

**HIT Policy Committee  
Quality Measures Workgroup  
Transcript  
September 18, 2013**

**Presentation**

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

Good afternoon, everyone. This is a meeting of the Health IT Policy Quality Measures Workgroup. Uh, this is Michelle Consolazio with the Office of the National Coordinator. This is a public call and there will be time for public comment at the end of the call. As a reminder, this meeting is being transcribed and recorded, so please state your name before speaking. Now, I'll take roll. Helen Burstin?

**Helen Burstin – National Quality Forum – Chair**

Here.

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

Terry Cohen? Ahmed Calvo? Aldo Tinoco?

**Aldo Tinoco – National Committee for Quality Assurance**

Here.

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

Carolyn Clancy? Terry Sennett? Charles Kennedy? Cheryl Damberg? Chris Boone?

**Chris Boone – Avalere Health**

Here.

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

Daniel Green? David Kendrick? David Lansky? Eva Powell? Westley Clark?

**H. Westley Clark – Director, Center for Substance Abuse Treatment – Substance Abuse and Mental Health Services Administration**

Here.

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

Mark Overview? James Walker? Jesse Singer? John White? Caitlin Taylor-Clark? Kate Goodrich? Kathleen Blake?

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

Here.

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

Letha Fisher? Mark Weiner? Marsha Lillie-Blanton? Michael Rapp? Niall Brennan? Norma Lang?

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

Here.

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

Olivier Bodenreider? Paul Tang? Paul Wallace? Peter Lee? Russ Branzell? Sarah Scholle? Saul Kravitz? Steven Solomon? Timothy Ferris? Tony Trenkle? Tripp Bradd?

**Tripp Bradd – Skyline Family Practice, VA**

Here.

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

Are there any ONC staff members on the line?

**Kevin Larsen – Office of the National Coordinator**

Kevin Larsen.

**Elise Anthony – Office of the National Coordinator**

Elise Anthony.

**Heidi Bossley – Office of the National Coordinator**

Heidi Bossley.

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

Hi, Heidi. And I will turn it back to you, Helen.

**Helen Burstin – National Quality Forum – Chair**

Great. Thanks so much, Michelle. And thanks everybody for joining. I'm sure we'll have others who will join us as we get started. I know we haven't met in a while and it's somewhat as a result of the work of the new ACO Workgroup that I think we're somewhat back in business to be handed off I think an important item that Kevin will walk through about this idea of potentially a deeming pathway. so we'll have Kevin do the presentation and then we'll open it up for discussion. We've also left some time to queue up what the other issues might be for the call.

**Kevin Larsen – Office of the National Coordinator**

Certainly, so many of you know Paul and the Meaningful Use Workgroup have been working on the, the framing of this idea of deeming. And he has given the charge to the Quality Measures Group as well as the combined workgroup of the ACO Workgroup and the Quality Measures Workgroup to flesh out the specifics of how this deeming would work.

So, for any of you that, that haven't been part of the deeming discussions, I'll talk about it briefly, but then we'll dive into more details and talk about how the charge to this group is, is related to the charge of the other group, but not exactly the same.

So the, the concept of deeming is that to live out what we want and need for Meaningful Use Stage 3 that potentially we could eliminate some of the some of the requirements for reporting objective measures by reporting outcomes to clinical quality measures. And the notion is that that really lives out the goal of Stage 3 and that providers that have been doing Meaningful Use for two stages already have many of the care processes and tools in place to accomplish what we've asked them to accomplish under the first two stages. Presumably, they're leveraging those if they're able to get clinical care outcomes in Stage 3.

So the uh, the charge that Paul had to – the ACO Quality Measures Workgroup we – was a com – an, an intentionally combined workgroup that has both members of the Meaningful Use Work – uh, ACO Workgroup and members of this Clinical Quality Measures Workgroup. Uh, he wanted that group to think first about this deeming pathway, because the ACO Workgroup is, is future facing into the work of integrated care delivery team-based care and outcomes-oriented care in this accountability model.

So that group is led by Terry Cohen and from this group and Joe Kimora from the ACO Workgroup. And that group has, has had three meetings to date talking through a series of questions and looking at a framework for how to think about quality, outcome quality measures in the context of an ACO.

So the, eh, initial discussions from that group were, were in this framework basis. Uh, we leveraged the work of Janet Corrigan, Elliott Fisher and others who published a paper in *Health Affairs* about a year ago looking at a framework for how – we might – one might think about measurement in the context of ACOs, triple A measurement in the context of ACOs.

And the, those slides are here. Sorry, there's a train going by. Uh, so that framework talks about some high level that would really be, um truly outcomes, things like readmission and total cost of care and an, and an overall patient experience or an overall function of status outcome with that, and that has been referred to by this ACO Quality Measures Workgroup as above the line. Uh, then there is a, a number of process measures or intermediate outcome measures that we've been talking about as below the, the line measures in that framework.

I'm just gonna – I don't know what slide we're displaying now. So are we still on the beginning slide, Michelle?

**Helen Burstin – National Quality Forum – Chair**

Yes. She's still on the overarching charge.

**Kevin Larsen – Office of the National Coordinator**

Okay. So I guess so then as that group has moved along, what we've been talking with Paul and the Meaningful Use Workgroup about is subdividing that charge, because we need to think not just about the context of deeming for these large groups and integrated health systems, but also to think about deeming in the context of the current state of deeper service medicine and individual care providers and individual hospitals.

So the, the charge to the Quality Measures Workgroup is to do, to do the latter. Is to think about this not in terms of the large-scale deeming at the ACO level, but what does deeming look like for an eligible provider and eligible hospital in the current landscape that most of them are practicing in right now, which is not an accountable care environment, um with a special focus on what are the current opportunities in the measures that we already have and people are already using that we could re – that this group could suggest a way for those to be used in deeming.

So that's a long discussion of the charge, but I'll stop there and, and get any questions. And then we can go through some of the slides in more detail.

**Helen Burstin – National Quality Forum – Chair**

I think you can probably proceed, Kevin. I think the subsequent slides actually help explain it, so.

**Kevin Larsen – Office of the National Coordinator**

All right. So why don't you move on to the next slide. I don't have them up, so. Uh, so this is a slide of the framework, I think. Is that correct?

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

We're on "Goals for this Call", but, um –

**Kevin Larsen – Office of the National Coordinator**

All right.

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

– you let us know where you'd like to be *[laughter]*.

**Kevin Larsen – Office of the National Coordinator**

Well, let me, uh – sorry, I forgot I was first. I was hoping I was second, so I got to my next stop. but just a sec

So the, the goals for the call, I, I highlighted I think already. The goals for the call are for this group to understand the deeming charge, understand this group's specific role in the deeming charge, review the work of the ACO Quality Measures Workgroup and then, um start thinking through what the, the output of this group would be.

We have some thoughts based on the – what the ACO Quality Measures Workgroup has done which is to really think about criteria by which we would assess measures or measure groups for deeming as well as some exemplars. So rather than giving recommendations of this is exactly how the whole thing should work instead saying here are the criteria we would suggest you – be used for this work the criteria used to pick how we would decide about deeming and which measures would work for deeming and examples of where and how deeming would work.

**Helen Burstin – National Quality Forum – Chair**

Uh-huh. Okay.

**Kevin Larsen – Office of the National Coordinator**

So, next slide what – can someone again tell me what's on the next slide? I just about have them up, but I don't have them up yet.

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

The, the “Deeming Pathway”.

**Kevin Larsen – Office of the National Coordinator**

So the deeming pathway, um –

**Helen Burstin – National Quality Forum – Chair**

No. It, it's, it's just a slide before the next.

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

Yes. Just a transition slide.

**Helen Burstin – National Quality Forum – Chair**

Yeah.

**Kevin Larsen – Office of the National Coordinator**

Okay.

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

So then it goes into “Meaningful Use Stage 2”.

**Kevin Larsen – Office of the National Coordinator**

All right. So I think talked about this already. Um –

**Heidi Bossley – Office of the National Coordinator**

Yeah. Kevin, this is Heidi. It's just the, um – to show what the meaningful use objective requirements are. I just put that there in for you.

**Kevin Larsen – Office of the National Coordinator**

Oh, yeah. So we had a – when we had a recent call with Helen we realized that many of the people that are engaged in the quality measures primarily aren't necessarily engaged in what these uh – what these objective measures are that we might be replacing or no longer requiring their measurement by going to the deeming pathway. So, this is a slide to highlight to the group just exactly what is in Meaningful Use 2 as far as the objective measures.

**Helen Burstin – National Quality Forum – Chair**

Uh-huh.

**Kevin Larsen – Office of the National Coordinator**

And, also, to kind of get some level-setting with the group. Uh, with the discussions I've heard from the Meaningful Use Workgroup and from the Policy Committee are that's likely the deeming pathway would not eliminate all of these. It would likely eliminate some good percentage of them but there may be some things that are centered around patient engagement or other key important topics like public health reporting that may not be encompassed in the, in the deeming in a, in the most straightforward way.

**Helen Burstin – National Quality Forum – Chair**

Okay.

**Kevin Larsen – Office of the National Coordinator**

Uh, I think some of that is, uh – are still details to be worked out, but that's the general discussion. There's also been discussion about how one to one the deeming is, um – uh, how one to one the measures for deeming should be to these objectives. And, in general, the, the direction that we've been given from the Meaningful Use Workgroup is that this is not an exact one to one. It's not that the hypertension measure means you collect hypertension and BMI and so, therefore, those are the only two things you can eliminate. It is also to think more broadly like there's a – the measures for clinical decision support in order to get good control for hypertension, it may be that you've had to use clinical decision support so that would also not be required although it's not as clearly a one-to-one relationship. So, questions about that?

**Female**

No. Very helpful.

**Male**

No questions.

**Tripp Bradd – Skyline Family Practice, VA**

Kevin, this, this is Tripp. How would this you – considering the ACO framework would, would the deeming be kind of along a patient-centered medical home kind of a path if you will?

**Kevin Larsen – Office of the National Coordinator**

Well, so it's been taking – it's been a really interesting discussion with the qual – with the ACO Workgroup about how this would look. And it's taken three calls I think for them to really formulate around a strategy. And there's the strategy that they've kind of coalesced around is a population oriented strategy. So they were thinking that we would identify certain populated – priority populations.

So, for example, the frail elderly might be a priority population. And there might be a deeming pathway around the frail elderly by which you would demonstrate that you have good outcome measures that somehow leverage health IT in managing the frail elderly in a triple aim sort of way. and that keeps us in a patient-centric, holistic care model as opposed to in a condition-oriented model like, you know, you did a good job with cardiology measures or you did a good job with some specific some specific specialty orientation.

So we're just in the process of starting to flesh out some of those exemplar populations. Um and one of them would be people with chronic disease and the behavioral health conditions, for example, that might be another exemplar population that they're looking at in the ACO CQM Workgroup. That's helpful. Mill, Million Hearts was also used as a possible example of a – thinking about a population that's also risk for cardiovascular disease.

**Tripp Bradd – Skyline Family Practice, VA**

This is Tripp again. So you're, you're really talking about registries then in some fashion.

**Kevin Larsen – Office of the National Coordinator**

Well, yes or no. I mean the – they're talking about from the ACO standpoint that instead of the ACO being responsible for only the care of asthma and proving that because they had good numbers on four asthma measures, they didn't have to do a bunch of things. The ACO feels it's responsible for a holistic care of a patient. And so the tools required to do that are the DHR and they're related to the tools. I think many of them are, are probably using registries and would say that that is certainly one core way that maybe ACOs achieve those goals, but they're not – has not presupposed a tool like a registry. They've been trying to stay out of tools as much as possible and instead talk about here would be the five measures in the frail elderly. It would be the readmission rates, and the, maybe, the total cost of care and, maybe measures of global functional status. And if you did well on those in the frail elderly population, we will assume that you're leveraging health IT effectively.

**Tripp Bradd – Skyline Family Practice, VA**

Thank, thank you.

**Kevin Larsen – Office of the National Coordinator**

And, and it, it's still early in their discussions, so I'm, I'm only kind of painting a broad brushstroke of their, of their discussion as opposed to trying to box them into a corner, because they're still in the middle of their deliberating how they would work in this in the ACO context.

**Tripp Bradd – Skyline Family Practice, VA**

Thank you.

**Kevin Larsen – Office of the National Coordinator**

All right. So, next slide.

**Helen Burstin – National Quality Forum – Chair**

You, you're on the slide about recommendations on functional deeming.

**Kevin Larsen – Office of the National Coordinator**

Do you want to just read it out loud, Helen, 'cause I still haven't been able to find it on my brand new – I have a newly migrated computer to Windows 7, so I don't know where everything is yet.

**Helen Burstin – National Quality Forum – Chair**

There you go. Sure. So the recommendations on functional deeming here. The first is that the providers have already met all the functional objectives in Stages 1 and 2 and should be allowed to deem. The second is that deeming could allow for high MU performers or significant improvers to attest for MU by satisfying a subset of the MU objectives. This would be an optional pathway to achieve MU. The third point is that deeming promotes innovation, reduces burden and rewards good performance. And the last bullet is that CMS should survey the landscape for available eQMs that are outcome-oriented and consider their use as deeming measures. And, also, in addition, new development of eQMs may be necessary. So this, Kevin, emerged from the discussions of the ACO Workgroup, correct?

**Kevin Larsen – Office of the National Coordinator**

Yeah. The – that's correct. there's certainly a lot of discussion – I mean there's been through this, uh – the, the qual – the Policy Committee, the Meaningful Use Committee and this workgroup for years that the measures that we want to have we don't have yet.

**Helen Burstin – National Quality Forum – Chair**

Uh-huh.

**Kevin Larsen – Office of the National Coordinator**

So there is definitely some activity in the kind of trajectory of this recommendation about what are the kind of measures that we would want to have both in a general sense and a specific sense.

**Helen Burstin – National Quality Forum – Chair**

Uh-huh.

**Kevin Larsen – Office of the National Coordinator**

And also as we think about a particular deeming pathway as an exemplar, what would be the objective measures or the functional measures that we would recommend or the committee would recommend that would be necessarily contained within that deeming pathway?

**Helen Burstin – National Quality Forum – Chair**

Got it.

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

Uh, this is Michelle. Just to clarify, though, Helen. I think what you're asking – these specific recommendations did come out of the Meaningful Use Workgroup, um –

**Helen Burstin – National Quality Forum – Chair**

I see. Okay.

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

– and – yes.

**Kevin Larsen – Office of the National Coordinator**

Yeah. That's correct. That's sort of the, the – this was a report that the Meaningful Use Workgroup gave to the Policy Committee. I think was it, Michelle, in, in September, no, in August?

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

Eh well, they've been working on this for a bit, but, yes this was reviewed both in August and September.

**Kevin Larsen – Office of the National Coordinator**

Okay. And, and, so it, it's from this that our charge has come.

**Helen Burstin – National Quality Forum – Chair**

Got it. Okay. So the next slide, uh – sh, should I just keep doing these, Kevin, until you tell me ...

**Kevin Larsen – Office of the National Coordinator**

Yeah. That'd be, that'd be great.

**Helen Burstin – National Quality Forum – Chair**

*[Laughter]*. Unless somebody else from ONC wants to do it, but, um basically, the, the next slide, um – and it'd be helpful to put it in context at least, Kevin, is the "Draft Framework for Deeming for EPs".

and it says draft high top quartile or improved performance (20 percent reduction of the gap between last year's performance and the top quartile) and reduction in disparities. And you can select two items from each of the two categories. And these are illustrative categories. Do you want to give a –

**Kevin Larsen – Office of the National Coordinator**

Yeah. So this – yeah, this was the first path by the Meaningful Use Workgroup to, to be able to even articulate and explain what this looks like.

**Helen Burstin – National Quality Forum – Chair**

Right.

**Kevin Larsen – Office of the National Coordinator**

And so this is the work of our group is to really flesh this out and not necessarily take this as the what we need to do, but, but this is the sort of specificity they're looking at – looking to us to give them with even a little more specificity if possible.

**Helen Burstin – National Quality Forum – Chair**

Great. So just as an example it lists there prevention kind of related measures, high-priority measures cardiovascular disease screening, for example, colon cancer. Control of high-priority conditions like hypertension, diabetes. and then, lastly, thinking about something specifically about a reduction of the gap in performance around disparity. So I guess that's more illustrative for us. That's actually a very helpful context. Okay.

Uh, next slide, Michelle.

so this one is, I guess, a very comparable slide Kevin. This just demonstrates a similar deeming framework for eligible hospitals again, set up very similarly. Uh, patient safety, for example, listing out some of the HAIs readmissions, for example, and CAPS under care coordination. Um –

**Kevin Larsen – Office of the National Coordinator**

Yeah. And, and I think one thing for our group to think really carefully about as we go through this, you'll see that none of this has been constrained to only the electronic clinical quality measures that, that are part of the Meaningful Use Program. So all the way through we've been broadly thinking or the FOCA have been broadly thinking about what measures could be used readmissions, total cost of care, et cetera.

**Helen Burstin – National Quality Forum – Chair**

Got it. Okay. Next slide, Michelle.

and this one, Kevin, is about the deemed MU objectives. deemed in satisfaction of and it lists things like CDS, reminders, test tracking. and then remaining items. Do you want to say anything about this slide, Kevin?

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

Uh, this is Michelle. I will. This is really just a draft of the types of things that could potentially be deemed. So, um they show the Stage 2 measures and object or objectives. you know, starting to think about what objectives for Stage 2 and, and Stage 3 could possibly be deemed. So if you do the things that we just discussed could you deem and not actually have to kind of for a lack of a better of way saying, check the box for, for a number of different functional objectives? So this was just the first stab at some of the things, the items that could be deemed. So, on the left side, there was – those are the items that could be deemed. And, on the right side, are the things that would still be remaining. Now, this would all depend upon the types of measures that are selected and experience from Stage 2 but this was really just a draft.

**Helen Burstin – National Quality Forum – Chair**

Okay. So, so is there an expectation that we are limited towards thinking through what's on the left or could we make an argument for something on the right as well?

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

I think part of, you know, based on the measures that are identified that will make a significant difference in experience from Stage 2, but you should certainly think about, you know, what you think should possibly be deemed.

**Helen Burstin – National Quality Forum – Chair**

Right.

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

And that goes back to what Kevin was mentioning earlier that it doesn't have to be one-to-one ratio.

**Helen Burstin – National Quality Forum – Chair**

Got it. Okay. Very good. Any questions on this slide or any comments from Kevin or Heidi on this slide? All right. Let's proceed to the next one then, "Additional Considerations". and do you want to do this one, Michelle, or should I just keep going? If you know this, feel free.

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

it is up to you. So, um [laughter], I'll start and then –

**Helen Burstin – National Quality Forum – Chair**

Okay.

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

– so there are additional considerations. So, proposing that baseline reporting be for 12 months prior to the performance for the reporting period. so providers anticipating that they will participate in the deeming pathway are advised that the deeming program uses the prior year's performance as the baseline for determining improvement on performance.

**Helen Burstin – National Quality Forum – Chair**

Okay.

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

and we know that specialists may have fewer options for deeming as determined by the available NQF quality measures. so if they're not able to report on at least four performance measures, they may not be eligible to participate in this new deeming pathway.

**Helen Burstin – National Quality Forum – Chair**

Okay.

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

And since effective use of health IT is an enabler for many of the performance improvement programs at CMS the Meaningful Use Workgroup recommends that qualifications for meaningful use in a given year should be deemed partial satisfaction of other CMS programs such as ACOs, PCMH, e-prescribing, CPCI, PQRS. so, and I think Kevin could kind of speak to that that, you know, we are trying to align across federal programs and across CMS related to the different programs and quality measures that are used for all of those programs.

**Helen Burstin – National Quality Forum – Chair**

Okay.

**Kevin Larsen – Office of the National Coordinator**

Yeah. This, this is Kevin. Uh that gives us a lot of opportunities. It also gives us a lot of complexity challenges in that the programs that, for example, for CPC, the Comprehensive Primary Care Program, it – they are aligned with meaningful use, but they've picked a certain set of quality measures that you need to use in order to participate in the CPC Program. So you know, a potential suggestion is if you participate in CPC, you're automatically a meaningful user. There's a bit of a, a circular logic, because they've also said that to be a participant in CPC you need to be a meaningful user.

So, so there are alignment opportunities. We're happy to talk those through. Um but, but that's another way to do this is align by program either something like PCMH certification or CMS Program participation.

**Helen Burstin – National Quality Forum – Chair**

All right. Okay. So why don't we go to the next slide, Michelle. So "Criteria Needed to Move Forward on the Deeming of EPs", and the next slide.

Kevin, do you – how do you want to talk about the accountable care quality measures about the subgroup discussions to date?

**Kevin Larsen – Office of the National Coordinator**

Sure. This, this is Kevin. I think I talked through quite a bit of that already.

**Helen Burstin – National Quality Forum – Chair**

Great. Okay.

**Kevin Larsen – Office of the National Coordinator**

again, that's really been at the population level.

**Helen Burstin – National Quality Forum – Chair**

Right.

**Kevin Larsen – Office of the National Coordinator**

It's been thinking about the framework. It's been – uh, their kind of breakthrough is when they decided to focus on these population definitions that weren't a, a disease population, but rather a more holistic patient centered like kind – like patient population. And they also had discussion about whether it should be aligned around a programmatic need like end-stage renal disease as a CMS program could also be a deeming pathway. And they're less excited about the programmatic alignment than they are about aligning around a like set of patients in a holistic, patient-centered way.

**Helen Burstin – National Quality Forum – Chair**

Okay. So this refers to the table we all received that was titled, "Accountable Care Population" with the, the six columns of subpopulations. Is that correct?

**Kevin Larsen – Office of the National Coordinator**

Yeah. That's correct. So after our last call, Joe Kimora, who was one of the co-chairs, put that together as a, as an example of how we're going to start to have discussions with that workgroup to flesh out. Uh, I think a couple of exemplars to pick a population and then look at what that might look like across that population in part, to help us inform what would we be the criteria that we would use to select the measures –

**Helen Burstin – National Quality Forum – Chair**

Okay.

**Kevin Larsen – Office of the National Coordinator**

– and the populations for deeming.

**Helen Burstin – National Quality Forum – Chair**

Okay. Any questions for Kevin or anyone on this? It was sent along with the slides. Okay. It's an interesting mix of populations and populations with conditions, um.

**Kevin Larsen – Office of the National Coordinator**

Uh, so, so, again, we're still in the discussion phase, right –

**Helen Burstin – National Quality Forum – Chair**

Got it.

**Kevin Larsen – Office of the National Coordinator**

– so we, um – the, the work that has been done to date has been populations with conditions, and so that's the easiest place for us to start with where there is actually work.

**Helen Burstin – National Quality Forum – Chair**

Got it.

**Kevin Larsen – Office of the National Coordinator**

But there was real excitement about moving more to whole – patient-centered populations rather than populations by condition.

**Helen Burstin – National Quality Forum – Chair**

Great. Okay. Very good. so, at least on this slide, if you still can't see it, Kevin, I think the other thing is just the framework the idea would – it would support improved performance, reduce disparities encompass the aspects of the MU Stage 2 objectives, but not the one on one discussion Kevin gave us earlier, and more of the patient-reported outcome focus.

Okay. Next slide.

and this goes back to – this is the thing – I’ll do this one anyway. This is the one of the things when I spoke with Kevin and Heidi yesterday was, as we think about what criteria we might want to consider we did some work a couple years ago for ONC, actually, Heidi and I, looking at what would be potential criteria you could use to identify what potential eMeasures you might want to use going forward for future implementation. So, since you’re kind of on this criteria orientation, I thought it might be useful to pull it in as an example. This, this was actually emerged out of a lot of the same work as the Gretsky work that you discussed earlier, the Janet Corrigan et, Elliott Fisher work. So we really did refine with Paul Tang’s help and many others this set of criteria. So, very briefly, the state of readiness or the measures actually available.

HIT sensitivity, I think in some ways given the context of how this relates to the objectives is an especially interesting one. you know, for example, is there evidence that this was measures or any EHR systems that have the right kind of functions, you would likely result in improved outcomes or performance.

Thinking of ways to promote parsimony and some of that may get at that above-the-line orientation from where those cross-cutting population level measures. Next slide, please. The last three were about, you know, potentially, picking some of those measures based on how much potential – uh, sorry, I can’t speak today – preventable burden you might be able to alleviate. The fifth was really thinking about how it might support health risk status and outcomes assessment for much of the PRO focus we just heard on those last slide. And then, lastly, the sixth one there, which is the ability to – those measures could promote that longitudinal assessment over time.

So next slide. I think we’re then opening the discussion. essentially, I think the questions that have been teed up for the Quality Measures Workgroup today to begin this discussion really to brainstorm about what criteria could be used to determine if measures should be included for deeming of eligible providers? and we are talking about both eligible professionals as well as hospitals. and which existing EP measures, perhaps, as exemplars as Kevin referred to them earlier, would be appropriate for deeming? So there may be a logic to thinking about a set of criteria and then logically thinking about a couple of measures that may go along with that.

So Kevin, anything – Heidi or Kevin, anything else you’d like to share before we open it up?

**Kevin Larsen – Office of the National Coordinator**

Yeah. The only thing is I think that don’t just limit to individual measures. Maybe thinking of them as sets is something that we came to with the, with the ACO Workgroup ... not – so we couldn’t think of them just individually, but another way to do this is to think about measure sets, like a Million Hearts measure set, for example.

**Helen Burstin – National Quality Forum – Chair**

Okay. Well, a little bit harder to operationalize since all those may not be available. But, yeah, okay. That’s, that’s a helpful context. Let’s open it up. Any thoughts, reactions to what’s been presented so far by Kevin?

**Aldo Tinoco – National Committee for Quality Assurance**

Hi, everybody. It’s Aldo. Let me open up and I think it’s very interesting. And I’ve, I’ve run this by a couple of others here at NCQA and we are – there is support for this, uh. We’re also considering this type of deeming approach for renewals in one of our programs. Uh, so there is interest and we want to learn more, of course.

Also, there – in a couple of slides, there was a mention of the measures don’t have to map one to one with objectives then. and I, I think that makes sense. What would be also, of course, important and helpful, and forgive me if this obvious, is we do want to track, though, which of the objectives would be subsumed by the, the measures going forward if this deeming option were to – or when it comes to pass. It might be a one to many, but as, as we think about these things, let’s, let’s keep an eye on that.

**Helen Burstin – National Quality Forum – Chair**

I think that's a great point, Aldo. Eh, as I was looking at the core and menu measures earlier in the day before I looked at the same thing, don't worry about one to one, I had naturally, immediately started going down a list of core objectives and making notations for the kind of measures I thought that could be associative. So while it's not one on one, it's, it's a useful framing at least, perhaps, to begin the discussion.

**Aldo Tinoco – National Committee for Quality Assurance**

Thank you. I agree, and I don't want to jump the gun and talk about exemplars, but because of our recent interest and work in quality measure development and, and Kevin is asking us to think about families of measures care coordination measures may be one of those potential families that include not just the MU2 version of the closing or FROD measure where the report comes back to the referring provider, but there are other measures within this related set that not only makes sense to move along together or be implemented together, but also, collectively, they, they may provide different perspectives on the same clinical process that leads to a better outcome. So that may be one potential exemplar –

**Helen Burstin – National Quality Forum – Chair**

Yeah. Yeah.

**Aldo Tinoco – National Committee for Quality Assurance**

– we can talk about going forward.

**Helen Burstin – National Quality Forum – Chair**

Okay. Other thoughts, comments? Oh, boy, a quiet group.

All right. So, maybe, it's worth trying to think a little bit about what criteria you might use and whether any of the ones we had put up earlier, um again, from an, an earlier time, but I think trying to get somewhat at that same core issue might be useful. So, for example, the issue of being sensitive to HIT. Is that a way to think about if you're taking away an objective that's a more structural measure of your use of your EHR, would you then potentially, logically want to measure that might reflect, for example how that measure is actually, um – a perf, a, an eCQM that could actually demonstrate improved performance related to what – not necessarily one on one, but what, perhaps, one of those more structural interventions might be? So just, you know, as an example, not being one-to-one oriented, but certainly you know, if you thought about medication reconciliation as being one of the one of the items under the under the menu here be logical, for example, to think that if you're – if you have a set of uh, structural things in place, you'd probably do well in medical, on Medrack, and, hopefully, then likely to result in, perhaps, fewer medical errors and, perhaps, the measures of patient – of medication safety then might be a logical approach. Kevin, anything you'd want to add here?

**Kevin Larsen – Office of the National Coordinator**

Yeah. I would say I was thinking it's a quiet group. I was hoping the group might sort of think out loud a little bit. You know, some of the things that we've talked through with ACO Workgroup are what constitutes an outcome measure for this purpose. the outcome measures available to eligible providers are a little bit less robust than those available for large population hospitals or health systems. So is outcome measure here more something like LDL like goals or is outcome here stroke prevention? and, I think, I think that kind of criteria discussion would also be useful as a way to level set.

**Helen Burstin – National Quality Forum – Chair**

Uh-huh. Okay.

**Tripp Bradd – Skyline Family Practice, VA**

Kevin, this is, this is Tripp Bradd. *[clears throat]*, would that intermediaries be assisting us? Like, for instance small groups in this process?

**Kevin Larsen – Office of the National Coordinator**

Well, so, the goal of this is not to just tell you how to make this happen. You could make that happen in a way you wanted to.

**Tripp Bradd – Skyline Family Practice, VA**

[Laughter]. Okay.

**Kevin Larsen – Office of the National Coordinator**

The goal is to, to set up what the ta – what's the finish line that you can get to in any way you want to. You can run. You can walk. You can take a motorcycle. You can take a horse. But as long as you cross the finish line, you cross the finish line.

**Tripp Bradd – Skyline Family Practice, VA**

Hmm.

**Helen Burstin – National Quality Forum – Chair**

Okay. Anyone else?

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

Helen, this is Kathy Blake with AMA. And you know, as I, I look at this and I think you know, to the practical realities of a medical practice I think it'll be important for there to be almost some pretesting and demi-testing of these kinds of configurations to see for large swaths potentially on a specialty-by-specialty basis and at various practice environments to see if this is, is really feasible, 'cause I'm – I admit to being a bit concerned that the practicing physicians and especially those who are trying to engage in this, the smaller practices, the independent practices, they're already experiencing whiplash. And so I think some good kicking of the tires beforehand would be warranted.

**Kevin Larsen – Office of the National Coordinator**

Uh, this is Kevin. Uh, absolutely, we agree with you. Uh, the deeming pathway has always been viewed as an optional pathway. So, the, the discussions of the, of the Meaningful Use Workgroup are the just which there would be a traditional pathway and this would be an alternate pathway.

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

So, so, Kevin, this is Kathy, so that's helpful. So there would at – certainly, to the best of your ability at this point in time, you're not seeing that this would become a substitute for what's already available?

**Kevin Larsen – Office of the National Coordinator**

Well, there, there would be a Meaningful Use 3 that would have a large number of objective measures much in the same way that Meaningful Use 2 does. But for people that would rather, they could opt for deeming. And instead of attesting to all of the 17 objective measures, they could say I got these great clinical outcomes so I don't have to do 10 to 17 objective measures.

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

Got it. Okay. So side-by-side options.

**Kevin Larsen – Office of the National Coordinator**

Exactly. That has been the discussion and the charge.

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

Good.

**Tripp Bradd – Skyline Family Practice, VA**

So, this is Tripp again. Uh, this is for the gifted and talented huh –

**Helen Burstin – National Quality Forum – Chair**

Yes.

**Tripp Bradd – Skyline Family Practice, VA**

– using the educational model, I guess, instead of the equestrian model [laughter].

**Helen Burstin – National Quality Forum – Chair**

I'm a city person, Tripp. At some point, you'll have to explain the equestrian model to me, but it *[laughter]* sounds ...

**Tripp Bradd – Skyline Family Practice, VA**

And not the Gold Cup, right? Oh, yeah.

**Helen Burstin – National Quality Forum – Chair**

Okay. I think it is helpful thinking of it somewhat in that context, though – this is Helen again – that it is about you know, for those who are already – and, again, that, that first slide or one of those earlier first went over one of those earlier slides may the case be, these are people who already accomplishing those objectives. They're already top of the class already in terms of being able to do these more functional objectives. And so the question is can they avoid – to make sure I'm getting this right – can they avoid the check-boxing to make sure they're in fact doing them again in the next round? Or can they instead say I already did great the last round, instead I'm perfectly happy having you judge me based on my actual performance on highly relevant outcomes or other entities that would be, um –

**Tripp Bradd – Skyline Family Practice, VA**

Hmm.

**Helen Burstin – National Quality Forum – Chair**

– or other measures that would reflect that? Does, does that capture it, Kevin?

**Kevin Larsen – Office of the National Coordinator**

Yeah. Absolutely. That captures very well what, what Paul has been talking about all the way through. it's really to live out meaningful use, you know. Your meaningful use is actually your performance in improving care. And it's not your ability to check boxes about process.

**Helen Burstin – National Quality Forum – Chair**

Right.

**Tripp Bradd – Skyline Family Practice, VA**

Being out in the community – this is Tripp again – I will tell you that this might pluck a few more strings of the physicians in the right way to know that they could do something to make a difference versus meaningless is a, a frequent *[laughter]* term they talk about with meaningful use. you know, we're actually making a difference. I think this is a great aspirational pathway.

**Helen Burstin – National Quality Forum – Chair**

Yeah. Okay. Anybody else?

**Kevin Larsen – Office of the National Coordinator**

Does, does the group want to dive into maybe Aldo's example? Or do you want to talk a little bit more about criteria?

**Helen Burstin – National Quality Forum – Chair**

I think we can go in either direction of whatever the group would prefer. I mean I think in some ways Aldo's point may make it a bit more concrete from which, I think, criteria might emerge. So if that's useful, we can go in that direction.

So, Aldo, do you want to try to play out a couple of examples? Put you on the spot a bit maybe we just to get the discussion going.

**Aldo Tinoco – National Committee for Quality Assurance**

Let me think on my feet a little bit. So just, just to help everyone understand more about the concrete example. care coordination in the outpatient setting, we view it as a loop, which I'm sure you're familiar with, where it begins with the request of the referral by the requesting provider and the receipt of the request by the receiving provider, um. And then the information about that referral request, it follows along from the requesting provider to the receiving provider. So that's one end of the loop is getting the request out there through technology means as well as ensuring that there is sufficient or critical information provided with that request so that the recipient knows what to do with it. So it's not just sending a document saying are we sending the right information so that's, so that's actionable and we have decreased delays, um in terms of getting the patient to receive the services that will make a difference for that particular problem. And to, to bring the loop back or to close the loop is we want the receiving provider or the specialist, in some cases, to be able to send back certain types of information to the referring provider to close that coordination, that loop of coordination so that all of the members of the care team uh, stay on the same page.

I, I think that that particular example has elements of objective measures, of, of functional objectives where the EHR system must or the health IT module must be able to gather certain types of information automatically or by pumping the referring provider and transmitting that. Uh, and those are things which may be traditionally viewed as functional objectives.

the, the downstream to that, of course, is understanding, well, you know, did this actually lead to better coordinated care does this actually lead to tighter closures of the referral in terms of decreased time, decreased wait time. Um and then, of course, there are some ultimate downstream objectives.

So this particular example has a collection of aspects which can be quality, they can be functional. And if we think about it a little bit more perhaps this could be one of those places to start.

**Tripp Bradd – Skyline Family Practice, VA**

Aldo, this is Tripp. you know, and I'll use an example of our practice. We're kind of suffering trying to get through the standards of the patient-centered medical home ourselves. Uh, do you think there might be a, a real clear crosswalk to demonstrate to eligible providers that if they are you know, trying to reach these patient-centered medical home goals that they might be able to in fact, reach meaningful use deeming pathways?

**Aldo Tinoco – National Committee for Quality Assurance**

I believe that – and, Tripp, there are some discussions I believe to understand what the crosswalk is between the patient-centered medical home standards as well as the meaningful use functional objectives and the quality objectives. So this concept of deeming can cross programs if you will. I mean not only will a quality measure potentially fulfill a meaningful-use requirement. It also potentially or hypothetically, could fill, um a similar requirement in another program. Uh, that, that's something that folks are talking about internally as well and, and trying to make sure that that folks are recognized for both by doing the same thing right.

**Tripp Bradd – Skyline Family Practice, VA**

Yeah. Thank you.

**Aldo Tinoco – National Committee for Quality Assurance**

Yeah. And, yeah, we're, we're looking forwards to streamline the burden in places as well. So deeming helps.

I think what's interesting about the care core – the thing about criteria for care coordination again, there's not a true threshold of performance for care coordination to my understanding. I mean whether a provider has 75 percent of referrals closed in a timely fashion versus 85 percent. It's – there's no threshold, right? So this is an example. If we're gonna use our criteria for today's discussion where proven from Year 1 to Year 2 would be meaningful. whether or not it's meaningful for eh for the top 25 or for the top quartile, excuse me it's not really clear right now as to whether or not that would be the metrics though. In terms of criteria, this would replace where year-to-year performance that's reported and potential improvement by a site would be the way to allow deeming to occur, um.

**Helen Burstin – National Quality Forum – Chair**

Okay. Good example.

**Aldo Tinoco – National Committee for Quality Assurance**

You know, we – and we can continue walking down the, the criteria that Helen had mentioned through Kevin's slides.

You know, Health IT sensitivity, yes. I mean there are certain functions within the EHR or the Health IT Module that can support this whether it's through a panel of patients with a related concern or whether it's through reminders and notification that there are outstanding referrals that haven't been closed within a certain timeframe. So the potential for Health IT sensitivity is there for these as well.

**Helen Burstin – National Quality Forum – Chair**

Yeah.

**Aldo Tinoco – National Committee for Quality Assurance**

One thing that is – you know, and here's a criterion that may not have been directly mentioned you know, the status of NQF endorsement and where this measure fits in the pipeline. Uh, to use care coordination there is, um – you know, I believe there is, there's agreement that improving care coordination is very important and it leads to better outcomes and better care and better satisfaction both on the provider side as well as the patient side. Um the, those, those are meaningful outcomes. Uh, whether or not those are, those are the types of outcomes that would fulfill for example, NQF endorsement requirements, you know, those, those we'll be seeing soon when these measures are put forth for NQF or, um –

**Helen Burstin – National Quality Forum – Chair**

Uh-huh.

**Aldo Tinoco – National Committee for Quality Assurance**

– submitted to NQF for endorsement.

**Helen Burstin – National Quality Forum – Chair**

Right.

**Aldo Tinoco – National Committee for Quality Assurance**

And so, here, here we have a criterion that's important that's mentioned yet it's not clear where – whether or not these measures at – in this current state would fulfill that criterion. So it's interesting how this one example addresses some criteria fully or it could, but in other criteria it may not.

**Helen Burstin – National Quality Forum – Chair**

Right. I think that's the nature of criteria to a certain extent. Not that you have to get them all right, but does it at least, you know – and uh, again, we mainly put these up as an example of other criteria that have been identified to identify potential eMeasures, not necessarily that these are the ones we would think about necessarily, although that they are obviously – you know, if you looked, for example, at the Million Hearts campaign example, it would certainly fit, I think, around HIT sensitivity, parsimony and re, and preventable burden as well as actually health risk assessment. So, you know, there are some that obviously will fit better than others. I think state of readiness is also a bit in play at the moment *[laughter]* of exactly what that means in the current eMeasure environment and testing environment as lots of us have been talking about recently.

Anybody else have any thoughts?

**Kevin Larsen – Office of the National Coordinator**

So, so this is Kevin. Here's one thought. Um –

**Helen Burstin – National Quality Forum – Chair**

Okay.

**Kevin Larsen – Office of the National Coordinator**

– there's been a lot of a lot of requests for patient-reported outcomes to become a routine part of measurement. Uh, but although there are now patient \_\_\_\_\_ is becoming available their uptake is fairly slow. What would be the plates or what could be some criteria around patient-reported outcomes in this deeming framework?

**Helen Burstin – National Quality Forum – Chair**

I get your point, Kevin. I'm not sure I – this is Helen again – I'm not sure I understand how that relates back to criteria.

**Kevin Larsen – Office of the National Coordinator**

Uh, so a criteria could be you have to have one patient-reported outcome.

**Helen Burstin – National Quality Forum – Chair**

Oh, I see.

**Kevin Larsen – Office of the National Coordinator**

For example.

**Helen Burstin – National Quality Forum – Chair**

And –

**Kevin Larsen – Office of the National Coordinator**

That was a guess what I'm thinking question I proposed.

**Helen Burstin – National Quality Forum – Chair**

Okay. Good. Yeah [laughter]. I kind of thought that's where you're going, Kevin, but I didn't want to, I didn't want to jump, jump to that conclusion. Okay.

**Kevin Larsen – Office of the National Coordinator**

Well, so, maybe, we want to walk through the Million Hearts example and see if people feel like that feels like a good example. And, if it does, why it does? And that might help get us some more discussion about criteria.

**Helen Burstin – National Quality Forum – Chair**

Okay. That's fine. So that would be essentially, um uh, being able to sort of en, ensure people – just to make sure I'm, I, I, I'm getting this right – so people are screened. People have their blood pressure under control, their lipids in control and non-smoking. Is that essentially the package?

**Kevin Larsen – Office of the National Coordinator**

Yeah. That, that's correct. And the clot – so the blood pressure and cholesterol measures are both, um is the blood pressure at goal, is the cholesterol at goal?

**Helen Burstin – National Quality Forum – Chair**

Right.

**Kevin Larsen – Office of the National Coordinator**

And then, and then it's smoking currently smoking cessation counseling –

**Helen Burstin – National Quality Forum – Chair**

Right.

**Kevin Larsen – Office of the National Coordinator**

– is the requirement for smoking.

**Helen Burstin – National Quality Forum – Chair**

Okay. That makes sense.

**Kevin Larsen – Office of the National Coordinator**

And I guess you could throw diabetes – that goal in there as well.

**Helen Burstin – National Quality Forum – Chair**

Okay. So if we took that example as potentially what might be a set of measures that could be used to deem for some of these objectives people have a sense of how that might work in terms of criteria?

I'm happy to start if you would like. I mean, certainly you can just go through the, the older criteria, I think, getting people in control would certainly, uh – you'd want to ensure you've got systems that allow you to ensure people are effectively being screened in the first place, that you've got laboratory, um information getting to you in real time, that you've got reminders you're recording smoking status. So that example, I think, in some ways fits well. going back to the old criteria I think, you know, HIT sensitivity in my mind would be a check. Um uh, it certainly is a pretty high, if you think about it, a population level preventable burden. and it certainly supports health risk, status and outcomes assessment and longitudinality. So maybe that's actually not a bad framing in some ways of the way you would look at criteria to get to a set of eCQMs as exemplars, for example, um.

Thoughts? Does that work for folks? Other criteria that you think would be important to add to the mix?

**Aldo Tinoco – National Committee for Quality Assurance**

Uh so, so it's Aldo. And I, I think this is a great example. in my mind, I was mapping the, the, the first four or five elements back to functional objectives. So –

**Helen Burstin – National Quality Forum – Chair**

Yeah.

**Aldo Tinoco – National Committee for Quality Assurance**

– if, if, if – this makes perfect sense in saying, you know, once you've passed that first hurdle of getting to MU2 and you're just up for renewal, and if you're reporting these qual – clinical quality measures then the need for reporting those out isn't necessary. Uh, even with the diabetes, the fifth element there that makes sense, because there's some track record with those measures –

**Helen Burstin – National Quality Forum – Chair**

Hmm.

**Aldo Tinoco – National Committee for Quality Assurance**

– uh, both functional and quality measure.

I think the parsimony is a very interesting one there, because while typically all eligible professionals, and maybe all eligible hospitals, to be talking about screening, blood pressure control, lipids and smoking status. It's when you start getting to diabetes control where you – parsimony may have a little bit of an issue, because not all providers that a patient sees that are shooting for meaningful use would necessarily address diabetes. So, um –

**Helen Burstin – National Quality Forum – Chair**

Yeah.

**Aldo Tinoco – National Committee for Quality Assurance**

– and that's the, that's the one criterion in my mind that I think this may not be a eligible – excuse me – available for all meaningful users out there and they – because they simply don't control some of these things. Um –

**Helen Burstin – National Quality Forum – Chair**

Yeah.

**Aldo Tinoco – National Committee for Quality Assurance**

– that's, that's another – one thought.

The other thing is and just not to digress. I know that there were some criteria regarding improvement from year to year versus again a particular quartile in the, um – you know, of all performers. Um it's – one thing that would be very helpful to understand is what are the plans if there's any information now available, regarding the auditing or validation of what's being reported out there through clinical quality measures? Eh, that might be a hot topic; it might not be. But if we're talk – thinking about non-longitudinal ways of assessing improvement and we're thinking about comparing providers by performance even for the purposes of achieving meaningful use then that may be a piece we want to talk about at some point.

**Helen Burstin – National Quality Forum – Chair**

Uh-huh. Uh-huh.

**Kevin Larsen – Office of the National Coordinator**

Uh, Aldo, this is Kevin. Uh, I don't think that we have a comprehensive sense of what the auditing will be around the, the question for CMS.

**Aldo Tinoco – National Committee for Quality Assurance**

Thanks, Kevin. So, I mean, as, as I was mentioning, it's, it's good that we have the, the improvement of what's reported over time as, as a, as an indicator here just in case we don't have information about auditing available.

**Kevin Larsen – Office of the National Coordinator**

Well, the, the improvement is also an attempt to provide incentives to groups that have – uh, it's sort of another way to do risk adjustment. So if you in – are in a population for example, that has much less baseline blood pressure control you actually have a bigger opportunity for improvement than if you practice in a population where blood pressure control at baseline is quite high.

**Helen Burstin – National Quality Forum – Chair**

Okay. That's helpful. I –

**Kevin Larsen – Office of the National Coordinator**

So, so –

**Helen Burstin – National Quality Forum – Chair**

Go ahead, Kevin.

**Kevin Larsen – Office of the National Coordinator**

I was just gonna say, Aldo, you mentioned that Million Hearts, it could \_\_\_\_\_ similarly apply to, apply to everyone. I'll switch back a little and say, maybe, all adult primary care. But you – now imagine a pediatrician. You know, what, what could be the Million Hearts equivalent for a pediatrician aiming at deeming for meaningful use?

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

So this is Kathy Blake. I would add onto that. I think that it speaks to the need for us to really consider the Million Hearts as an example –

**Female**

Right.

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

– but there would be need for more than just this. and I go back to the earlier slides that talk about the sort of likelihood we might say or lesser uptake by specialist physicians as compared to primary care. What you've said, Kevin, identifies even within the primary care specialties that there will be individuals pediatricians, um. It could be people that really focus on adolescent medicine where this basically sort of knocks them out of considering this particular option. So seeing what the uptake would be and what the other options besides Million Hearts would be I think would give us some sense of how successfully, um – how successful this approach would be.

**Kevin Larsen – Office of the National Coordinator**

Yeah. So, Kathy, that's where we'd love your input, 'cause we, we – Paul and the Meaningful Use Workgroup have talked about this as being a pathway for specialists, who, who for many of them the objective measures aren't relevant. So if we could – if we can fashion this in some way, it might actually be a terrific option for specialists.

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

Right. So my own field, cardiovascular medicine, you bet *[laughter]* but an ENT surgeon more challenging. But this is where again, expanding the examples that could be applied might help. And we could certainly work through PCPI or potentially surveying our members if you wanted us to field some questions to where they would say, yep, my practice could do X, Y or Z. This isn't going to match my practice profile at all. it might just give us some – an early look at the actual uptake.

**Helen Burstin – National Quality Forum – Chair**

This is Helen. I, I think we've mainly been using Million Hearts to be illustrative more than anything else –

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

Yeah.

**Helen Burstin – National Quality Forum – Chair**

– kind of getting us thinking about it. but, you know, I think and if you – it also might be interesting if you want to just pull out the table that was sent to us that was started to be populated by the ACO Workgroup just in terms of thinking through what those eight accountable care subpopulations may be. It – you know, you, you could start to imagine more of our framework and criteria as you start thinking about subpopulations for which your practice or your – you know, or for which, for which you're responsible for and maybe have more generic assessments. to get back to Kevin's earlier point about if you look at the one that's listed as an example of total joint replacement, you might, for example, come up with a, a, a set of the kinds of measures that would be required for a given disciplines, not the specific measure, perhaps, but that it would be an outcome measure that included a patient report. It could you know, be required to include something that gets at efficiency in terms of efficient use of resources. just again, to get more of that triple aim perspective of what population health is, is often oriented towards.

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

And I'm gonna have to go off the call, but look forward to further discussions.

**Helen Burstin – National Quality Forum – Chair**

Okay. Thanks, Kathy.

**Kathleen Blake – Vice President, Physician Consortium for Performance Improvement – American Medical Association**

Thank you.

**Helen Burstin – National Quality Forum – Chair**

Um – \_\_\_\_\_ if Norma was still on the line. I was curious to get a non-doc perspective. Norma, are you still with us?

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

I am.

**Helen Burstin – National Quality Forum – Chair**

Uh, any thoughts? As you think about this?

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

Uh, well, I keep looking at the eligible providers –

**Helen Burstin – National Quality Forum – Chair**

Yeah.

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

– and think of probably some advanced nurse practitioners –

**Helen Burstin – National Quality Forum – Chair**

Uh-huh.

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

– who might be very much involved with these measures. But then I also think, particularly when we get to care coordination –

**Helen Burstin – National Quality Forum – Chair**

Yeah.

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

– there's so much more to that that I don't know whether one waits, um for another set of, of measures or – because now it's so limited with just going from specialist to specialist back to specialist. So it's it, it's, it's a very limited approach from, I think, the viewpoint of the, the broad perspectives of nursing. And I hear the holistic. I hear the other terms you used. But it's hard to reflect that in the measures that are under consideration.

**Helen Burstin – National Quality Forum – Chair**

Yeah. That's a very good point, especially since few of those have been, uh – are yet available on the eMeasures space, which I guess was to your point, Kevin, if you're still with us. I think this question of, you know, what's the timing of when these measures would need to be available would be helpful? 'Cause, as you pointed out earlier, some of them just may not be there yet as eMeasures.

**Kevin Larsen – Office of the National Coordinator**

Well, so, if you remember, Meaningful Use 2, the pro, the reporting year starts for many people in 2014. so, for Meaningful Use 3, that we're looking at least at 2016 or beyond that these measures would have to be available.

**Helen Burstin – National Quality Forum – Chair**

Okay. So we really can think quite prospectively about – eh, eh, to Norma's point about what could be and what might these more holistic measures look like that would actually be appropriate for this deeming pathway.

**Kevin Larsen – Office of the National Coordinator**

That's correct. So, for example, the Promise 10 was one listed at the top –

**Helen Burstin – National Quality Forum – Chair**

Right.

**Kevin Larsen – Office of the National Coordinator**

– by Elliott and Janet. And you could imagine if that could apply to nearly any specialty, because it's the global functional status assessments. And, presumably, that should at least stay the same or have some, some expected trajectory with the kind of practice that you have.

**Helen Burstin – National Quality Forum – Chair**

Yeah. I wish we had more research there, but we have till 2016, so *[laughter]* maybe that's helpful.

Healthy Days is an interesting one that also might be applicable broadly across multiple specialties and a more holistic view as being a logical one. Certainly, the patient experience measures.

now, do, do you view any of those more patient experience measures Kevin, if they're, if they're not somehow tethered in some way towards an EHR? Do those – are those still fair game?

**Kevin Larsen – Office of the National Coordinator**

I think that's the, the kind of thing we want this group to, to give input on.

**Helen Burstin – National Quality Forum – Chair**

Okay.

**Kevin Larsen – Office of the National Coordinator**

the discussion of the ACO Workgroup is they're absolutely at play. the ACO Workgroup is looking at total cost of care, for example, and readmissions as a couple key examples they might use. but, but you can see why those have more relevance to an ACO than they might to an individual provider.

**Helen Burstin – National Quality Forum – Chair**

Uh-huh. Uh-huh.

**Aldo Tinoco – National Committee for Quality Assurance**

And it's Aldo. Thanks for highlighting that Helen and Kevin, because as one can imagine, um some of the secret sauce to success of CAPS and other patient experience tools has been their anonymity of the respondent. you know, it's good to open this up to other types of health IT that are not necessarily EHR, EHRs managed by a provider, because, oh, you know, that may skew the responses of the patient and bias them so that they're not looked unfavorably upon or they don't – they're not really concerned about the provider changing their behavior a certain way, because – based on a bad review, for example. So opening this up to non-EHR types of health IT, it would be very meaningful.

**Helen Burstin – National Quality Forum – Chair**

Okay. That's actually helpful, 'cause I mean it, it, it does open up the box of what's potential there and also greater alignment than to the other programs the other CMS programs as you pointed out earlier, Kevin although it doesn't feel quite as tethered to meaningful use, um. Okay.

Other thoughts? Getting the sense from the – this feels a little, um ethereal an exercise. So, perhaps one option might be for us to try to come up with you know, maybe, a modified set of criteria of what we were just looking at earlier to see if that works and, maybe, come up with a few examples that we could potentially walk through with the Meaningful Use Measures, um seeing if the criteria kind of play out for a few other areas.

**Kevin Larsen – Office of the National Coordinator**

Yeah. And, maybe, what would be helpful, Helen, is if this group would give some input in what, what would be the boundaries of those exemplars? Do you want us to do it by specialty type? Do you want us to do it by patient populations? Should we do it by programs like Million Hearts? What's the, what's a way that we could help the group cu – sort of clarify thinking?

**Helen Burstin – National Quality Forum – Chair**

Okay. Any thoughts on that for those of you who remain on the line? I'm just afraid were – we, we lost some folks. I think we're down to a precious few. Um –

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

This, this, this, this is Norma. May, maybe, one takes an example from a couple of different perspectives.

**Helen Burstin – National Quality Forum – Chair**

Uh-huh.

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

So I particularly would be interested in frail elders, for example, because it has the whole set of things for it. Uh, I don't know if that's a population of focus more age focused. But, maybe, a, a couple of those that would be framed a, a different one, take one population, one disease, one specialty.

**Helen Burstin – National Quality Forum – Chair**

Yep. \_\_\_\_\_ good idea. Yeah.

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

\_\_\_\_\_. I think it, I think my, my – I think you're getting a lot of silence today, 'cause some of us have not been intimately involved in this and so we're thinking very carefully. Where I think some of you have been working on this almost every day. So we're trying – I'm trying, particularly, to listen and absorb and give some careful thought to it. So, maybe, if one had some examples after this initial overview, we would be able to be a little more responsive.

**Kevin Larsen – Office of the National Coordinator**

Yeah. Norma, this is Kevin. This is exactly the same thing that we've been going through with the ACO Quality Measures Workgroup. It really took a, a, a discussion or two before people felt like they had enough of a sense of where to go. This is so much in the formative stage that, that we hate to over-prescribe your thinking to limit it but it is a little blue sky. So this is the same place the ACO Workgroup is in.

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

And, and I think – this is Norma again. I think we would really like to be helpful. I know I would. But I also am a – kind of somebody who really thinks things through. So if you could just think of us as a new – as another group that you might have to spend a little more time in order to benefit from our input.

**Kevin Larsen – Office of the National Coordinator**

Absolutely.

**Norma Lang – University of Wisconsin – Professor of Health Care Quality & Informatics**

Thank you.

**Helen Burstin – National Quality Forum – Chair**

And, and isn't there an ACO Workgroup coming up this week as well, heaven, uh – heaven, listen to me. Okay. *[Laughter]*. Kevin and Heidi?

**Kevin Larsen – Office of the National Coordinator**

\_\_\_\_\_. There is one on, there's one on Friday. So we'll be, we'll be continuing to work with them, but we've given them permission not to focus on the eligible providers. So they're charging ahead on big populations and group reporting.

**Female**

Ooh, that would be neat.

**Helen Burstin – National Quality Forum – Chair**

Okay. But it, it still may, I, I think, be quite iterative though, Kevin, that if we hear their thinking, I think it may give us more grounding for this group as well.

**Kevin Larsen – Office of the National Coordinator**

Absolutely. Well, we'll keep feeding things back and forth. There's quite a bit of cross-pollination between the two groups by design.

**Helen Burstin – National Quality Forum – Chair**

Right.

**Kevin Larsen – Office of the National Coordinator**

And that group is a subgroup of your groups, but they will eventually report back to you their finding for you to report to the Meaningful Use Workgroup and ultimately to the Policy Committee.

**Helen Burstin – National Quality Forum – Chair**

Great.

**Kevin Larsen – Office of the National Coordinator**

Um –

**Helen Burstin – National Quality Forum – Chair**

And can you re, re, remind us when that discussion will happen with the Policy Committee? What's the timeline here? \_\_\_\_\_.

**Kevin Larsen – Office of the National Coordinator**

Michelle, do you want to highlight that? Are you still on?

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

I'm still here. So the Meaningful Use Workgroup was hoping for draft recommendations in October. So it's a very fast timeline. The October meeting is October 2<sup>nd</sup>.

**Helen Burstin – National Quality Forum – Chair**

Ah, okay. Okay. Uh-huh. Okay. So maybe, just to wrap this portion of it up maybe we'll try to take the input we've had today, maybe, assemble something on e-mail we could share back around with folks. And I believe I'm on the call next week with the ACO Workgroup, and see if maybe we can present some of this thinking and do a little bit of back and forth to see if we can get something we can send out to all of you to kind of chew on a bit.

**Female**

That would be good.

**Helen Burstin – National Quality Forum – Chair**

Okay. All right. so I, I think we probably should just – and I'm not sure we actually need to spend too much time on this last portion. I just want to sort of at least mention the fact that we recognize we haven't met for a little bit in terms of the Quality Measures Workgroup.

And there are a couple of things we know we're gonna want to return to like this innovation pathway, which we had talked about a couple months ago which was specifically grounded in the role of data intermediaries in terms of the innovation pathway, but not as much grounded in you know, providers and clinicians and other innovators who might want to use that pathway. So that's something we'll potentially want to return to as well as we did a lot of work early on about what would be sort of measure concepts going forward for Meaningful Use. and I thought it might be helpful to return to that, obviously not today in terms of what the planning is for Meaningful Use Stage 3 and what is the role of the Workgroup.

and I was just curious if there are any other issues that you'd want to tee up. But, perhaps, just given our small numbers today, we'll just save that for an e-mail discussion with the full group when we send out the materials.

so, perhaps it might actually be a good time – unless anybody has any other comments to open for public comment.

**Female**

Uh-huh.

**Helen Burstin – National Quality Forum – Chair**

Okay.

**Public Comment**

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

Okay. Operator, can you please open the line?

**Ashley Griffin – Altarum Institute**

If you are on the phone and would like to make a public comment, please press Star 1 at this time. If you are listening via your computer speakers, you may dial 1-877-705-2976 and press Star 1 to be placed in the Comment Queue. We have no public comments at this time.

**Helen Burstin – National Quality Forum – Chair**

Okay. Thank you very much. All right. So, perhaps, we'll give you back 12 minutes in your day. And safe travels travel, travels to Kevin. And we'll try to get some material out to you on paper to, maybe, make it a bit more grounded for reactions.

**Kevin Larsen – Office of the National Coordinator**

Thank you much. See you soon.

## **Public Comment Received During the Meeting**

1. Why not adopt existing PQRS quality measures as eQMs for MU, for example there are 5 such measures for eye care that are NOT currently EHR-reportable. It seems unfair that specialists would not be able to "deem" for lack of available "performance eQMs", particularly for something so common yet detached from general medicine as eye care.
2. How about a patient-reported outcome for their experience with the "View, Download, Transmit" to 3rd Party" objective, as a eQM to optionally replace this MU measure.