



HIT Policy Committee Quality Measures Task Force Final Transcript June 8, 2015

Presentation

Operator

All lines are bridged.

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

Thank you. Good morning everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Quality Measurement Task Force. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Cheryl Damberg?

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

Here.

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

Hi, Cheryl.

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

Hi.

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

Kathy Blake?

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

Here.

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

Hi, Kathy. Dan Riskin? David Lansky? Elizabeth Mitchell? Floyd Eisenberg? Frank Opelka? Ginny Meadows?

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

Here.

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

Hi, Ginny. Jason Mitchell? Joe Kimura? Lori Coyner? And Sally Okun?

Sally Okun, RN, MMHS – Vice President Advocacy, Policy & Patient Safety - PatientsLikeMe

Here.

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

Hi, Sally. And from ONC do we have Kevin Larsen?

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

Here.

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

Hi, Kevin. Lauren Wu?

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Here.

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

Hi, Lauren. Samantha Meklir?

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

Here.

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

Hi, Sam. And Stephanie Lee?

Stephanie Lee – Public Health Analyst – United States Department of Health and Human Services

Here.

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

Hi, Stephanie. Anyone else from ONC on the line. Okay, with that I'll turn it to you Cheryl and Kathy.

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

Great.

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

And this is Floyd Eisenberg I just joined, sorry.

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

Thanks, Floyd.

Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network

And Frank Opelka has joined.

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

Hi, Frank.

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

Great, thanks, you guys for joining us this morning. So, we had a very robust conversation last week and this like a fast moving train and I appreciate everybody's responsiveness to participating in these calls and giving us feedback. And I want to thank, very much, Stephanie and Lauren for assembling the discussion and trying to start shaping some recommendations for us based on our call last week that was tremendously helpful and I know you guys worked hard over the weekend to pull that together. So, many thanks from all of us.

So, why don't we go onto slide three I believe it is. So just to reiterate these were the two areas we were specifically asked to focus on and I'm going to move to the next slide which starts to provide the distillation of our conversation and I guess what I would like to do since we only have an hour this morning is that right Stephanie?

Stephanie Lee – Public Health Analyst – United States Department of Health and Human Services

Yes, that's correct.

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

I guess what I would like to do if folks are okay with this is sort of quickly move to talking about what was the focus of the discussion last week, see if we potentially missed anything because I know some folks were not able to join the call and in particular there were some questions tee'd up at the end of the presentation on slide 7 because we felt like we needed to get some additional input or perspective from the vendors because there are a fair number of changes that are being recommended and really understanding the implications of those changes.

So, just in brief, to highlight the focus of the conversation the other day, so I think there was recognition that, at least at this stage, given where the FHIR and interoperability resources-based draft standard is it's really not yet ready for prime time, it's going to undergo a balloting process and I think generally the group felt like while that may be the desired place to be in the future moving there immediately might be premature.

And so the group supported release 3 of the QRDA Category I standard for individual level quality reports and then the November 2012 version of the QRDA Category III standard with a 2014 errata for aggregate level quality reports.

There was, I think, recognition that these versions would be good to move to because they represent incremental fixes, help, you know, move toward improvements based on issues that have been identified and that also it was flagged during the last call that a number of stakeholders are still working to support QRDA reporting so trying to leapfrog to a more advanced standard when people aren't even to the most basic standard might be a bit challenging particularly if that standard is immature.

That said, I think there was general recognition that we wanted to try to signal soon to eligible providers and vendors in particular that, you know, they should be closely monitoring and looking to implement the QUICK FHIR-based standards as they are basically balloted approved and move toward a fully baked standard.

And so, the idea here is go with whatever is the...or go with the most stable advanced piece now but recognize there is going to be a shift in the future and people should be preparing now for that. So, let me just pause there, Kathy please chime in if you think I've missed anything from the conversation last week.

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

No, I don't think so Cheryl. Thanks.

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

And I sort of feel like we should potentially jump to the questions on seven because they pertain to this slide just to make sure that we haven't missed any additional input related to this particular area where we were asked to comment on. So, the three questions at the top, in particular, what milestones need to be met to develop to the July 2012 Category I QRDA with the September 2014 errata, so that was the second option for individual reporting that was put on the table for comment.

And then question two is, when would it be realistic to expect that the industry would be ready to update and implement to either standard and I'm presuming the either standard here is the option two or three, so the July 2012 with the 2014 errata or the QUICK FHIR-based draft standard. So, let me pause there and see if folks have any additional thoughts or comments that they would like to see reflected?

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

Cheryl, this is Ginny, so, I guess the only thing in thinking about, you know, kind of the question it seems like the overriding question here is "when" would either these standards be ready and I think we addressed that somewhat in the comments you already went through on the other slide, but, I mean, I think that the thing that we need to keep in mind is the time needed to implement any new standard once it becomes something final in a rule and I don't think it is necessarily time needed just by vendors but if we think about the downstream implications to CMS and their ability to accept a new standard, they have also been very open in discussions with us that it takes them about the same amount of time to do that as well.

So, I think that maybe we should consider going to kind of what we've used as an industry standard for anything new, as far as...I think this would apply to the July 2012 Category I QRDA with September 2014 errata is fairly minor but going to release 3 is a bit of an upgrade for vendors to do and I don't think any vendors have a lot of experience with that as it's very newly balloted.

So, I think we need to think about that 18 month timeline as far as if the release 3 is what becomes final in a rule there needs to be at least 18 months to actually do that implementation piece and the testing and everything else that would have to go along with that.

So, that, you know, kind of ties into some of the concerns I think we have with the timing of the payment rules because, as we know, when a final payment rule comes out a lot of the times many of the requirements in that payment rule have to be implemented with a less than 6 month timeframe. So, I don't know if that makes sense.

I think we just need to make sure we say that, you know, that 6 month timeframe is not going to be adequate.

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

Okay.

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

But we need to allow plenty of time for everyone to not only implement but do all the testing and everything else that has to happen. And I would use that 18 month timeline because that's something that I think we've been very consistent about verbalizing.

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

Thanks, Ginny for flagging that. I know that came up on an earlier or a call when we were talking about the other rule that we were asked to comment on. Do folks have thoughts about Ginny's comment? Is that, you know, Floyd, is that consistent from your perspective as to the timeline that's required?

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

Well, it's...I think it's consistent. I think the issue, again, is not just EHR vendor but CMS, I think my question is, from the discussion on Friday I thought we were talking about these things becoming...when does this become effective, the rule that would come out from this?

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

I thought it was...it goes into effect in 2018 but 2017 is optional, is that right Lauren and Stephanie?

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Right, so an effective date is kind of a particular term, so when ONC might issue a final rule to adopt a reporting for CQM criterion the effective date is usually, you know, within 30 or 60 days immediately after, but in this case it depends on the program that's going to require the use of this CQM reporting functionality for its program and so, as proposed in IPPS, yes you are right that what we're referencing is what CMS has proposed for Stage 3 to require the use of this CQM criterion for all providers participating in the EHR Incentive Programs in 2018, but that providers can optionally choose to upgrade during 2017 if they so choose.

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

So, if it...and I realize I was just checking during Ginny's discussion, it's that release 3 is to be published to the HL7 page, within a week or two, but it is not there today. So, assuming that it does get published as expected then...because it's been completed it's just a formality issue, than the 18 months would fall in the middle of 2017, wait a minute, at the end of 2016. So, it's potentially feasible, but that's what I would ask, is it potentially feasible.

Jason Mitchell, MD - Chief Medical and Clinical Transformation Officer - Presbyterian Healthcare Services

This is Jason Mitchell I'm sorry I wasn't on the first call I'm with Presbyterian. Just a quick clarification, the 18 months is that on the software vendor's side or is that the aggregate of what the vendor as well as the customer has to implement? Because we may want to separate those two and have separate timeline requirements for the vendor and then that way they have a hard stop when the customer could start working.

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

Yes, I mean that's a good point we've done a lot of work actually in a previous Kaizen in trying to map out all of those different dependencies because there are so many people that are required not just vendor...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Right.

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

Customer.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Exactly.

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

I think typically the minimum that we think it would need not just for a vendor to do the implementation and rollout but the customer to do the actual implementation on their side that is a minimum though. As we know...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

But...

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

It's much more than that...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Yeah, my thought...

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

If it's...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

My thought is if you have one vendor that takes 6 months to do the work and another vendor that takes 17 months to do the work then depending on which vendor you have those customers have an advantage or disadvantage, or even ability to be compliant. So, I'm just wondering how do you...if we say it takes 18 months and one vendor takes 17 months of that then those customers are really going to have a hard time.

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

Yeah, I mean that's a good point. I will say that, you know, as kind of the representative of the vendor industry that I have a role in playing because of my participation with the Electronic Health Record Vendor Association where we have a number of vendors both small and large kind of providing that input that's what was agreed upon by all of those vendors and they include some very small vendors as well as large.

So, that's...I guess I'm not just speaking, even though I'm from McKesson, from McKesson's view point but this is kind of our standard. And so, you know, I don't...I'm not trying to discount any of the other vendors at all. I do know there could be some outliers.

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

Ginny, this is Kathy Blake, and it may also be a question for Lauren, Stephanie and for Kevin, but in addition to the implementation by the customers the question I would have is, is that happening concurrently, implementation at CMS happening concurrently or is there a further lag in terms of when CMS is also able to implement the standard?

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

Yeah, no that's a really good point, because I think we've kind of seen a lot of the work that's been happening recently on the validation process and the piloting of being able to send these formats to CMS and I know CMS has had to do quite a few corrections on their side, so it seems it would be reasonable to think about adding an extra timeline for that process as well.

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

But, so to Floyd's comment, you know, if you think 18 months from I guess 2 weeks from now and then you add on some does it seem reasonable to expect that this would be ready by 2018?

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

So, can I just add to that, and again, I mean, you're welcome to come to whatever conclusion we come to, but the concern is this update...this is a new version but it actually simplifies or makes...improves some of the things that were problematic in the earlier release that effect practitioners and physicians and others, things like having to enter a reason or entering the thing you didn't do when you didn't do any of them. So, you didn't do...you used a certain medication and you have to say which medication you didn't order, that in a sense is clinically incorrect and this does correct those and there are other issues in there that are corrected in this update to the standard.

So, I understand that we have to be careful people can implement and that does take some work, but we also don't necessarily want to work on a version of the standard that has content that may not be as valid as the new one.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

So, it sounds like what you're saying is we're really delaying the benefit of improved metrics by...

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

Right.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Implementation timeline, that kind of stuff, but there is a cost. It makes it easier as long as you can push it out kind of, but there is a cost to the clinicians and to the quality reporting and all the stuff that we do.

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

Right, it doesn't fix everything but it fixes some of the issues that were there.

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

Yeah, and Floyd, that's a really good point. I mean, I think it's a very different question when we're thinking about going incrementally to release 3 of the QRDA Category I versus the FHIR-based QUICK model which would be a very much larger project for everyone. So, I think when we're talking about just upgrading to a new release that fixes a lot of things we can look at a more streamlined process and the 18 months would be sufficient.

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

Okay, so I guess I'm hearing consensus that people are supporting the release 3 because of these fixes and that it would appear there's adequate time for the rollout. Anyone take issue with that?

Okay, and then I guess before we move onto the second thing we were asked to comment on, I wanted to just get people's feedback on the language that we might put forth about supporting the general direction in the future to upgrade to QUICK. So, did we capture the essence of that correctly? I just want to give folks a change to tweak it if we need to.

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Should we move back to slide four so folks can look at that draft language Cheryl?

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

Sure, thanks.

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

So, I think this would be the fourth bullet here.

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

Yeah. And for those who weren't on the call last week, I think there was a desire to try to move to the new standard once it was released and that people should be getting prepared and anticipate this shift so that when the...when it's ready people can move more quickly to this standard.

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

So, this is Floyd, I think you addressed it, we talked about in this particular case it's also a bigger lift for CMS as we've talked about in the other standards they have to change as well, but QUICK involves, for them, a change to a new data model.

First of all QUICK hasn't been balloted yet it's coming in October but it's also a new data model compared to the QDM they use today, Quality Data Model, and they haven't determined when they're making that switch. So, that's another reason for not pushing too fast to require a model for vendors to implement that hasn't yet been determined when CMS will approach it. That is a big lift.

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

Okay, so we should probably add some language about that. Any other thoughts, comments about this?

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

Cheryl, this is Ginny, I was unable to attend most of Friday's meeting but these comments look very similar to the kind that we've made around the QUICK FHIR-based standards, we do feel that it's the right direction but as Floyd said, there will be quite a bit of implementation work not just on the vendor's side but with CMS and with some of the tools that they use and the capabilities that they have. So, this will be a pretty big implementation once the standards are actually available.

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

Yeah, so I think we can add some language to signal that set of implementation issues both for the vendors and CMS to provide at least some grounding in reality of what it will take. So, that's great. Before we move on anything else?

Sally Okun, RN, MMHS – Vice President Advocacy, Policy & Patient Safety – PatientsLikeMe

This is Sally Okun from PatientsLikeMe, I'm going to recognize my naïveté on some of the language here, I wasn't able to be on the call on Friday, but I also wanted to ask whether or not words like encourage and anticipate are taken seriously in terms of the way that we're suggesting that people start to prepare is there...and maybe just articulating some of what we just said, you know, being more realistic about the kinds of things that people might be up against would help it, but it feels to me like encouraging and anticipate are things that people may or may not do and I just don't know what the track record is on sort of acknowledging that these are recommendations that we think we should be paying attention to and how much will people actually do that?

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

Yeah, that's a very good point and I think the essence of the conversation the other day was that, you know, CMS can, through the various rules and notices to vendors and eligible providers start signaling and I think this particular recommendation was around signaling what their anticipated, you know, next move was going to be such that people would be, you know, beginning the process of getting prepared, but I think per some of the comments on today's call it's not just the vendors and providers who need to get prepared but it's also CMS. So, anyway that was sort of the flavor of this comment.

Sally Okun, RN, MMHS – Vice President Advocacy, Policy & Patient Safety – PatientsLikeMe

Thank you, that was helpful.

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

So, Cheryl, this is Kathy Blake and I would reiterate that. I think that what does need to perhaps be put in to tweak the language is an explicit statement about that in the proposed rule CMS is of course signaling and in some instances instructing vendors as well as providers, but it is also making its own commitment as an agency to achieve the milestones with respect to implementation so that we don't have a situation of vendors are ready and providers are ready, and there is no place to, shall we say, for the information to be sent and received. So, this is where I think our sending that feedback to CMS will be important because it is a set of mutually agreed upon obligations.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

I really like that language, you know, the idea of mutually agreed upon obligations that the vendors, CMS and those of us practicing healthcare all commit to. I think that will help everyone get aligned much quicker.

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

I would agree. Thanks, Kathy for that language.

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

Yes.

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

So, I'm keeping track of the clock, anything else on this first piece before we go to the next? All right. So, let's go to slide five. So, the other thing that we were asked to comment on...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Can I, I'm sorry, can I just...

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

Sure.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

On that previous slide, you know, are we...is it being too wishy-washy on harmonization of these different data elements and metrics? Because to me that holds us back as a nation in the medical community more than almost anything else and it seems like the statement we make is pretty soft on that.

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

So, are you talking about bullet four?

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Yes.

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

So, can you suggest some language?

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

I think, you know, starting with...I think maybe if we just say...in support of direction, right, to harmonize CDS 2 standards and then we can say, you know, they're not...I think we need to say that...I think we kind of discount ourselves by saying...and in general direction and be more specific that we absolutely support harmonization, you know, and we're looking to drive that as quickly as possible and given that the level of maturity is there we're recommending these changes. Something that maybe a little more...a little stronger language around that.

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

This is Elizabeth Mitchell, I was able to participate on Friday and I really support that change. I think one of the things that didn't quite come through was the urgency that we discussed the need for change while we were trying to be mindful of not going so fast that we do so before we're ready that there was a clear recognition that this needed to happen and needed to happen quickly.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Yeah, so I think putting something like that in there would be helpful and I just...thinking of our own organization I know the time and effort we spend trying to deal with the lack of harmony could be spent doing, you know amazing things with regards to reporting and analytics and so it's just...it truly does hold us back from doing better clinical care.

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

Great suggestions. So, Lauren and staff just as a reminder to me as well as the workgroup, so after today's call we will be doing some editing of the language here and then will we have another opportunity to circulate this for folks to just do a quick review?

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Yes, we will but I will say that I think we're still working toward the June 16th deadline for when these comments close. So, it would probably happen in this next week.

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

Okay. So, thanks Elizabeth. Thanks Jason. We will work to strengthen this language and look to you to make sure that we've done it in a way consistent with your comments. Okay, all right, onto slide five.

So, the other area that we were asked to comment on, so there is a proposal to collect core clinical data elements to enable risk adjustment of outcome measures, hospital outcome measures, and the focus here was, you know, claims data provide so much in the way of information to be able to do adjustment and so there is an opportunity to bring in data from the electronic health record that would supplement or enrich the data available to do risk adjustment for outcome measures.

And so, the group here had a robust conversation the other day and I think there was support for having information that would allow for outcome measures to be generated and for risk adjustment to occur but I think there was a question about how best to go about this.

And so one approach that CMS is basically teeing up is that they would collect this limited set of elements on everyone kind of an all payer way. And they've signaled that they would, in the future, be looking potentially to expand out this list of data elements that they would collect.

And so a couple of issues came up in our discussion the other day, one that is critically important is that CMS and ONC need to better align the data elements so that, you know, when they ask for race they're asking for it in the same way.

And Ginny was kind enough to provide us an additional attachment, so if you were to go back to your e-mails of last week you would see a number of the examples that she called out where there are inconsistencies. So, again, an effort to harmonize should be first and foremost on the table.

The other thing that we batted around and I'm not sure that we came to any consensus on so this would be worth our spending more time on, is, you know, whether we should support the recommendation that is on the table in the notice about an all payer approach to this limited set of data elements versus, as Floyd had noted, can we look to specify needed data elements in the context of the quality measures themselves and their particular application so it doesn't just become this large list of measures that are collected on everyone. And Floyd I hope I've represented that accurately.

So, I think it would be helpful to continue that discussion a bit more and see where we want to land. So, I'm going to open up the floor for any additional thoughts as well as thinking about how we might frame that particular recommendation.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

I have a clarifying question just to start with, how does this...with the hierarchical conditions and Medicare Star those types of measurements, how does this align...how do you think it aligns with those two big measurement systems?

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

I'm sorry, Jason you were cutting out for part of it.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

I'm sorry.

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

I got the Medicare part.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Yeah, with Medicare Star and then HCC, right the Hierarchical Conditions, for our Medicare patients, how do those data elements and requirements line up with what's being said here?

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

You know I'm not sure that these are the same things that are captured for the HCCs, because, you know, these are capturing lab results and vital signs, and my understanding of the HCC is they're capturing comorbidities.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Yeah, it's, you know, HCC is a strange, you know, risk adjustment tool where it's really just looking at, you know, dropping...capturing and billing for codes for the patient's disease burden, but the way it actually is meaningful is you're actually looking at clinical data, responding to clinical data that helps you understand what to do with the patient, but I wonder if there is an opportunity here to help make HCC as a nation more valuable to patients as opposed to a data capture of, you know, diagnosis codes. It's just a question, because, you know, it's a big ticket item across the United States people do a lot of work around it, but I question the...is it really improving the healthcare of patients and I don't know that it is.

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

Could you say a bit more on how that might be measured?

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Yeah, I'm just thinking if we're looking at...so HCC is basically a way of...capturing the disease burden of an individual, right, to risk adjust and then differentially cost and save the provider or organizations for the care of those more complex patients. And often times what happens is to get that risk adjustment you have to go and do chart reviews, and look at labs, and so internal to the organization you're looking at all these things to then figure out which codes are appropriate to then address and bill for that patient.

And I'm just wondering if instead of, you know, looking at "here's the codes I submitted for 2014" it would really be the actual real data so the stuff that I look at to try to figure out what the patient has, do they have heart failure, do they have something like that. It would be more of that type of thing.

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

So, the HCCs are used to adjust for payment purposes.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Right.

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

My sense of what the data here are about is adjusting clinical quality measures.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Right.

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

And there will be things that overlap potentially but potentially not and I was working under the assumption, because they were trying to marry claims-based data where you would capture the kinds of things that, you know, are captured, you know, by the HCCs with more enriched information about the patient that would otherwise not be available for adjustment...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Right.

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

Clinical outcomes so...and this is how these lab results and vital signs, you know, became part of the...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Yeah.

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

Recommendation here. I'm still not necessarily connecting what...HCC...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

You know I...

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

...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

I think, you know, HCC feels like a very administrative component...

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

Right.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

That drives a lot of work and may not actually increase the care a patient receives.

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

Right.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

And so I probably have a bias that HCC needs to evolve to really drive better outcomes for patients is that how do we better connect HCC to outcomes and so, you know, this is just...as a large system kind of where I'm thinking.

Is there something we can do that helps signal or get...get our nation moving in that direction to be thinking about, hey, how HCC actually ties to clinical quality as opposed to just reimbursement mechanism.

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

Right.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

So, that's really what it is. It may not be for this Task Force, in fact it's probably not, but I just wanted to raise it if there was an opportunity.

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

Yeah, no, I think it's a really interesting question and I probably would agree with you, it's not clear how the HCCs are working to improve patient outcomes or patient care, but, I would ask others to reflect on and comment on what Jason's recommending here or at least asking us to consider?

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

It sounds like unanimous agreement. That was a joke. That was a joke.

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

So...

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

Cheryl, this is Kathy Blake, so we can't let that remark go un-responded to. Here's a thought which is that currently and I think some others on the call maybe aware, CMS is working in a collaborative fashion with a number of the medical specialty societies as well as with AHIP, America's Health Insurance Plans, to be able to come to what we might say is a core set of performance measures.

There is a strong sentiment on the part of the health plans that they want to continue to collect administrative claims data and to have measures that use those as kind of the ingredients.

At the same time CMS has signaled that it would like to see clinically, you know, clinical data to be able to get as much, as we've said, enriched nuanced pictures about patients.

And so I think one of the challenges that we can refer to is the fact that there will continue to be this tension between the two inputs, the two categories of inputs and that secondly that CMS as it goes through its rulemaking process will need to look very carefully at the burden and the return on the investment of continuing to collect both.

But I think the reality will be...we'll need to continue to have claims data and we'll need to continue or will want to grow the clinical data as well. But there will be this tension related to burden.

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

Right and I think that this was partly captured in this issue of could we...rather than asking hospitals to collect this data on everyone, could it be done in the context of specific measures, so don't collect more information than is needed. So, I think there is sort of that issue related to burden but I'm also hearing Jason talk about, you know, data that's going to be more meaningful or useful for improving clinical care and outcomes.

So, I'm trying to figure out can we balance expressing both of those thoughts, you know, but as you note, recognizing the burden issue that is ever present.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

And I, you know...it really is kind of a separate piece, so, you know, I'm okay if we don't put language, any language in there about it. I just wanted to bring up the issue in case the group was thinking about it.

So, I don't want to get us off track on HCC and how to make it more of a quality type system but if there is something like Kathleen mentioned that we could put in there I'd appreciate that. It's not a hardened fact for me, I just thought it was a good chance to bring it up.

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

Okay, great. So, let's kind of work down this because we only have about 15 minutes left. So, I think, you know, my guess is that the group would support this issue that Ginny has flagged about CMS and ONC better aligning the data elements that are captured. So, is there any disagreement on that particular point that's bullet point three? Everybody agrees to that one.

And then, how do folks feel about what's in bullet point five? Because I do think we probably need to send some signal about which way we're recommending CMS go. So, supporting collection of all of these data elements for everybody, you know, potentially as a mechanism to advance the development of outcome measures beyond the two that CMS is currently considering the use of this information for or trying to really narrow their focus and keeping it in the context of specific measures.

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

So, this is Floyd, and since it was my suggestion I'll try to give a reason for it and I'd be interested to see if it's actually harder for a vendor to do that or is it...it doesn't matter?

The two reasons where one, collecting the data set on everybody means that you're really...you may not know what kinds of stratification you want to do and you might want to change your risk adjustment model based on the information you get and we're not sure what that outcome will be, and so it's in some ways allowing some research which has benefits but risks.

The other is, when you know a condition that you're measuring and you know there are specific data points that would affect or might affect outcome and you have a risk adjustment algorithm that you want to work on you ask for the supplemental data elements that you know you want to use in your algorithm and that is more specific to the condition you're measuring.

So, there are two approaches and the approach there was you can ask for those additional elements directly with the measure as supplemental elements. One question is does that make it harder for the vendors then just sending on everybody and the other is it does decrease the amount of, I guess, research that can be done to develop new risk models. So, there are positives and negatives. So, I'll just put it out there and see what people say.

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

So, this is Ginny, and I would say that when thinking about the best way to do this I know, you know, within our own capabilities we would support actually doing a set of data on all patients not specific to the measure because I agree with Floyd and I think we've brought this point up before, you don't really know exactly what you might need to use that data for.

So, to predefine it and say you're only going to send this data for this measure limits your ability to do then some additional analytics and other capabilities. And it seems that if there was a broader set of data that was always included for every patient that would give you more flexibility and I don't see that as long as it was accurately defined and standardized, and harmonized that it would be a bigger burden.

Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network

Yeah, this is Frank...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

This is...

Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network

I understand where you're coming from when you talk about that, but practically speaking when you do this in the field I almost always find that we have very specific data needs and we reduce the burden more to the second bullet point of specifying data needed for the measure and don't collect more than you need and when you do need to go back and ask a new question of the data you end up needing to be very specific in that metadata definition and so I'm less of the collect more for research and more of the specify the data, but that's just one approach to it.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

This is Jason, you know...

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

So...

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Oh, go ahead.

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

This is Floyd, I was just trying to be neutral in my earlier comments, but I actually support Frank's comment a little more because I think that is true that when you decide what you need you find that the data you collected in the broad set isn't specific enough, you don't have the right metadata and you have to go back and look anyway sometimes.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

You know one of the ways that we've been thinking about it and I think about it is, you know, how do create value. So, collecting a whole lot of data takes a lot of work if you're not actually thinking about what value it's going to bring to the patient then you're really wasting resources.

So, I think maybe one context of this is, you know, we collect data that we believe is going to bring value to the patient and so we're not just, you know, fishing for lots of data but we're very targeted as to where we require more data.

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

Yeah, this is Cheryl, you know, as I look down the list of elements I could see how they would be valuable related to the two measures that the Yale team considering right now, but I think of lots of other outcomes measures that I've dealt with where the types of data elements are not represented on this list and I think that the lists needs to be informed by the specific applications and generally those specific applications have been informed by literature that shows some relationship say between the person's acuity level and the likelihood of dying within 30 days after a bypass procedure or something like that.

So, I guess I would be inclined to support kind of a more narrow focused effort to collect what is really going to be useful for specific applications.

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

This is Kathy and I would add to that also that there is experience from the registry world and particularly with the National Cardiovascular Data Registry of initially collecting and doing risk adjustment that appeared to need just over 20 specific variables and then with more experience and with collection of, you know, hundreds of thousands of patients data being able to then say that the same predictive value was accomplished with a much smaller set of data elements.

So, I think language to the effect of the ongoing monitoring of the need to continue to collect that same set certainly the NCDR's experience would suggest that this is a way to wisely prune these lists once they are promulgated.

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

So, are there other folks who want to comment on this approach?

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

So are we going to...have we come to an agreement? I know bullet point 1, 2, 3, 4, 5 is says we're at different viewpoints, so have we come to a single viewpoint on this?

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

I'm not sure yet and so I'm just...I want to test the waters to see, because I know there were some folks on the call last week who were supporting a broader collection and I want to give them an opportunity to comment.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Okay.

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

Unless we've persuaded them.

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

So Cheryl while maybe folks are mulling that over I know we're running short on time so I did want to point out, I think there was one more question on this topic that CMS is soliciting comment on and that's a question on which content exchange standard should be used for collecting this data and whether if they use a standard that ONC has adopted that they should require the use of ONC certified technology for the sending of that data.

So, I wonder if we want to schedule one more call maybe an hour call this week to again review the revised language and then also have some time to discuss that last item.

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

That would be fine. It would have to be later in the week for me, but would folks be able to participate? I'm sort of wondering might we be able to knock this off in 30 minutes.

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

Yeah, I was thinking about where we are with this discussion, I would think we could knock it out pretty quickly because to me it's a little early to define what standard we should use before we get a little bit more stability with what the data is actually going to be and what it's going to look like.

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

So, I guess Lauren and Steph, I'm fine with scheduling another call later in the week and I guess if folks cannot join the call if you could help us iterate by sending in some e-mail comments on the language that we craft based on the comments we've received today and then maybe we can spend an additional 30 minutes to talk about this other question that we didn't get to today.

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Okay, so we'll work with Michelle and Altarum to find time on your and Kathy's schedules.

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

Okay that sounds good. And I guess just to close out the last discussion, so were there any issues with going with the recommendation about reducing the burden by specifying the data needed for each measure as opposed to sort of collecting everything for everyone?

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

This is Elizabeth and I think I was probably one of the people who commented last week and I'm reluctant to counter Frank in any way. What the discussion was I think about more providing flexibility on a data set and also enabling the evolution of the measures used and trying to balance that interest in using data for perhaps unforeseen instances, but I'd be happy to follow-up with you about that. But, I think it's a balance.

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

So, Elizabeth, could you maybe help us a bit, particularly since the group is going to come back together later in the week, I don't know whether you want to take a stab at crafting a sentence that might reflect that.

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

Sure.

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

Because I appreciate that tension, you know, having been involved in measure development and, you know, there's always this challenge of, you know, being able to have access to data to be able to test models and, you know, we don't clearly know at this stage all the possible outcomes we might want to measure and what kinds of elements might be useful for doing that. So, I agree, I think there is sort of a balancing act here.

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

I think it's more important to have a clear set of measures and to design the right data set to produce them, but, again just keeping some flexibility in mind, but I'd be happy to try to write something.

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

Great, thank you, we would appreciate that. All right, so I guess Stephanie, Lauren next steps?

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Sure, so I think we've gotten your suggestions for how to revise the existing draft language. So, we'll revise these slides and send them out maybe today for everyone to look at off line and then in the meantime we'll also look to schedule a short half hour call sometime later this week to discuss the remaining issue and then to get any last discussion or input on the revisions to the language and then that should keep us pretty well on track to the comment submission deadline of June 16th. So, I think we've gotten a lot done in a very short amount of time. So, thank you everybody for, you know, moving quickly on this.

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

Great, thanks.

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

Okay, are we ready to open for public comment?

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

Please do so.

Public Comment

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

Caitlin or Lonnie, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

Yes, if you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the telephone and would like to make a public comment, please press *1 at this time.

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

While we wait to see if there's public comment Lauren maybe I can follow-up with you just regarding the next charge that this Task Force will be given we should start thinking about getting meetings on the calendar so that we're not quite as rushed as we were this time.

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Yeah, that's a good idea. I think we can have those off line discussions and then loop in Cheryl and Kathy for planning.

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

Okay, thanks, Lauren.

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Sure.

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

And it looks like we have no public comment so thank you everyone.

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

Yes, thank you, everyone.

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

Thank you.

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

Bye-bye.

Lauren Wu – Policy Analyst, Office of Policy & Planning – Office of the National Coordinator for Health Information Technology – US Department of Health & Human Services

Thanks, bye.

Stephanie Lee – Public Health Analyst – United States Department of Health and Human Services

Thanks, bye.

Jason Mitchell, MD – Chief Medical and Clinical Transformation Officer – Presbyterian Healthcare Services

Thanks.