

**HIT Policy Committee  
Quality Measures Workgroup  
Transcript  
Friday, November 15, 2013**

**Presentation**

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

Thank you. Good afternoon everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Quality Measures. 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. I'll now take roll.

**Helen Burstin, MD, MPH – National Quality Forum**

I'm here.

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

Gary Cullen. Kathleen Blake. Chris Spoon. Tripp Bradd.

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

Here.

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

Russ Branzell. Cheryl Damberg. Timothy Ferris. Lisa Fisher. David Kendrick. Charles Kennedy. Saul Kravitz. Norma Lang.

**Norma Lang, RN – University of Wisconsin**

Here. Norma is here.

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

David Lansky. Marc Overhage.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

Present.

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

Hi, Mark. Eva Powell?

**Eva Powell – National Partnership for Women & Families**

Here.

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

Hi, Eva. Sara Scholle? Cary Sennett? Jesse Singer? Paul Tang? Kahlan Taylor-Clark? Aldo Tinoco? Jim Walker?

**Jim Walker – Chief Information Officer – Geisinger Health System**

Here.

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

Hi, Jim. Paul Wallace? Mark Warner? Mark Weiner, I'm sorry.

**Mark Weiner – Perelman School of Medicine, University of Pennsylvania**

Here.

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

Olivier Bodenreider.

**Olivier Bodenreider, MD, PhD – National Library of Medicine**

Here.

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

Niall Brennan? Ahmed Calvo? Caroline Clancy? Westley Clark? Kate Goodrich? Daniel Green? Peter Lee? Marsha Lillie Blanton? Michael Rapp?

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

Westley Clark is here.

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

Thank you. Stephen Salmon? Tony Trenkel? Jon White? Are there any ONC staff members on the line?

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

This is Kevin.

**Lauren Wu – Office of the National Coordinator**

Lauren Wu.

**Kim Wilson – Office of the National Coordinator**

Kim Wilson.

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

Thank you, guys, and I will turn it back to Helen.

**Helen Burstin, MD, MPH – National Quality Forum**

Great. Thanks, everybody, welcome again. Not a large group, but we're glad to have you. This is our chance to go over with you what transpired at the Policy Committee Meeting and get continued input from you. So, Kevin, should I just walk through these or would you like to?

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

It's up to you, Helen, if you'd like me to I can, but go ahead.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay, next slide, please, Michelle, or Lauren.

So as I mentioned, we want to give you a little bit of feedback about the deeming recommendations that were brought forward to the Policy Committee. We'll continue some discussions about deeming. We've cued up some questions for you. And then as relates to the questions you'll see a couple of additional exemplars or examples of what these CQM sets could look like depending on ETEH's or perhaps a new version, a blended version of the two. So next slide.

So in terms of the discussion last week, I think, the Policy Committee generally was in agreement with the proposal on deeming. They did have some questions, as we did as well, about how to operationalize it and really think about how top performance correlates with deeming. Those are going to be issues where we need to think through. We've been given back this charge to think through additional work on deeming, and the ACO Quality Measures subgroup will continue to go back to their original charge. They had original areas to look at around ACOs and population health, but for now the deeming issue has been kicked back to our court. So next slide.

So I think Kevin and Lauren wisely decided we want to just put this slide in since it was pretty unclear at the Policy Committee a couple of key things about deeming and some assumptions here. The first is that this optional deeming program would only be if you are already a high performer in Stage 1 and Stage 2, and it applies to functions that were part of Stage 1 and Stage 2. So, for example, a new MU objective couldn't be eligible for deeming, and of course deeming is optional, at least as is currently conceived for Stage 3. Next slide.

So based on our discussion with you and the ACO Quality Measures subgroup, we put forward a set of potentially next steps that we would need to work on around this topic area of deeming, and actually this raises a lot of very important infrastructure issues, so I'm glad we've got some folks who have a lot of thoughts about those issues on the call with us today.

The first was really beginning to think about how the program might be able to evolve to be able to allow potentially eligible hospitals and eligible professionals to report and measure together to get at those more measures that matter for more mutual benefit, potentially looking towards more of a group reporting option. Thinking about this next step of how does population health align with some of the new business models we talked about on our last call in terms of accountability.

And then really I think a major take-home, a lot of discussion at the Policy Committee overall about this topic as well, was that interoperability matters. And that in some ways, measures that could depend on data from outside the current provider/organization would be prioritized, and that there also could even be further than even relationship between the EPs and the EHS to actually think about measure coordination with non-eligible providers, like behavioral health or long term care. And we'd also need to think through – which I think is more so for the ACO group—the infrastructure and the architecture for what ACO measurement would look like. So next slide please.

So the next couple slides lay out the criteria as we put them forward. The first column there applies across all the different categories – EPs, EHS, as well as this broader population focus. Very briefly, the first being the idea that it is somewhat HIT sensitive or leveraged data from HIT systems, longitudinal view of care, supporting health risk status and assessment and outcomes. And then the second column, more applicable certainly at the group or population level would be the idea that you'd want to try to get to the point of having reporting once across programs that aggregate data rather than having multiple different measures for different programs. Obviously it would be applicable at the population level, and again, considering it's a pretty heavy lift, the thought would be that hopefully these measures as they come forward at that level, the benefit would outweigh the burden. And then finally, similarly to the other column as well, this would actually – actually move us closer towards the idea of shared responsibility across providers for a more patient-centered approach. Next slide.

And a few additional ones listed on this slide, a little bit more detail. As I mentioned, the one about HIT – leveraging data from HIT systems, for example, CDS systems. The second one has a bit more detail about this longitudinal view of care, really thinking of care over time, very patient centered, across EPs or EHS, across groups of providers, and potentially with eligible – non-eligible providers as we mentioned, and help with assessment and outcomes, one we mentioned earlier, to really help drive improvement. Next slide.

And again, I think I've actually gone through these. This just lists out the programs and a bit more detail here about the one-time programmatic reporting, and applicable to populations. I think I've actually kind of gone through all of that. The last one really is, I think, really important, about the collaboration or interoperability across settings and providers.

So with that in mind – next slide please – when we had our pre-call, Kevin and Lauren and I had a chat about how it might be helpful to work through a few more examples of these exemplars as we call them, if these measure sets that are applicable – potentially applicable – and we tried to sort out a couple of examples, and you've got these slides. So difficult to look at all on the screen, but the first one is really a service line that's largely applicable to an eligible hospital setting. The second one is largely applicable to an eligible professional setting. The next one would be more a set that would require – the next world would require collaboration as well.

So just briefly going through each of these, the first one here – and thanks to Heidi Bosley for putting these together – so Large Joint Care. You can easily see the measures listed here. These are actually for the most part almost all outcome measures – complications, readmissions, mortality, functional status, after knee or hip – and although individual surgeons and other providers, PTOT, are involved, it would largely be a measure set that could be primarily applicable to the eligible hospital setting.

In contrast to the next one – next slide please – which is a service line example of rheumatoid arthritis, where if you look down the list of measures they are primarily ones that would occur in the more ambulatory setting, so likely to be more eligible professional related, primarily a blend of process and outcome here, but not ones that would necessarily require information across a broader – beyond the EP setting. Next slide please.

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

Can I just remind everyone, if you're not speaking, if you could please mute your eyes, we're getting some feedback.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay, and there was a question, I'm sorry.

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

Helen, I've been confused, can you just define the low, medium and high?

**Helen Burstin, MD, MPH – National Quality Forum**

Oh, I'm sorry, we kind of whipped through that because we've done it before. So I think the idea here was – and this was Heidi's attempt to just sort of really, on face value, say would this be high, medium or low in terms of how well it would fit that particular criteria. So if you look, for example, here at the Million Hearts Exemplar that's up, having, you know, a measure that's focused exclusively on AMI total cost of care would rate low on health risk outcomes and improvement, but would rate quite high on benefits outweigh burdens and promotes shared responsibility, as an idea, as well as longitudinal view. So it's just to give us a sense of across the color spectrum, are we generally seeing that these criteria would kind of work. But again, this is something for discussion today because we're trying to get a bit more into the details of understanding how it might work, and in which kinds of settings, which kinds of providers. So does that help?

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

A bit. I think if we discuss it more and get specific.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay. Well, let me just wrap up.

**Lauren Woo – Office of the National Coordinator**

Helen, this is Lauren. Heidi did provide us some notes about what assumptions she made in making these sort of subjective rankings on her end, so if folks have interest we can kind of go through what her assumptions were and whether the group feels those are right.

**Helen Burstin, MD, MPH – National Quality Forum**

Sure, and if nothing else, we should probably share it with the group.

**Lauren Woo – Office of the National Coordinator**

Sure.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay, great.

**David Lansky - Pacific Business Group on Health - President & CEO**

Helen –

**Helen Burstin, MD, MPH – National Quality Forum**

Yes, go ahead.

**David Lansky - Pacific Business Group on Health - President & CEO**

Hi, it's David. I wondered about the applicable to population. Can you just explain what that column means?

**Helen Burstin, MD, MPH – National Quality Forum**

I believe that is the one that specifically refers to the criteria that was specifically recommended for potential deeming more at the population or group level, David, and the idea would be that these measures would be most reflective of the broadest possible patient experience.

**David Lansky - Pacific Business Group on Health - President & CEO**

I didn't follow it. When I saw both for the arthritis and joint replacement examples it was very negative, but I couldn't quite compute what it signified.

**Helen Burstin, MD, MPH – National Quality Forum**

Right. No, I think it's a valid point.

**David Lansky - Pacific Business Group on Health - President & CEO**

Okay.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay, so this is the Million Hearts Exemplar, which I think if you look down it, you can again see that there's – to really be able to accomplish the full range of these you would likely need to have some clear coordination between eligible hospitals and eligible professionals, particularly when you're getting to some of the, you know, for example, the total cost of care that might include inpatient and outpatient, for example, or being able to actually get somebody in adequate control.

And lastly – next slide – the Frail Elderly example here again clearly would require – not as much green across this one – collaboration, coordination and hopefully interoperability across those settings to really be able to look at, for example, something like readmission, total cost of care, as examples. And in some instances, this might be an example where you might even want to bring in the non-eligible entities like post-acute or long term care entities who might be able to provide additional data to really help with these.

So, Kevin or Lauren, anything you want to add before we open it up?

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

Only to say that these mappings are just Heidi's, as you said, base value mapping, and certainly if people think it's worthwhile we can do this other ways, or spend time on the specifics of the mapping. But don't get too caught up on just exactly how they're mapped, it's an example.

**Lauren Wu – Office of the National Coordinator**

Right, and I would also add that Heidi used existing measures for the exemplars, but we clarified that we're not limited to existing measures for recommendations for sets for deeming. We could if we thought there were some gaps for measures and make recommendations to those for a good set that could be used for deeming.

**Helen Burstin, MD, MPH – National Quality Forum**

Right. Right, thank you for that clarification.

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

This is Westley. That would include primary care and a package for mental health conditions like depression or alcoholism?

**Helen Burstin, MD, MPH – National Quality Forum**

Yes, potentially yes. Heidi did a whole number of additional exemplars, we didn't want to overwhelm you.

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

Not a problem. I agree, I just wanted to, you know, be able – a little reminder, that's all.

**Helen Burstin, MD, MPH – National Quality Forum**

Absolutely.

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

Thank you.

**Helen Burstin, MD, MPH – National Quality Forum**

Sure. So I think that's all the formal presentation we have. Actually, David, you were at the policy committee, any reflections on the broader conversation?

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

I think as you said today, the group still is getting clarified on what is intended by the strategy, and there was a strong interest in the population health dimension and the linkage to public health. So I think the content that we're looking at here is just very well aligned with what we heard from the policy committee.

**Helen Burstin, MD, MPH – National Quality Forum**

Right. Other thoughts?

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

Helen, this is Michelle. I would just like to add that following the Policy Committee, Paul did bring up deeming at the Meaningful Use Workgroup meeting, and there was some discussion just because, as you know, every time deeming has been brought up there is always kind of a back to basics about what it is and how, you know, who will be affected. You know, you included the assumptions in today's presentation, but based upon all the questions that come there typically – there was a discussion during the Meaningful Use Workgroup that perhaps there may be – it may be more difficult than originally thought to execute and operationalize, so that's just something they're considering. So this work may not necessarily develop into a recommendation for deeming but has certainly helped understand where measures could possibly be going and could help in community efforts, but just to kind of share the information that was discussed at the Meaningful Use Workgroup. David, were you on that call too?

**David Lansky - Pacific Business Group on Health - President & CEO**

I think I was only on part of it so I don't have anything to add.

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

Okay.

**Helen Burstin, MD, MPH – National Quality Forum**

Reactions from others? Do people have any concerns about at least the initial set of criteria as put forward or this idea of really, I think, one of the important issues is going to be really thinking through can this work in the context of the current program, and, you know, how can we continue to push on the interoperability angle to be more patient-centered.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

Helen, this is Marc, and maybe I'm thinking about this wrong, we're looking at this from the quality measures standpoint. There's another sort of layer of deeming issues that we're not sort of accountable for figuring out that have to do with the kinds of organizations that are making these other measures and the scale of those organizations. Our scope is just good measures.

**Helen Burstin, MD, MPH – National Quality Forum**

I'm going to turn to Kevin for that answer.

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

Yeah, this is Kevin. From what we've heard from Paul, the Meaningful Use Workgroup will take on the policy details of the deeming program. So which measures would be eliminated and kind of what the scaling might look like in the measures space. And our job is to help come up with measures we have and measures we want and kind of frame around how the measures would work to do deeming.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

So that's the part where it starts to cross over a little bit and why I asked the question, Kevin. How the measures would work. Is that sort of in scope for us? Then there might be some discussion we'd want to have around that, because I don't think we have. We talked about the characteristics of the measures, not so much about – so, for example, in other venues we've talked about the issue of if this is going to be helpful that there may need to be some scale specification. In other words, these measures may need to apply to 80 percent of providers in a particular specialty or something in order to be useful, but that starts to segue into the policy side and I wasn't sure where the boundaries ought to be.

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

I would say that is stuff you should go ahead and discuss. Paul and group are very willing to listen and take advice and input from us, so I would say go where you feel you need to.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

And I don't want to take the group somewhere you don't want to go, Helen, but I guess this is sort of the – so we've got this framework for measures, good, so you get a measure, somebody had done something and they want to participate through deeming. They've done some measures that fit the kinds of criteria and fit into the framework that we're describing, but it's, for example, the orthopedists in Montana, and only Montana that are doing it. So is that a useful measure for deeming or not. I don't think it is if it's just the orthopedists in Montana who are doing it.

**Helen Burstin, MD, MPH – National Quality Forum**

I think it's a valid question. I don't think you're taking us off topic at all. I think that's really what we need to tackle.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

It's one dimension, it's sort of the scale of, you know, how many providers are doing it to be useful to payers, to CMFs, to patients, you have to be able to compare it. Or, you know, or something. And there are some other things like that, I think, about, you know, for example, the organizations that are creating these measures, there's probably some obligation to maintain them, because people are going to gear up and do all the work to start measuring these things, and then the measure goes away next year because it's not updated and maintained.

**Helen Burstin, MD, MPH – National Quality Forum**

Yeah.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

You know, where are ya? So it's sort of protecting the providers, if you will.

**Helen Burstin, MD, MPH – National Quality Forum**

Yes, so some of this goes back to some of our older discussions about this –

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

Yeah.

**Helen Burstin, MD, MPH – National Quality Forum**

Pathway for innovative measures.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

I don't want to duplicate things but it feels like it has a lot of the same issues.

**Helen Burstin, MD, MPH – National Quality Forum**

Yes. And, you know, maybe that's a question more so for the Policy Committee and the MU Workgroup, but I'd also wonder whether there is an expectation or not that these measures that could be used for deeming have to be comparable, or is it sufficient to have some of the really, really innovative measures that matter kind of out there in that space and feed innovation as opposed to feed comparable performance, and this is where, you know, it's still not clear. Is it about \_\_\_\_\_ [beeping/cuts out] active reporting them, or is it really about looking at different levels of performance, at least in this program.

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

Helen, this is Kevin. I would say that's open for discussion. Paul has talked in the past about it being about performance, but I would say that he knows, so feel free to discuss, because it's not fully articulated.

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

This is Tripp. What is the definition of a high performing eligible provider or hospital? I mean, is that some percentage of some measure or what does that mean?

**Helen Burstin, MD, MPH – National Quality Forum**

Kevin, can you take care of that?

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

Yeah, so, what the Meaningful Use Workgroup has been talking about is looking at the prior years' data, or having that group look at their own data over the course of the year that would compare to the benchmark of those measures in the prior year. So it would be it assumes that there is aggregated – because remember this starts in about 2016 or 17, so there will have already been data aggregated on the 2014 and potentially some even on the 2015 results of these measures, and that would serve as the baseline that people could then benchmark to for performance here.

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

This is Tripp again. The other perspective would be, you know, if someone may not be the highest performing but showing good improvement that is dealt of change across different years that would allow them to qualify for deeming. In other words, trying to get people to aspire to this particular deeming path. Is that a concept that's been discussed?

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

Yes, this is Michelle. So from the Meaningful Use worker perspective, they discuss, I want to say top quartile and those who have, you know, they're still talking about percentages, but some percentage of improvement to both options that were just discussed.

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

Thank you.

**Helen Burstin, MD, MPH – National Quality Forum**

Anybody else want to reflect on this question? I think it's a really important one.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

[Laughs] Everybody's tired.

**Helen Burstin, MD, MPH – National Quality Forum**

I know it is a tough time of day on a Friday. This week hasn't felt short, even though it was short. [Laughs] All right. Well, maybe these are questions we need to perhaps key up, Lauren and Kevin, with a bit more background and series of questions to kind of lead people through them with perhaps some options that emerge out of the Meaningful Use Committee, because I think it is – it is kind of hard to know which direction to go if we're that really into the policy details. And maybe the better use of our time in the short term is really thinking about if you have these criteria that we just walked through, it might be helpful particularly as we think towards Meaningful Use Stage 3, of what kinds of measures perhaps that aren't even available yet, could help satisfy these and populate these exemplars. That may not yet exist, but would reflect that, you know, interoperability and patient centered view etcetera. So it would be useful, Michelle, to go back to the slide with the criteria, maybe slide 5, and just leave that up for a moment. Super, thanks.

So this issue of preference for reporting once across programs is an important – this issue we just discussed of whether it's about reporting or performance is going to be especially important because you'd want to make sure the measure is in fact comparable if somebody could then use it for one of the pay for performance programs through CMS as well. Like a value based purchasing program for hospitals.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

I guess to me we're getting beyond the just reporting stage, and that we ought to be looking towards measurement.

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

Yeah, I'm with Marc, and what it opens up for me is all the infrastructure questions which maybe aren't our purview, that any of the measures we might want to anticipate as desirable and we think they may be used for payment and performance measurement, then we raise all the high stakes questions about the quality of the data and the comparability and risk adjusting and all those things. But that next generation of measures, where there's some crosscutting issues we should be thinking about now that would put in place a stronger infrastructure to support those uses. Not only so what the measures are but what the cross cutting attributes are that permit them to be valuable.

**Helen Burstin, MD, MPH – National Quality Forum**

Mm-hmm. Kevin, does that seem like a logical path for us? I want to make sure we're not stepping on anybody else's infrastructure toes.

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

I think that the APO Quality Measures Workgroup is going to focus on some related things, that they have very much an ACO frame and I think this is not the same frame as that, so not at all.

**Helen Burstin, MD, MPH – National Quality Forum**

Great, okay.

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

Well we do have to – this is Westley – we need to make sure that that's understood by the ACO Workgroup, particularly if we're talking about measures that have utility for pay for performance.

**Helen Burstin, MD, MPH – National Quality Forum**

Right.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

Is there anything that we want to think about – like you said, we will set these things out, but I'm just generating some ideas here if that's helpful. Something around the scale, like, you know, so if there are – I'm making this up – if they're – how many measures are helpful. And this gets to some of these fundamental things that we're starting to wrestle with. You know, is it 400 process measures or is it 25 good outcome measures? If there's something about the general size? If we just said, here's what an individual measure should be like, how about the suite of measures? Are there things we want to say about it should be multi-dimensional and it should capture – represent 25 percent or more of the care ... is there something about the collection of measures that we want to say as opposed to just what the individual measures get at?

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

This is Tripp. The other thing that I thought about as far as groupings is basically that's an organizational thing that the organizations will provide. For instance, the patient centered medical home wouldn't have any measures related to the hospital but they may have things like closing the referral list and things like that. So the organization is critical to this whole process. So if it's out of our scope, it's going to be hard for us to decide what measures are going to be actually addressed, wouldn't you think?

**Helen Burstin, MD, MPH – National Quality Forum**

Yeah, I think that seems logical. And the question would also be, I think, potentially, logically from that would be could you look across a set of measures for EPs and then a set of measures for EHs, and think about some of the key cross-cutting themes that you're all raising and seeing if the set of measures gets you there, or is there also potentially an opportunity to think about, you know, a new set of measures that really do require interoperability across hospitals and outpatient settings that could be more patient focused.

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

This is Tripp again, we'll pick on NCQA for the time being, but you know, just by being recognized or having a certification with that would take care of all of these items because of the organizational reporting structure that they have, I would think. And the goal, I thought, was to, if you will, make it a stapled easy button for the particular, you know, clinical organization that wanted to do the deeming path. Is that what the ultimate purpose of a deeming path is is the right to perhaps have people aspire to that with organizations that cover all those particular thoughts and ideas and processes. Am I off base here?

**Helen Burstin, MD, MPH – National Quality Forum**

I don't know, what do people think?

**Joe Francis**

Let me reflect back on that. I spoke at a meeting in Orlando about deeming, at least how I understood it. I presented it like that, and groups liked that idea. They again, Meaningful Use Group for some is considered a burden in that they were already doing something – back to David's cross-cutting perspective – if they're already doing some of those things in other realms that are health IT sensitive anyway, they really jumped on the idea of, hey, wouldn't it be nice to be recognized with an organization that would be, if you will, a deeming organization for ... at Stage 3.

**Helen Burstin, MD, MPH – National Quality Forum**

That's a very interesting perspective, especially if you start thinking across the programs.

**Joe Francis**

Right.

**Helen Burstin, MD, MPH – National Quality Forum**

This could also have a pretty significant impact on the other programs, hopefully, like value based purchasing, and potentially move some of these kind of measures towards some of those pay for performance kinds of measures, programs, where the idea is to get towards performance in this program as well.

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

This is Westley. As we move forward, are we clear that others have a clear understanding of what we mean by deeming in this context?

**Male**

I'm sorry, I couldn't understand that question – could you repeat it?

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

Are we clear that others have a good understanding of what we mean by deeming in this context? Because the word is used in different contexts, both in Medicare and Medicare Advantage and such.

**Helen Burstin, MD, MPH – National Quality Forum**

I think that's a valid question and probably one that suggests that, as we kind of go down this path, maybe a bit more specificity, like adding the slide on assumptions, but maybe even something a little bit further that explains what it means in the context of this program would be useful. Although that may be what we're charged with figuring out. But I don't think, and certainly my impression of the policy committee even, I think there were people coming at it from very different places. Kevin, any thoughts about what we should do?

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

So one of the things I'm wondering is if you might want to just spend some time going through these exemplars. There are a lot of these unanswered questions about the mechanics of how the deeming program would work, and certainly the Meaningful Use Workgroup has agreed to take that on. We've talked about these exemplars, but I don't know that we've ever dived into one and really pulled it apart, and I wonder if that might really help us have more clarity of purpose.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay, that sounds reasonable. Lauren, if you have it, it might be helpful if you could just give us a high-level overview then of Heidi's notes on how she came up with high, medium, low.

**Lauren Wu – Office of the National Coordinator**

Sure. So if you look across the top at the blue line with the columns, here are some of the assumptions and rationale that Heidi provides. So for eCQM leveraged HIT, the first one, she gave it a low rating if it was paper-based, medium if you could get through claims now, and high if it is in the MU program or slated for development as an eCQM. Shall I move on?

**Helen Burstin, MD, MPH – National Quality Forum**

Sure. Stop Lauren if you have any questions.

**Lauren Wu – Office of the National Coordinator**

If you go over to the fourth column over, Prefer Report Once, it's low if it's not in any federal programs now, medium if in at least one federal program now, and high if currently in the MU program.

The next column over is Applicable to Populations. She gave it a low rating if limited to one disease condition or setting, a medium if she was unable to determine, and high if it has applicability across more than one population. And I think that kind of addresses the point that was made earlier.

And then she has a note that for, I believe, the rest of the criteria for longitudinal care, health risks, benefits outweigh burden and promotes shared accountability, it was really subjective for her and she did invite us to provide some guidance on how we would rank these.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay, so perhaps it's worth taking a little bit of a deeper dive perhaps on the two newer ones, the Joint Care and the Rheumatoid Arthritis, does that sound reasonable, Kevin and Lauren?

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

Yes, we picked the Joint Care because David brought that up at the policy meeting so that might be a good one.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay. So with the context you just heard from Lauren you can see, for example, across there's a measure we've endorsed that looks at, for example, the standardized complication rate following elective THA and TKA. That's in the first row. Applicable to population health she has rated here as low. Most of them are high and medium for HIT I think because at this point it's a claims based measure. Hip fracture mortality, again a claims based measure currently but it is, I believe, an inpatient only mortality rate, so I think that's the logic for the low applicability to broader populations I think. Medium across some of the others there since it already exists. Mortality rate similarly, hip replacement mortality rate, very similar measure, same ratings. And then I assume, Kevin, these are the new measures under development?

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

Correct, these are under development for an MU 3 timeframe, and it's a change in functional status from your pre-surgical functional status to right now the extra panel is seeing about a six-month post-surgical reassessment.

**Helen Burstin, MD, MPH – National Quality Forum**

Wow. Okay, great. And what's the timeline on when those will be available?

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

MU 3.

**Helen Burstin, MD, MPH – National Quality Forum**

Okay. So could you remind us again if she had any notes around applicable to populations? I'm not sure I would have put that low here.

**Lauren Wu – Office of the National Coordinator**

Yes. So she rated it low if it was limited to just one disease or condition or setting.

**Helen Burstin, MD, MPH – National Quality Forum**

I see.

**Lauren Wu – Office of the National Coordinator**

And high if it was applicable across more than one population. Medium was sort of in determinant.

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

I think this was to Joe's point where we had talked about things like Frail Elderly and potentially crossing multiple – crossing multiple different groups of patients it could apply to.

**Helen Burstin, MD, MPH – National Quality Forum**

Gotcha. Okay. So to me, those are particularly nice because they do bring in the more – surgery may be inpatient but the actual result at six months out obviously goes across all providers and is very patient focused, and that's why I think it's green for that shared responsibility column as well. Any thoughts on this one about whether a set like this might be something appropriate for deeming, for an eligible hospital?

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

The mortality rate one is sort of interesting. I know obviously we're talking about joint care, so that's clearly one type of patient, but the mortality rate – particularly the hip replacement mortality rate – could be one of those things where you get the hip replacement at the big hospital but then if you have a complication you get hospitalized at the smaller community hospital. And I do have a sense that mortality is under appreciated across the two types of institutions.

**Helen Burstin, MD, MPH – National Quality Forum**

Yeah. No, I think that's a fair comment. So if you thought about this large joint care service line, would there be other ones you think might be more appropriate for a set like this, whether existing or new?

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

Does post-cardiac care fall in? I'm not sure where large joint care comes into play, but obviously cardiac care and hospitalization following angioplasty and bypass surgery is in the area.

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

And also HIV care would be another good one that would cross probably multiple providers over time. This is Tripp.

**Helen Burstin, MD, MPH – National Quality Forum**

Kevin, this is Helen. Unfortunately I'm getting called away for a few minutes but I'll come back, as I warned you.

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

Okay, I can take it. So I think the question to the group is around this – the ideas of HIV care are great and the ideas of post-cardiac care are fantastic, and if you look at our Million Hearts exemplar it actually has a number of measures that would include some of that cardiac care. We have it up now. AMI Total Cost of Care and AMI Mortality. So we've included those in this measure set already. The question I think is, are we on the right track in building these bundles or are we somehow either missing something key and important or have we veered too far away from what we should be veering from. So really it's to say, is this the right kind of bundle we've been creating.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare:**

I think in general, Kevin, this is Marc – I think this makes sense to me. The one thing that when I look at this example I wonder about and understand we can't do everything is at one level what you're trying to do is really prevent things, right? You've got a number of measures that are around the process things. But we don't have anything about are we being effective at preventing. You know, how many AMI ... we've got AMI mortality, which I guess kind of gets at it. But that becomes partly driven by the acute care in the event. So I guess in some ways I'd like to see if there's process measures so that the corresponding outcome measures at least begin to be bundled in.

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

So you're looking at something like a rate of AMI in the population?

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare:**

Yeah, that's kind of what came to mind is, yeah – this is what we're really trying to avoid, right?

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

That would be a kind of measure to propose. I suppose someone could argue that it would be hard to impact that in a year.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare:**

Yes, they're absolutely correct. But then we might as well get rid of LDL control, blood pressure control, smoking status. You know? Those aren't going to have an effect in a year either. I mean, you can measure them, if the change in the process ...

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

Yep.

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

I'd say also related to AMI mortality, those very measures, are contributing factors.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

You mean the measures above?

**H. Westley Clark – Substance Abuse & Mental Health Services Administration**

Yeah, blood pressure control, smoking status, are they prevention measures in and of themselves associated with AMI?

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

I thought the purpose of this was not so much that you're going to notice changes in outcomes, but across different institutions, different piece of these data get collected and so if you're running your quality measure, you may miss an A1C because it was done at that other place and the patient mentioned that, oh, I already had the A1C done so you don't draw it here. And then it doesn't become part of the quality measure. So I thought the purpose of all this is to capture the data from across institutions that allow you to centralize or at least have access to the decentralized data elements so that you can run a quality measure.

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

This is Kevin. When we talked about deeming the goal has been to say, here are really high performers that really are focused on outcomes in a certain area, and they prove they're high performers in this way. There may be secondary benefits to that like having encouraging data sharing through multiple organizations or through some kind of exchange. The goal for deeming has always been articulated to be these are people that are doing a really great job of care. They're doing a really great job of meaningful use, therefore they don't need to monkey around with reporting lots of other stuff.

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

Kevin, this is Tripp again. It seems to me it keeps going back to the organization you're actually submitting your measures to for recognition or whatever, don't you agree?

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

I think that I would agree, although I think that one of the issues that we talked about quite a bit is this likely works most effectively for a group, and it's hard to wrap your head around what it means for an individual reporting one at a time. Now, that might be possible that an individual could do this, but when you look at things like total cost of care and AMI mortality, and thinking how much an individual has impact on those, that's a harder – a bigger stretch.

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

But how does blood pressure control promote shared responsibility across different institutions?

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

Well, maybe it doesn't. Maybe we mis-scored that here, part of the reason we're having this conversation.

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

I have to admit as I'm listening to all this stuff, I'm always thinking about examples where patients in my clinic or my hospital are also seen at the VA and how often that affects quality reporting because some of their data just exists at the VA, and [blip] lost to me, at least for these electronic measures.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

Absolutely. And it is true, you know, everywhere, even if you don't think you do. Like one of the PTOs that actually got incent – got the shared gain dollars in this last year in Indianapolis, 30 percent of the data was from somewhere outside of their organization. And only 60 percent of the care was inside if you measure it by encounters. So yeah, I think that's true everywhere. We may not know it.

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

Right, that's great you measure that.

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

So we have only five minutes left, are there particular items you'd like us to explore? Things that you want to cue up for the next call?

**Lauren Wu – Office of the National Coordinator**

And our next call is next Thursday, so really we could continue some of these discussion points. What we're hoping to do is to have something to report back to the policy committee at the December 4<sup>th</sup> meeting on some of this deeper dive into the deeming issue.

**Jim Walker – Chief Information Officer – Geisinger Health System:**

This is Jim. Is there a one-page statement somewhere of the intention and general framework of the deeming approach?

**Lauren Wu – Office of the National Coordinator**

Michelle?

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

There are slides from the Meaningful Use Workgroup but the general framework hasn't been decided yet, so, you know, much of it is really just draft and their initial thoughts on what it could possibly be.

**Jim Walker – Chief Information Officer – Geisinger Health System:**

Do we have a draft one pager?

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

They're just in slides, but we can share those again.

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

Yeah, why don't we revisit that, I agree with having a common understanding.

**Jim Walker – Chief Information Officer – Geisinger Health System:**

This sounds like a group that's talking about it doesn't know quite what.

**Lauren Wu – Office of the National Coordinator**

Michelle, this is Lauren, and I know that those discussions happened over the course of a few meetings or a few months earlier this year. Do you think there's a transcription of one of the meetings that particularly summarizes this issue well?

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

Sure, we can probably go back to the meeting when it was first introduced. I think Paul was on that call as well. So we can pull the transcript from that meeting and the slides and redistribute them.

**Lauren Wu – Office of the National Coordinator**

Great, thank you.

**Norma Lang, RN – University of Wisconsin**

This is Norma, I understand that Heidi has some assumptions. Would it be useful for her to share those? And also, I wouldn't mind having a couple more. You said she tried these on a couple more topic areas? The more you kind of look at it, the more you come up with some of the general ideas in your head. So if that's possible, please send those.

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

Yeah, absolutely, we're happy to send all of them. Heidi, because she worked at NQF for a long time has a really comprehensive knowledge of NQF endorsed measures and what programs they're in, so she can churn these out pretty quickly, we're lucky. So we'll be happy to send them. She's worked on – I had her work on one around pediatric prevention, one around something we talked about before, which is behavioral health, primary care integration, and one around perinatal care, to try to flesh out some of the various populations that would likely be encountered by providers and hospitals.

**Norma Lang, RN – University of Wisconsin**

That would be great, thank you.

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

Michelle, should we open it up for public comments?

**Public Comment**

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

Sure, are there any other comments from the group before I do?

Okay, Operator, can you please open the lines?

**Ashley Griffin – Altarum Institute**

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

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

This is Kevin, thank you all very much, and we will talk to you again next week.

**Lauren Wu – Office of the National Coordinator**

All right, thanks Kevin.

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

Bye.