

**HIT Policy Committee
Quality Measures Workgroup
Vendor Tiger Team
Transcript
April 5, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Good afternoon everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup Vendor Tiger Team. This is a public call and there is time for public comment built into the agenda. The call is also being recorded, so please make sure you identify yourselves when speaking. I'll now go through the roll call. Ginny Meadows?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Ginny. Jim Walker? Mike Aswell? Chris Bontempi?

Chris Bontempi – McKesson Provider Technologies – Software Architect Advisor

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Chris. Annette Edmonds? Joe Geretz? David Lansky? Kip LeCrone? Maggie Lohnes?

Margaret Lohnes – McKesson – Quality Measures Manager

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Maggie. And Sterling Martin is not on and Sasha we have you on?

Sasha TerMaat – Epic Systems Corporation – Legislative Analyst

Yes.

MacKenzie Robertson – Office of the National Coordinator

Great. Jon Morrow?

Jon D. Morrow, MD – GE Healthcare – Senior Medical Leader & MQIC Director

Yup.

MacKenzie Robertson – Office of the National Coordinator

Thanks Jon. Karen Nielsen?

Karen Nielsen – Siemens Medical Solutions – R&D, Analytics and Business Intelligence

Hello.

MacKenzie Robertson – Office of the National Coordinator

Thanks Karen. Lynn Scheps? Melissa Swanfeldt?

Christine Silva – Meditech – Senior Manager, Marketing Support

This is Christine Silva attending for Melissa Swanfeldt.

MacKenzie Robertson – Office of the National Coordinator

And any ONC staff members that are on the line?

Jesse C. James, MD, MBA – Office of the National Coordinator

Jesse James from ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks Jesse. And I believe we have Kevin Larsen?

Jesse C. James, MD, MBA – Office of the National Coordinator

He may be in a tunnel he's on the train.

MacKenzie Robertson – Office of the National Coordinator

Okay. With that, I will turn the agenda back to you Ginny.

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

Thanks so much MacKenzie. Good afternoon everybody; it's Friday afternoon, we were saying nice spring day here in Atlanta, so hopefully you guys are enjoying some better weather than we've had in the past couple of days. This is actually our first official meeting I think of the year, so welcome and thanks to everyone for joining. And we definitely have a couple of key things to talk about today. If you look at the agenda, we're going to talk about the RFI that was recently released, I think on February 7th, by CMS on Qualified Clinical Data Registries and they're relationship to PQRS and the EHR Incentive Program. A couple of key questions we want to talk about then, and then if we have time, we're going to also discuss our thoughts on what we might want to add to the data elements catalog that's recently been released with the new version of the measures in April. Anything else to add to that Jesse or are we good to start the discussion of the first item?

Jesse C. James, MD, MBA – Office of the National Coordinator

No, I think that's a thorough introduction for what we want to go through today. So, it might help – I'm not sure how familiar all the group is with the Qualified Clinical Data Registries, but if everyone is familiar with them, we could just open into a discussion as opposed to going into background.

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

I think most of us are fairly familiar with it. We as the EHR actually finished our response that we'll be sending in on Monday to CMS on the questions that were posed in the RFI. Does anybody have any specific questions about it or could we just launch into the areas that I know that ONC really wanted us to cover today. Does anybody have any specific questions or things they want to go through on it?

Unidentified Speaker

I'm good.

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

Okay. So I think – so Jesse, do you want to just talk about the two specific questions you had or do you want to – we don't really have time to go through all of the questions, so we could...

Jesse C. James, MD, MBA – Office of the National Coordinator

Oh, absolutely, yeah, absolutely not. I guess it would be helpful to start with the questions about whether in the RFI it mentioned both PQRS and the EHR Incentive Program. So it would be good to get the groups opinions and their discussion on whether participation in a registry should be able to deem or give a physician credit for like CQMs in the Meaningful Use program.

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

That's a great question. I think that one of the things, if we kind of consider how we responded jointly, and then I would let everybody kind of pipe in with their own specific responses from their individual kind of perspective. We were really thinking about the fact that what we needed to look at is how aligned the specific registry requirements would be with what we know are the – is in the CQM requirements for the EHR Incentive Program. So, for example, some registries may not be as stringent as far as how the data is actually incorporated. There are some issues around data quality that I think we need to think about and there are also questions about exactly what quality measurement outcomes those registries are looking at to see whether they would be fairly comparable to the kind of measurement that the EHR Incentive CQM is also looking at. So I think those were some of the broad comments that we were really trying to make in our RFI response. Does anybody have some really more specific kind of granular thoughts on that?

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

This is Jim Walker, sorry I missed roll call. It seems to me Jesse that if there was just a definition of the capabilities and behaviors of entities that are authorized to receive and transmit quality information. Then you could – then you wouldn't be trying to define each individual kind of class of that kind of entity, it just could be anybody, I don't see why it couldn't at least, anybody who meets the criteria in some demonstrable way, could then be able to do it.

Jesse C. James, MD, MBA – Office of the National Coordinator

Well, that might also be a discussion that's worth having, because the RFI, well, two points. To Ginny's point, and from the group, it doesn't seem like the comments from the EHRA or vendors in general is to push back on the inclusion of data from registries or participation in registries, giving credit for Meaningful Use, that there's perhaps a concern that the registries that are used have some attributes that can be proven or tested, to be sure that their data is of high quality and that their measures make sense.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Yeah, otherwise, you're going to be in the position of saying, well we trust you and we don't trust you, that doesn't seem like a sustainable approach.

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

Yeah.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

If it's just a set of requirements, then you meet the requirements, you do it.

Jesse C. James, MD, MBA – Office of the National Coordinator

Well, that opens two questions, but one being, the point you're making Jim is that there isn't clarity on what an entity, what entities can act as a registry, and we in-house had discussions on in the Data

Intermediaries Tiger Team sort of started a discussion on, how should registry be defined? Can it be as simple as, if your software is certified technology and it produces a list of patients, is that simply a registry, is the data warehouse the registry, is an HIE a registry or is a delivery network with their own population health management platform, is that a registry?

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

And again, my answer would be anyone who meets the criteria as a registry.

Jesse C. James, MD, MBA – Office of the National Coordinator

What criteria would be important to you Jim?

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Well, I think that's...I don't know that I have a list in mind, but whatever – I mean, when we say, is so and so capable of being a registry, I assume we're assuming some kind of general idea that they're capable of receiving information in standardized formats. They're capable of providing security, data integrity and security and confidentiality protections, that they sign BAAs with the people that they're serving, I suppose. You know, that they're capable of transmitting the data in acceptably secure standard formats, that they keep audits probably so CMS could review their work if they needed to, you know. I would make it pretty parsimonious, but I would think with 8 or 10 sort of criteria that wouldn't be too hard to validate, you could describe what people have in mind when they think of an adequate registry.

Jesse C. James, MD, MBA – Office of the National Coordinator

Absolutely, but at the same time, you're not describing a threshold that's so low that your average sole practitioner with a typical piece of software could deem herself a registry.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Right, I mean, but I wouldn't, I mean, if a solo practitioner met all the criteria ...

Jesse C. James, MD, MBA – Office of the National Coordinator

Right.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

... then why would you care? We wouldn't, that's...I mean it might be a set of criteria that a solo practitioner would be nuts to try to achieve, but, that's the thing, it could, then a big ACO could do it themselves, a small ACO might say, that's just too much money for us. That's fine, so it isn't ACO-ness; it's that you meet these eight criteria.

Margaret Lohnes – McKesson – Quality Measures Manager

This is Maggie Lohnes. I'm thinking another way to look at it might be, as we start to combine data sources and measures from various different entities, we need to make sure that they all meet whatever is the highest bar of requirements among that cohort. So, if meaningful use today is, for instance, the highest bar in terms of requirements to have data delivered from a certified electronic health record, then we just need to make sure that the other contributing sources have that same high bar. I don't know if that made sense.

Karen Nielsen – Siemens Medical Solutions – R&D, Analytics and Business Intelligence

Yeah. In fact, if I could just add to that real quick. This is Karen. One of the things that Meaningful Use has done is it has provided a certification tool now right, Cypress, which has created a standard that ensures that there is accuracy concerning the actual calculation of the clinical quality measures. And I would think that when you're starting to look at having any kind of measure that's going to be accepted by

CMS, there needs to be validity and reliability. This is non-incumbent to the standards we already have in place for quality measures obviously. But from the standpoint of ensuring that if whatever registry is going to be reporting on the measure in question, we would want to ensure, I would think, the same kind of standard that we're seeing with Meaningful Use Stage 2 certification that we would expect to see from the registries as well.

Jesse C. James, MD, MBA – Office of the National Coordinator

Thanks Karen and Maggie, those are both every good points. I'd – my question back to you and the group would be, so there are ways to endorse measures and NQF is one of the national endorsers for measures, and of course, they have standards for feasibility, validity and reliability. And we had similar questions in our RFC around if we add additional measures into the program, and this is assuming that the group also thinks that it is a reasonable idea to add, to have registries own their own measures. That's where the ACC, the cardiologists have measures for cath labs and the orthopods have measures for orthopedic surgery. But if they can create their own measures and their measures count in PQRS and Meaningful Use, that they're – the standards for the measures being up to snuff nationally might be NQF. So that's one option. But a more, perhaps a radical option that might give room for more innovation would be to say that NQF endorsement might not be a requirement, but the requirement might be that there's some other avenue to ensure interoperability, like they have to pass Cypress certification. So are both equally important or is one more important than the other, the presence of that national endorsement, a national body to endorse it, or is it really the functionality that counts, the measure works and it calculates in a way that's expected.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

This is Jim. I think it's their ability to deliver and there's plenty of studies that show that organizations that you might think could create valid guidelines don't, and I'd be glad to send the reference if you need it. So, I – and besides it's invidious, I mean – so, it's Joe's Bar and Registry a registry? I mean, what is it based on reputation, is it based on political clout. If you base it on ability to perform the required functions, you just got a sustainable, defensible program.

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

Yeah, this is Ginny and I completely agree with that. There definitely needs to be some kind of structure, whether it's through NQF or some other way of ensuring that whatever measures are being used are kind of meeting that expected structure, so that there are predictable results and we can be assured of the quality of the results and the quality of the data that's being used. I think that's really where it comes down to kind of thinking about the fact that you really do need to have some kind of structured way of measuring whatever someone wants to actually offer as their performance measures for their registry.

Margaret Lohnes – McKesson – Quality Measures Manager

This is Maggie. Just to add to that, I recall from the NQF annual meeting discussion on another more fast track for endorsement, where there might be a preliminary endorsement process. And a part of the discussion is whether we would need to wait for the amount of time it takes to put all of these other measures through endorsement, which can be lengthy. But if there were a second option to at least start them through the process and make sure that they meet basic requirements before moving forward, that might be another alternative.

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

And...this is Ginny again. I mean one of the things in thinking about what Maggie just said, and having some kind of fast track way to do that through NQF. I mean the advantage of having someone like NQF doing this is that you don't end up having 10 different measures that are all measuring the same thing but in different ways, which I think we've seen in the past as being a challenge. So, I think that's part of the

challenge is how do we ensure that we're not getting 10 or 20 different ways of measuring something when there really should be one method, one evidence-based, reliable way of doing a measurement. So that physicians again don't get into that dilemma that they're in today, where they for several different programs they are measuring the same types of things but in very different ways. Does anybody...

Jesse C. James, MD, MBA – Office of the National Coordinator

Yeah I ...

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

Yeah, I'm sorry. Go ahead Jesse.

Jesse C. James, MD, MBA – Office of the National Coordinator

I was just going to say, from a timing standpoint, the program would start in 2014. That for the initial year and for if measures were going to be used in 2015, 2016 and beyond there – NQF endorsement were a requirement, I think there would have to operationally be some sort of fast track to get through NQF in a much shorter period than it typically takes.

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

Absolutely. With that kind of time constraint, that is definitely a challenge, but at the same time, I guess we...there would really need to be some way of ensuring some of the components that we've already talked about. So, be it through NQF fast track endorsement or some other method that we maybe haven't thought of yet.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

You know, you could imagine – this is Jim – you could imagine perhaps, well, anyway, you could imagine a thing where people would attest that they can do this and this and this and this and this, the eight or 10 things. And then NQF would – or whoever, would come back around and validate that and so you could say, if it's that important, let these people start working. But, if they, in 6 months, when they're actually audited, if they aren't doing it, then they have some penalty. So, you know, you could even imagine something that crazy.

Jesse C. James, MD, MBA – Office of the National Coordinator

Well, I've – yes. Here's what I would imagine might be a concern from the software developer end, that if we expand the number of measures and the types of measures that clinicians can use to report for PQRS and Meaningful Use, then we also might, then it's expected that the types of data that are used in those measures, especially as we move towards measures that are geared toward some specialties and sub-sub-specialties, the data types will change and expand as well. And many clinicians will have an expectation that, I have this EHR, it should be able to communicate with my registry and to send the data in a structured format that they can receive. When we think about interoperability between the qualified registries and between certified technologies, will there be a need that registries are able to accept data in a manner that's consistent to the technology that's in place. And if that is there, is that additional workload on the EHR software developer side?

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Well, this is Jim. Why would – I don't understand why we would allow people to create their own measures but not use standard terminologies for them, that seems, well, way counterproductive. And if they transmit the data, or if the data required for the measure is RxNorm and SNOMED and LOINC, and NCPDP, what would the problem be?

Jesse C. James, MD, MBA – Office of the National Coordinator

There wouldn't or there shouldn't be, but I am speaking to the current state more than the future or ideal state. If they're using certified technology, then they will be transmitting their clinical information according to the expected, standardized, accepted vocabularies as described in our SCC rule for ONC. If they are not, then we essentially in the program would be saying, if you have certified technology, you can report through your clinical registry. If you don't, then this isn't a pathway that's available to you.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

I'd say if you don't, it ain't a measure. But anyway.

Jesse C. James, MD, MBA – Office of the National Coordinator

Well for the sake of interoperability, that may be a bar, to Maggie's point about building the measures and having our expectations for the measures be that they are a floor is what was before the ceiling, that they're built to the highest standards we have for measures. If the EHR Incentive Program has the most stringent data requirements for measure reporting, then it might make sense to say that if you're – if you have a clinical data registry that's going to submit for, to get credit for the EHR Incentive Program, then your system must be able to – you must be able to accept information in a consolidated CDA for patient or QRDA, which would also mean that the specialty societies would have to build their measures...the societies would have to be able to accept the output from the EHR, which would be a QRDA. So the specialty societies would have to design a QRDA for their measures. But that's what we've been doing for our CQMs for meaningful use.

Sasha TerMaat – Epic Systems Corporation – Legislative Analyst

This is Sasha. Can I maybe echo that back and just make sure I understand the way it's envisioned? So if there is a particular registry for a condition of cardiology, for example. They would – the registry's already calculating some cardiology specific measures; they might or might not submit those measures for NQF endorsement. And as part of that endorsement process, there would be a specification for the measures and QRDA specifications for what data elements are needed to calculate those measures. Then the expectation would be that some EHRs would build out the ability to capture those data elements and transmit them in a QRDA. So that specialists who are interested in continuing to submit through the registry would send their QRDA to the registry for the computation of the measures in a more automated fashion than maybe they are today. And that would be sufficient for meaningful use in lieu of the provider submitting their QRDA directly to CMS, as they might with some of the existing measures that are part of the program. Do I have that kind of – the vision correct?

Kevin Larsen, MD – Office of the National Coordinator

This is Kevin. I would say that we...that there's not a particular vision yet, we're exploring different ideas, but the example you gave is definitely one of those ideas. I would say with the likely caveat that some sort of information goes from the registry to CMS as well, and that might be an aggregate report, it might be some other kind of information, but that the bulk of the data lives at the registry and then something goes from the registry to CMS to confirm the inclusion.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

And if the cardiologist's EHR is capable of sending the standard format message to CMS, why would they send it to their learned society?

Kevin Larsen, MD – Office of the National Coordinator

So that when we – this is Kevin Larsen again – when we talk to these societies, they tell us that the scope of the measures is too narrow for the needs of their specialties. So if we...I just was at the AMA PCSPI

meeting today and the neurosurgeons came and talked and they're concerned that there aren't very many appropriate measures for neurosurgery.

Unidentified Speaker

Right.

Kevin Larsen, MD – Office of the National Coordinator

I've heard the same thing from the podiatrists.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

No, no, I get that part, but if their members are going to do this, they'll have to do it in their HER.

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

Um hmm.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

And the EHR will have to be able to send standard format, you know terminology format signals, message somewhere so why send it to the learned society instead of directly to CMS? I mean, the doctors still stuck with working in their EHR.

Jesse C. James, MD, MBA – Office of the National Coordinator

Well, the society would own the secret sauce for the measure calculation and reporting.

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

Okay, so.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Why ...?

Jesse C. James, MD, MBA – Office of the National Coordinator

So this would remove CMS from – like right now, all the measures in the EHR Incentive Program, CMS owns the measures, is responsible for the development, responsible for their updating, responsible for the logic, responsible for the value sets. And ...

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

And so no one's going to validate all those things about the learned society measures?

Jesse C. James, MD, MBA – Office of the National Coordinator

Well that's what we've been thinking about is how can we make sure that the learned societies are playing ball, are using, are making measures that are consistent, that are using the value sets that are in place and that use terminologies like SNOMED CT and RxNorm, when they describe their measures, when we know up to this point they by and large have not.

Karen Nielsen – Siemens Medical Solutions – R&D, Analytics and Business Intelligence

This is Karen again. Something just pops to mind as I'm listening to this. At the NQF meeting, in one of the breakout sessions, somebody stood up, and I think it was from the AMA PCPI group, and they articulated the costs associated with creating measures and then maintaining measures. And I can tell you, having been a measure maintenance contract owner in the past for CMS; I understand fully the costs associated with this. And so my concern immediately is that what we are suggesting, and please correct me if I'm wrong, but I appreciate the fact that the measures could be owned and managed by these

organizations. So they would then absorb all of the costs, or I'm assuming then the societies would then direct the costs back to their stakeholders for the development and maintenance of these measures. And then CMS would no longer incur the costs of measure maintenance and development, is that correct?

Kevin Larsen, MD – Office of the National Coordinator

So this is Kevin Larsen again. What I would say is, we don't know what the business model will be, and our role isn't necessarily to figure out the business model, our role is to figure out what kind of recommendations we can give to CMS around the Taxpayer Relief Act registry requirements, as well as thinking about the role of registries and certification of registries and measures for Meaningful Use 3. So, I think that there are any number of business models that could exist, I agree with you that measure creation and maintenance has been expensive, but that's not really – that's not the main thing that's on the table.

Jesse C. James, MD, MBA – Office of the National Coordinator

But, that is an accurate description of the current state where the societies tend to have their own groups of measures and their own registries and they do tend to incur those costs for maintaining the registry and the measures.

Margaret Lohnes – McKesson – Quality Measures Manager

This is Maggie – the example that pops to mind most immediately for me, having worked in the hospital side, is the Society for Thoracic Surgeons cardiac database, they have adult and pediatric cardiac database's very robust, very sophisticated. And a long track record of collecting the data for issues like quality improvement, but also for clinical research and setting new standards for clinical care. So the...they've...with this notion of using that data for meaningful use or other programs is an adjunct, supplement to what their primary use of the data was. And I think that's where we get into the dynamic where we're trying to align the standards that have been developed for the quality reporting, electronically for meaningful use data and other federal programs, along with the specialty societies desire to advance their clinical expertise – she said to crickets.

Jesse C. James, MD, MBA – Office of the National Coordinator

Well, I just wanted to give time for folks to see if there were any more responses before I did a mini-summary. So, I think what we've said so far, or what the group seems to be agreeing on is that an ideal state or a recommendation would be, from a vendor perspective, that interoperability is maintained in measures and registries conform to the standards that are in place for eMeasures. Which are using the standardized vocabularies that are accepted in our standards and certification criteria and that the measures...that the quality of the measures is important, but it need not be as prescriptive as NQF endorsement. That really the quality of the measure is important, but really the quality of the data and the ability of the data to move from the EHR to the specialty society in a way that's useful, is what is key. Is that a fair summary?

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

This is Jim. It seems to me that the rigor and quality of their measures seems to be just as high as of NQFs, so while it might be an alternative system; it needs to have the same standards of performance. I'm not quite sure that's what you said about their quality. I mean, they need to be just as evidence-based, just as sensitive to population health care needs as any other set of measures.

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

And this is Ginny. I think another thing to add that as we talk about this and we assume that much of this data would come from the EHR, is thinking about the fact that today, much of the data that's being sent to registries is not automatically being consumed from an HER. There are a few cases I think to where that

happens, but in my experience, most of it is done through other methods and unfortunately, a lot of it is done manually today, which I'm sure people would love to get away from. But we really need to think about also, something that we've talked about a lot recently, and that's the feasibility of collecting the data within the EHR and how that fits into the clinician's workflow. And how much burden that could potentially put upon the physician, if he's the one or she's the one, trying to collect data that typically they are not doing as current practice, so I think that's another piece of it.

Kevin Larsen, MD – Office of the National Coordinator

So Ginny, this is Kevin. I'm interested in your observation that a lot of these registries currently have a fair bit of non-automated data transfer.

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

Um hmm.

Kevin Larsen, MD – Office of the National Coordinator

This would seem to be an opportunity for us to think about that and I'm wondering if you or others in the vendor group have ideas about how we could address that issue.

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

Well, I mean I think it's along the whole lines of what we're talking about with how do we actually kind of pull registries into this whole idea of automated eMeasures, knowing that today, so many of them are not automated. They're basically – I mean, I worked with some of our pediatric physicians who are trying to contribute to one of the asthma registries and everything was done manually. So how can that data actually reside within an EHR and then be collected and transferred automatically to the registry to them become part of that registries data that they can use to calculate the quality measure. So, I think we'd have to look at the same types of standards and guardrails that we've already talked about with meaningful use measures, along the lines of, as we talked about before, using standard terminology, making sure that the data can actually be collected within an EHR, that is it truly feasible to have it reside there?

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

This is Jim. One of the positive effects of registries being required to receive information in standard content and transmission formats would be that then it would become feasible...they would have already done much of the work required to enable care delivery organizations to submit information to them electronically, rather than in what is often the current paper-based mode. We need to remember that in a well-designed care process, it would not be the physician or the nurse that entered much of the information, you know, the lab, physiologic monitors, patients, other members of the care team would all, again in a well-designed system, would all input information. The only thing that doctors and nurses would put in is information that they create that matters particularly to them, that that's sort of process owners of. So, one of the things this could do is improve that whole process and among other things, decrease the cost of care delivery organizations that typically have scores – well, depending on their size, have many full-time equivalents that do nothing except do some kind of manual input or transmission of data to different kinds of registries.

Kevin Larsen, MD – Office of the National Coordinator

Yeah Jim, at my hospital that I came from, we had 17 FTEs doing that ...

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

Um hmm.

Kevin Larsen, MD – Office of the National Coordinator

... and we were a HIMSS level 7 organization.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Yeah. And often it's because, as you know, the registries well cannot or will not, whatever, receive standard format transmissions.

Jesse C. James, MD, MBA – Office of the National Coordinator

So, I think it's clear that there's work to be done on moving the registries into the eMeasures age, that they're primarily measuring with claims that are extracted from EHRs, but they're not transmitting data in the way that eMeasures will report data for 2014. And so, go ahead.

Sasha TerMaat – Epic Systems Corporation – Legislative Analyst

Oh sorry, this is Sasha. Is it primarily claims? My sense was that it was more specific forms custom to each registry, like more abstraction than claims.

Margaret Lohnes – McKesson – Quality Measures Manager

And right, this is Maggie. So I believe there's a wide variety across the spectrum of registries as to what they collect and how they collect it.

Jesse C. James, MD, MBA – Office of the National Coordinator

So let's say, multisource data that vary from registry to registry, but are more often than not, inconsistent with the standards for certification.

Unidentified Speaker

(Indiscernible)

Jesse C. James, MD, MBA – Office of the National Coordinator

And if we're going to use registry-derived data or EHR derived data for registry calculations, it would create a more seamless process for the user if the registries move their capabilities to automatically transfer or transmit data that's consistent with the reporting, the current standards for reporting for cert.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

You know one of the things Jesse – this is Karen again – one of the things that we learned last year when we did just some preliminary assessments to again look at registries from a feasibility standpoint from collecting certain data, the – it was surprising how much was in the registry that was currently not collected by EHRs. And so I think one of the things we would have to look at then it's just like any other feasibility type of assessment, is to really ensure that the measures that are being developed, before they do so, meet the feasibility. So, we've already discussed this, but I just wanted to bring up a tangible example that we experienced, that really reinforces this difference as far as what kind of data you would actually be able to get out of the EHR versus what's currently in registries, as we know.

Jesse C. James, MD, MBA – Office of the National Coordinator

So that's another key point and I'll add that to the notes. So, the feasibility of the data elements and the types of data that are used in the measures will be very important and there will be some gaps between the current measures and the measures that can be calculated only from EHR-generated data.

Karen Nielsen – R&D, Analytics and Business Intelligence – Siemens Medical Solutions

That sums it up nicely.

Jesse C. James, MD, MBA – Office of the National Coordinator

So are there other questions, recommendations or concerns as we consider – or as the Quality Measures Workgroup and the Health IT Policy Committee eventually consider how best to respond to the Fiscal Cliff Act and the policy work that'll be done to describe this program over the next year? This will start 2014 and the RFI is closing, but there will eventually be a proposed rule, there may be additional rulemaking on the ONC side in this area.

Margaret Lohnes – McKesson – Quality Measures Manager

And this is Maggie Lohnes. Just one other thought is maybe to just take advantage of the tremendous investment that's already been made by the Congress and administration in developing the standards that we need so this is just another iterative step forward to align and include registries.

Jesse C. James, MD, MBA – Office of the National Coordinator

Absolutely. Kevin, did you have another questions from the group?

Kevin Larsen, MD – Office of the National Coordinator

Well, as long as they have a little bit of time, one of the questions that the registries have had from us is the ability to extract multiple records at one time from EHRs. And I'm wondering if you guys have any thoughts about that part of this. Like what is the relationship between an EHR and a registry as far as data transfer?

Margaret Lohnes – McKesson – Quality Measures Manager

This is Maggie Lohnes. I wonder if what they're pointing out is the model for the continuity of care file format, which was designed around a single provid – a single patient at a time, for the purpose of transferring the care. Is that – that may be what they're responding to.

Kevin Larsen, MD – Office of the National Coordinator

Yeah I think – what they tell us, and then when we go and talk and say, can you leverage our interoperability standards, they say, well, if we're willing to do it one patient at a time, we can leverage your standard, but we have trouble doing it on any kind of scale.

Margaret Lohnes – McKesson – Quality Measures Manager

I would think they're not using the QRDA.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Yeah, this is Jim. I'm in no way technical, but that doesn't sound right. I mean we – care delivery organizations are capable of you know, if the data is in the EHR, are capable of sending reports, which are just specified data sets on thousands of patients, we'd do it in overnight batch. I'm not – I think you'd want to make sure you understand what precisely they mean.

Kevin Larsen, MD – Office of the National Coordinator

A little further context, I would – so that we're asking specifically about have the data standards for Meaningful Use 1 improved their ability to aggregate data as a registry, and that's the response we seem to sometimes get. The other thing to remember is that many of these registries are aggregating across hundreds of single doc practices that don't have a data team. So, they're trying to figure out ...

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Well, and may not have an EHR that – yeah, I mean that's entirely possible. But, that's not, that's a reflection of our current historical state, yeah. If they've got to deal with 10,000 members who use 54

different EHRs, many of which are very small and have extremely limited capabilities, yeah, then that's true.

Kevin Larsen, MD – Office of the National Coordinator

So my question ...

James Walker, MD, FACP - Principal Health Informatician – Siemens Medical Solution

But the solution is not to make all of the doctors do manual entry of data for the registry.

Kevin Larsen, MD – Office of the National Coordinator

Correct. My question is, as a vendor group, what thoughts or ideas do you have about this particular feedback we get from registries?

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

So this is Ginny. And I'm puzzled, as I think Jim and Maggie, that about why they think that, because I mean we've been in different instances using the CCD to communicate with – through our HIEs for quite a while now and using like hundreds of records. So, I guess I'm thinking that maybe it's back to what Jim's point was in that they're not receiving information in a standard way, because a lot of these practices aren't there yet, so potentially that's the issue. Maybe flat file transfers or something that they're trying to do just to cobble things together, but I don't see that that's an issue if you're actually using the standards.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

But again, even in Keystone Beacon, where we were working with small practices and small hospitals whose vendors didn't have the largest set of capabilities and didn't have full attention to spend on this issue, we were able to help those, particularly hospitals, send just flat files of relevant data for managing heart failure and COPD to evidence-based standards. So, I think – really, I think when they say that, you probably want to just sort of work through it and make sure you understand precisely what they mean.

Margaret Lohnes – McKesson – Quality Measures Manager

And this is Maggie Lohnes. I do suspect that what they're talking about was evidenced in for instance, the pilots that were done of the pop health application a couple of years ago, where in solo provider practices using a variety of different software, the systems were designed to produce one CCD document at a time, for the purpose of transition of care. And that these solo practitioners needed to have someone actually sit there and manually produce one at a time, so I think that history is probably what you're hearing now. There's been an evolution, especially in the hospital setting.

Kevin Larsen, MD – Office of the National Coordinator

Yeah, I would – we hear it even currently and we hear it, I've heard it from more than one place. We maybe have people come talk to this group about it. What I'm curious though, if you can think of solutions or ways that we can help make this – move this forward.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Well the more that EHRs are required to enable capture and transmission of data in standard format, the more this will cease to be a problem. Think about it – that even what is currently the current state of – if someone has to send a CCD, if it has the information that's needed, that's still factored in manual entry. And I would think, as seriously there are more measures, more requirements to be able to send codified structured, clinically relevant data, those EHRs will have to develop that capability and be able to send that kind of report on a scheduled, automated basis, I would think.

Margaret Lohnes – McKesson – Quality Measures Manager

Well one feature that's already part of the certification requirements in 2014 is, generation of multiple CCDAs. I mean, they're thinking of it, I think, from a slightly different perspective of transitioning EHRs, but the I guess expansion of from just doing it for one patient at time and only for transitions of care is already part of certification and probably already passing along the avenue that I think Jim is talking about.

Kevin Larsen, MD – Office of the National Coordinator

So do you think that the CCDAs will be a good solution as an interface to registries?

Margaret Lohnes – McKesson – Quality Measures Manager

I – so, I've only talked with a handful of registries myself, but every registry I've talked to wants more information than is currently in the CCDA. So I think it could be a start, but I think that – I don't think that using a CCDA gets us away from, unfortunately, some of the custom forms or abstraction with additional information or other feeds.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

And one of the things I think you'll want to understand from the registries is, my understanding of them, which is not very deep, is that they – their data structures are often not mapped to standard terminologies and for that reason, the – their information needs can seem idiosyncratic to the submitting organizations. And so I'm guessing one of the things that is probably going to have to happen is that registries will probably need to do some fairly hard and expensive work to make their data structures match the rest of the standard ecosystem. And this may raise – the people that submit information to these registries may want to negotiate with the registries standard and perhaps slightly more parsimonious set of data requirements. So – I mean, I think that will be part of this equation is that they probably have some tough decisions to make. But, that's part of the point of having real standards for them is that they just – if they're not required to receive and submit data in standard formats, then we've missed an opportunity to make care delivery organizations lives a lot easier and cheaper, and probably increase the amount and quality of the data that the registries actually do get.

Jesse C. James, MD, MBA – Office of the National Coordinator

I think that's actually a good place to close, one, because it's time for public comment and it reminds us why we are in this space, at the end of the day, you can make better decisions based on quality measures. When your data are of high quality, then your measurements are credible and you're comfortable with them influencing your clinical decision-making.

James Walker, MD, FACP – Siemens Medical Solutions – Principal Health Informatician

Right.

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

Absolutely. Okay, so I guess it's time to go to public comment.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the line for public comment?

Caitlin Collins – 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 do not have any comment at this time.

Jesse C. James, MD, MBA – Office of the National Coordinator

Thanks group so much. I'm going to send out notes and I think the next step will be a report to the Quality Measures Workgroup and Jim and Ginny can do that, based on the recommendations that we come up with from this discussion. But thanks so much for calling in. Thanks for everybody's input.

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

Thanks everybody.