma?

Norma Lang – University of Wisconsin and American Nurses Association

I find myself on the board of our HIE in Wisconsin, which is now struggling with some of these same questions. So I don't know does the staff, HIT and HIE staff, talk to each other and is there any merit to thinking together because some of these are going to be collected and exchanged and they're going to be available. It just seems to me—I'm speaking now I think from a state level—you can only absorb so much of this new stuff coming down the line. It's really nice if it connects one to the other but it's the key data elements that will be collected in the exchange, so I'm just asking if that's just another group to keep in

touch with. I'm not only raising that to you but I guess to everyone because some of the same struggles I hear and the same thing there.

M

Well, likewise I think as the staff connect I think the workgroups could also connect and there is an HIE workgroup within the Standards Committee. If you bubble up these concerns then it would then synchronize with that workgroup to the larger Standards Committee and if everyone's bringing up the same concern then it's really signaling to not only ONC but to all of the industry to think about some innovative way to tackle these problems.

Norma Lang – University of Wisconsin and American Nurses Association

But it's just that if you're in the state level and all these things are—So you're sitting here at the national level but if you live in the state level you know they're all coming down upon you to make this all work so I think that'd be a good—Whatever can be shared I think would be great.

David Lansky – Pacific Business Group on Health – President & CEO

So what I'm hearing on this topic so far is that Helen suggested some kind of another subgroup take a closure look at these and maybe staff can reassess the list for which things are already underway in one venue or another, what the higher priorities may be, which are more intractable and ... more intractable in the shorter term. Then I think Helen might reconvene a group to walk some committee members through that and then that may lead to some recommendation to the policies and Standards Committees about where to make some priority effort. Yes? Any other comment about the methodology? Anything else we want to say to ONC? Norma?

Norma Lang – University of Wisconsin and American Nurses Association

I just, for the most part today, heard all day pretty much one discipline and I just would encourage that these subgroups have a little broader representation. I heard Rosemary say that but it doesn't seem to necessarily be heard because we revert right back to specialty groups and physician groups. I can't help but sit here all day as a representative of the largest health professional group in the country saying, "Well, I said that a lot of the detail of this that rest upon them and also a lot to offer." So I'd just feel remiss not saying to get that much more visible in our deliberations or at least have some of those folks at the table.

David Lansky – Pacific Business Group on Health – President & CEO

Yes, Rosemary?

Rosemary

Rosemary, again, I just want to restate the recommendation to have the use cases be representative of the six areas and include all those other disciplines and not just specialty organizations. I think it's imperative and I think we heard it loud and clear this morning in the testimony.

David Lansky – Pacific Business Group on Health – President & CEO

Okay, any other topics you want to take up while you have us all together here?

M

I thought it might be useful for our workgroup to get clear, maybe from your perspective, what our scope of work is. I mean we're going to be setting up power teams to look at vocabulary sets that would support the various measures, is our task to take those measures and identify standards and get that done as rapidly as possible and get back to you? Is there anything beyond that that you see us doing?

David Lansky – Pacific Business Group on Health – President & CEO

I'll let Tom—

Tom Tsang – ONC – Medical Director

I think the discussion for the last two hours is actually more than needs. I think if we can first get the core and alternate core and menu thing settled, deciding that framework in terms of priorities, I think that would

be number one. Number two would be looking at the range of measures prioritize for stage two versus stage three. Number three would be, we'll work on this, the methodological challenges, and then working with this new subgroup. Then lastly, would be really focusing on, I think what, Jim, you're going to be highlighting the issues about the QDM and the work that we've been doing there, and perhaps some new activities in terms of engaging the FCOs and some of the members around the table to work on some of the taxonomy issues and vocabulary set issues.

M

... to you? That would—

Tom Tsang – ONC – Medical Director

Yes, it would provide what you need.

M

I think providing all the things we heard this morning as well, the technical infrastructure that supports the kinds of measures we're looking to and seeing that the QDM is robust enough to do what we need to do and how we support it for work in front of us, I think.

M

That's great, okay.

David Lansky – Pacific Business Group on Health – President & CEO

Does anyone else on the committee have any more things to put on the work list or— All right, Karen?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

... help with the ultimate core case studies or whatever we're calling them I'm happy to pitch in there. Storyboard ...

David Lansky – Pacific Business Group on Health – President & CEO

Thank you, great. Let me just check and see if anyone on the phone from the committee has any other comments or questions they want to add to our discussion. If anyone's out there they've been very patient, so thank you for listening. Judy, are we going to do some public comment as well?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, it is time for public comments. If anybody in the room wishes to make a comment please queue up to the microphone at the table. We have Lindsey in the room.

Lindsey Hogle – American Diabetic Association

Good afternoon. My name is Lindsey Hogle and I'm speaking today on behalf of the American Dietetic Association. ADA's a 71,000 professional member organization of ..., nutrition experts. I have several comments today starting with the one in regards to the discussion of BMI as a core measure for stage one. Having lived in the D.C. Metro area for 18 years and aware of the stigma of the label politically correct I want to assure you that ADA's recommendation to include BMI as a core measure, which was acknowledged by CMS in the final rule, had nothing to do with being politically correct. Regardless, we applaud the work of the first lady in bringing child obesity crisis to the forefront.

We recommended the use of BMI and the associated PQRI weight screening measures due to the spiraling crisis of obesity and its many covert morbidities in this country. My children's generation may potentially be the first generation to experience a decrease in life expectancy in large part due to obesity related diseases. These are things that I'm only reviewing because you probably know the cost of obesity alone in the United States is close to \$300 billion per year. Consistent with the request for parsimony and choice of measures BMI is a relatively easy low-cost measurement routinely performed in many office visits. BMI like several of the measures is not perfect nor does it apply appropriately to every encounter. I agree with comments that measuring it at each and every visit is a challenge.

BMI is useful as a screening tool and indicator and a longitudinal measurement over time and an outcome, if you will. I consider it to be among the same category as alerts and EHRs, critical for care but if overused it may lose its effectiveness. I applaud the inclusion of BMI and both PQR measures related to adult, adolescent and child weight screening and follow up. It helps keep the focus on actual change which can greatly impact healthcare.

Historically, our payment system has not supported reimbursement for nutrition intervention by our days, which limits education, personal goal setting, encouragement and support of patients, in affect setting them up for failure. This translates to comorbidities, more medication use, higher costs, and yet another failure for the patient. Historically, BMI is not a popular discussion with patients as evidenced by data suggesting patients change doctors when it is brought up. Allowing greater patient input to designing their own plan will likely improve this situation. Obesity referral to registered dieticians is only one of a multitude of reasons for creation of a nutrition care plan that represents one of many conditions seen in complex patients.

The last comment is in support of the team approach. I have been fortunate to have had great experiences on team approaches to patient care in the past. When the entire team understands the patient care plan that has been developed with the patient in mind and participating, the goals can be reiterated and embraced by all members of the team. In working with patients referred to me an earlier indicator of whether patients would be engaged in nutrition and diet changes was simple. If the physician referred a patient to me yet didn't expressly tell the patient that they expected them to adhere to the changes the patient didn't do it. The team approach share care plan is a powerful lever for patient engagement. Perhaps as we consider stage two and three measures we need to consider the use of consumer generated data between the encounters of care when the health activities of daily living part of healthcare occurs. Measurement acts as a communication tool, a priority tool and a focus of treatment. I remain eager and willing to participate in the discussion on how best to utilize nutrition including BMI and other wellness measures and a shared team approach to care. Thank you for this opportunity to comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Lindsey. Do we have any other comments in the room? We have no comments on the phone so thank you, everybody. I'll turn it over to you Dr. Lansky and Dr. Walker.

David Lansky – Pacific Business Group on Health – President & CEO

Thank you, all, for a very productive day, stay after it.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Thanks very much. We'll all be in touch.

David Lansky – Pacific Business Group on Health – President & CEO

And thank you, again, to the staff for all your help getting us here.

Public Comment Received During the Meeting

1. It is curious to me that no one has mentioned the oft quoted conundrum "the stakeholders who must implement these programs are not the primary beneficiaries of the hard value of eHR". Developing conceptual devices that engender soft value to the providers is very important. The only thing more important is placing the continuing cost on the beneficiary.

2. I would like to add a comment on mapping tools: Mapping tools need to be simplified and a process needs to be put in place to keep maps up to date. For example, the current UMLS problem list to ICD-9 map is out of date; many of the ICD-9 codes are no longer valid.

3. The question was asked of the vendors "What are they doing to assure interoperability". No one answered. This is the elephant in the room. This will be the next big problem if it is not addressed now. It might be a good practice to telegraph the committees intentions.

4. Is there any reason why CMS/ONC is not participating in/considering development of new/better cost reporting as a window into administrative QI. Administration represents around 30% of the cost of healthcare.