

**HIT Standards Committee
Clinical Quality Workgroup
Transcript
April 10, 2014**

Presentation

Operator

All lines are bridged with the public.

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

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Clinical Quality Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, this meeting is being transcribed and recorded so please state your name before speaking. I will now take roll. Majorie Rallins?

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Present.

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

Hi, Marjorie. Danny Rosenthal?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Present.

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

Hi, Danny.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Hi.

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

Bob Dolin? Brian Levy? Chris Chute? David Baker? David Lansky? Eric Rose? Floyd Eisenberg?

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

Present.

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

Hi, Floyd. Galen Murdock? Gene Nelson? Jason Colquitt? Joachim Roski? John Derr? Kate Goodrich? Keith Boone? Kim Schwartz? Michael Lincoln? Philip Renner? Randy Woodward? Rob McClure?

Robert McClure, MD – Owner and President – MD Partners, Inc.

Present.

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

Hi, Rob. And from ONC do we have Alicia Morton?

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

Present.

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

And Lauren Wu?

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Here.

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

And Kim Wilson?

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Here.

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

Are there any other ONC staff members on the line?

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

Yeah, this is Kevin Larsen.

Julia Skapik, MD, MPH – Medical Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Hello, Julia Skapik.

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

I heard Julia Skapik and Kevin Larsen. And with that, I'll turn it back to you Marjorie and Danny. So we do have a very small group today.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

I'm sorry, who's on – so it's Julia and, how many people did we have on the line I apologize.

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

From the workgroup, it's you and Danny and Floyd Eisenberg and Rob McClure, that's all.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay, so we do have a small group today.

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

Yes.

W

You guys are powerful; four people can set the agenda.

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

You may have people joining late because the Clinical Quality Framework call is just ending.

W

Yup.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

All right, and Floyd, thank you for your comments and maybe Alicia will – I'll start with summarizing what happened last week. Essentially, for the CQM, let me make sure I have the right slides we have different versions. So the population filtering discussion that we had last week was essentially at a high level, we didn't feel that the standards were ready for that. Am I capturing that correctly? And I know Floyd; you provided recently some more detail.

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

That is my recollection of our discussion, right.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

And what I thought we – what I don't think we got to was – we didn't really talk about specific standards for some of the patient characteristics that are necessary for patient population filtering. We also felt that maybe this wasn't the right group to have that discussion. Do you still feel that that is the case?

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

This is Floyd. I think the main issue that we discussed was some of the data requirements considered that are listed for data filtering haven't been – standards for identifying those that could be used across all systems haven't been identified and I believe it was the Vocabulary Task Force that made those recommendations in the past. Some of those people are on this call, but I don't know that it's the complete vocabulary community that made the other decisions.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

That is correct. So for the demographics, there is some recommendation, but not all. I think what we heard was there are some vocabularies that could represent that, albeit there might be some content gaps for some of these data elements. But there are vocabularies that currently exist that could represent some of this – these patient characteristics. That's what I heard. But again, what I essentially heard was that because the information, some of it administrative, some is clinical, there isn't a way for the EHRs for one – for the EHRs to capture that data – it doesn't live in one system and because of that, this is a very challenging proposal.

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

This is Kevin Larsen. A couple of additional items –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Hi, Kevin.

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

– that would be great to get input on here, are there some of these areas that are more ready than others? And does it matter if we're talking about different components of the certification process; so there's the capture part, there's the calculate and report part. So is it something that you're saying is difficult for just the capture, so just EHR, or is it also different at the calculate and report part of the EHR?

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

So I don't think we discussed that, Kevin, to be honest. I think what we discussed is – and is that part of – so we're –

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

– the thought, that wasn't a question in the NPRM, so we have to be careful that we aren't trying to expand the intent of the NPRM for some other fact-finding for public comment, other than what was in the NPRM.

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

Yeah, it's not the NPRM you mean the transmittal letter. So it's the transmittal letter from the Policy Committee.

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

So this is Floyd. Kevin, to answer your question, I don't think we addressed it specifically, but where there are missing standards for classification system or vocabulary, I think that would be an issue for documentation. For the aggregate, the question I would have is, unless the measure specifically says how to aggregate, some of these additional elements are – can be problematic. For example, in QRDA level I, you might be able to indicate supplemental data elements, if that's what these are, and that also comes up in a later slide.

But if you ask for that in Category III of QRDA, you're asking for some method of aggregating so without specifying how you want to do that, so if you, for instance, took preferred language, are you asking for the results based on every preferred language in that value set or how are you expecting that to be aggregated. So without specification it makes it hard to aggregate.

Robert McClure, MD – Owner and President – MD Partners, Inc.

So this is Rob. I don't remember if I specifically commented on this but, Kevin's right and I think we're talking about the right thing. So there are two things this particular ask is conflating and that makes the ask very complicated and I think that the – in part, this is – our response should be that this particular I don't know how you really say it, but there are two very different things in this particular suggested NPRM element. One of them is, do we accurately and consistently collect demo – do they actually say demographic or patient – information that would be useful in filtering patients, and the one, whatever it was, seven bullets.

And the answer to that question is, some of these are accurately and consistently captured, some are not. And then a separate question is, for those things that we accurately and consistently capture, because we should say, if you don't accurately and consistently capture this, then you should never try and do patient filtering on it, right, so that's – so we need to really separate these things. So we need to probably say, about patient population filtering, we suggest that we would not request that people, that receivers of QRDA data should never be trying to do patient filtering if there is good evidence that the thing that you're filtering on is not consistently and accurately captured.

Then separately, of the things that potentially of interest for doing patient population filtering, what are they, and I'm assuming this is the list. And we would say that some of these we believe are captured accurately and consistently, and some things are not. I can't speak to some of this, but I can speak to some of the demographics, which I think Floyd was also referring to, and some of those I think are and some of those are not and they are also kind of referred to separately in the NPRM.

So for example, in another place in the NPRM, they ask about some of these and I know that there's a suggestion about preferred language and I think has – there are some details of which I've spoken to elsewhere and I think that there's a good solution, but it currently is not implemented. There's I think – I don't know if there's actually anything specific on education level, but that is not consistently captured and that requires some guidance and then suggestions and everybody needs to adopt them. And I'm confident that socioeconomic status is not captured consistently anywhere. So that really needs to be separate focused area of terminology in the NPRM and because those aren't captured consistently, in my opinion, they should never be used for patient population filtering. But that's really kind of like, let's just say do patient population filtering where we know we're confident, and then let's go figure out places that we are confident.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

So Rob, thank you for that. So what I'm hearing is how we capture some of this might be challenging because one, there might be – there isn't a consistent way or this isn't necessarily captured consistently and there might not be – potentially there might not be standards to do that. And then, where this information resides, as it relates to patient filtering is also a challenge in that the, this is what we heard last week, that it resides in multiple systems. And then the ability to – because of the where, the ability for the EHR to require that – to require an EHR to do all of this is challenging because of the way the information resides in different systems. That's a bit of a clunky summary but did I capture that appropriately, and do we need to talk some more about.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah, the different systems issue that you guys talked about that I guess last time. I hear that and I certainly understand it. The idea for example of pulling out a diagnosis code is going to be out of a different system than whether they're a Medicaid dual-eligible. Whether – I mean, our Clinical Quality Workgroup recommendation with regards to that, I mean we're asking people to do a variety of things that are hard. The ability to associate a patient who's identified as a dual-eligible in the context of your practice, and their diagnosis, I don't find that an overly hard ask, personally. I don't care if they're in different systems, so – because you're not going to also – I mean it's just – it's a functional need of everybody's electronic health record system to identify their insurance eligibility in association with who they are and what they have. So, I don't find any of these particular things being terribly difficult asks, in terms of different systems. I find that not – I'm unimpressed with that being a problem.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Because there are a lot of other things that are hard that we're asking people, too; so all of a sudden for this one thing saying well, you have to combine ADT and insurance information with clinical information and demographic information is all of a sudden hard in this context, I don't see it.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yeah and then when I read more specifically on the slide it says, ONC – so there's an explanation of what's in the NPRM. And then ONC solicits comments on whether current CQM standards, e.g. QRDA Category I and III, can collect the metadata for characteristics listed above. So that –

Robert McClure, MD – Owner and President – MD Partners, Inc.

So QRDA I should, I think III is an interesting – I don't know how – because that's a summary and so –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yes.

Robert McClure, MD – Owner and President – MD Partners, Inc.

– I mean, I don't even un – I saw that and I was like, I'm confused because you're going to get – I mean maybe it's saying that – maybe it's – what it's probably saying is QRDA I, we would do it, i.e. the receiver would do it is what I mean to say. Category III is a little concerning because it might say, oh, all of a sudden we've decided that we're going to give you 15 different combinations of these things that you have to go and send us in a Cat III QRDA and I think – that's not an unreasonable thing to ask, some day. But I would hope that they don't start throwing those things out, because that's a lot of work for, I'd say, if you're going to make me send a QRDA Cat I, I'll send them, but it's up to you to start doing patient filtering on your end, don't ask me to do that.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay.

Robert McClure, MD – Owner and President – MD Partners, Inc.

I think – I guess you're asking my personal opinion these are my personal opinions.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

I'm asking the – anyone on the committee and it looks like it's you and Floyd that are here today.

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

Yeah, and I would agree with Rob's comments as well.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay. So, Danny, any thoughts from you.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

I agree with the assessment. Thank you Marjorie.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

So when we give our report can we say, Rob is unimpressed, is that what I can say?

Robert McClure, MD – Owner and President – MD Partners, Inc.

They'll read through it anyway. It doesn't matter.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Well, it's already in the transcript, right?

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah. Again, I mean, if I was going to summarize this, I'd say that this particular NPRM question, our assessment is there are really two things going on here. One is the desire – well, two and then subparts; one is the desire to be able to do patient filtering on a described set of things, which makes sense to us. But we would suggest that that kind of filtering be restricted to patient information that is patient – and entity information that is known to be captured consistently based on well-known standards. And that in that context, that the expectation would be that requests to submit QRDA Category I data can reasonably include the information that's listed here, as long as that information is consistently collected and is based on accepted standards. And we'll comment on some of those that we feel are not, separately. That we – so that's point one.

Point two is that – sub-point one, sub-point two is that we're unsure why Category III is included in this question, but we're concerned that it's included because there's a consideration of requesting that submitters do this pre-filtering. And we think that that request is premature right now, that we would expect that if the receivers would do filtering based on Category I data.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

And Rob, are – is the concern that requests then in the Category III being premature, would that be because – because one could argue that if you can get the data into a Category I, it's a matter of slicing dicing. Or is the concern that there's just – that there may be a large number of permutations of what is sliced and diced to be meaningfully expressed in the Category III?

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah, it's more – it's not that it's a totally unreasonable request, it's just that it's that if you – yeah, essentially saying the same thing. But I mean, if you can create a Category I, then you as the creator of this information, should be allowed to analyze the data in any way you want, right.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yup.

Robert McClure, MD – Owner and President – MD Partners, Inc.

And it has nothing to do with QR – Category III. Category III QRDA is about sending information someplace else, so if you can create a Category I and fill out all this information, then you have a lot of power yourself, which is part of why we're going through a lot of this, we want to kind of push people to get the power. The fact that you're asking somebody to create a Cat III QRDA is that you want them to do the work for you, and I think that's a little unfair, right now. It may be fair later, but if we can get them to do Cat I data, then we've pushed them down the path to do data analysis themselves. If we want to do data analysis, then we can do it on Cat I data ourselves. But I may be misinterpreting why Cat I and Cat III are here – or Cat III is here.

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

So Rob and Danny, I agree with what you both said. I think I need to add something else on Cat III I brought up last time. I'm not entirely sure why Category III is here either, unless it's, as you say, let the provider analyze it with – although it's basically saying, if you have multiple of these supplemental elements, you could have lots of analysis to do to actually figure out all the permutations of all the cells that you'd have to fill in. Based on those with one preferred language that also have a different socioeconomic status, for instance if we had a terminology for it and you could end up with small cells that really could lead to inappropriate conclusions.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Right.

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

And if you're only giving an aggregate out of one provider's practice, you could be making inappropriate conclusions. If you're taking all the Cat Is and pulling them into a large analysis for CMS or for some region, that's different because they can do that evaluation. But if you're asking for the provider to report it that way, that could be problematic.

Robert McClure, MD – Owner and President – MD Partners, Inc.

That's another important sub-bullet of this, yeah, that Cat IIIs are dangerous in small populations.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay, so...and sometimes, you know how you read something five times and finally you get it at the end? So I'm reading this last sentence about vocabulary standards as it relates to patient population filtering, just to make sure we're answering or responding correctly. And it says are there vocabulary standards that can be used to record the characteristics proposed above? It doesn't say which ones, right, but it – I guess it's asking us if we are of the opinion that those exist.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah, and that's what I'm trying to remember, because I thought this was also, I know its separately addressed in the NPRM about preferred language and I can't remember whether the other one's – because I know I commented on this and I don't know whether I sent that – those comments to you or not. But, that – as I say, that's why there really are two different things, we're answering the first one with regards to only, this is a reasonable ask for Cat I, only in those places where there are known and employed standards.

And then the second one is, some of the items on this bullet list are very much not collected in a consistent manner and really and/or, because sometimes they're not collected even though there is a standard, but there are some that are – to my knowledge, there aren't really good standards and that is the education level. I think there is a standard we can look at, and I think I may have sent that to you, I don't – it's someplace. If not, I can send it, and I can't remember now exactly. This is one of the things that we've looked it in FHIM, a lot of this stuff; kind of my most focused analysis has been associated with the FHA work for FHIMS. So, education level, there are some things around, but I'm confident nobody does it consistently and we would need to define that standard and get folks to adhere to it before we can do any kind of real analysis.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Right.

Robert McClure, MD – Owner and President – MD Partners, Inc.

And as I said, I'm not aware of a socioeconomic status standard that is usable. I know there's – I'm sure GAO probably has something and CDC may have some things, but that one's going to take some work.

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

Yeah, and this is Floyd. From our discussions back to September 2011 maybe, I forget exactly when that was, the discussions suggested that it wasn't really clear what was meant by socioeconomic status, that it may be a derived –

Robert McClure, MD – Owner and President – MD Partners, Inc.

Right.

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

– variable from education level, current income and it also changes over time. So I think that needs clear definition to determine what standards could be used to define it, and how.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Good. Yeah.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

I mean –

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah, it think it's better to get – in essence what we're saying, I think, is it would be better to get real objective data, like zip codes –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yeah.

Robert McClure, MD – Owner and President – MD Partners, Inc.

– and that – all that sort of stuff and not whatever that thing is, be careful.

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

Yeah, we also have –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Well I mean I think what we –

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

We have to be careful about forcing clinical providers to get information that patient's may not be willing to share for good reason.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yeah.

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

How many times do you get a question about your income level that you just don't want to answer?

Robert McClure, MD – Owner and President – MD Partners, Inc.

Right.

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

And so, some of these might be concerning.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yup.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay. So I think some of these elements then need clearer definition and we'll make sure we capture that in our comments. Any more thought on the patient population filtering?

Robert McClure, MD – Owner and President – MD Partners, Inc.

The only thing I would say is we kind of didn't talk about it but I think it is reasonable to do diagnosis and I think it's – we need to work towards SNOMED codes. So, I think the e.g. is certainly fine, too, but diagnosis is clearly something that is captured in the context of ICD and all that sort of stuff, so...

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

So my question is, and Floyd, if we were on that committee, that vocabulary task force that recommended SNOMED for diagnosis, correct?

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

Yes, I think Rob was on that, too, but yes.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yeah, so, could we reference that work or, could we reference that work for some of these things?

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

Well, I – that work has really filtered into the CQM development pretty significantly so I – and I believe has filtered into prior regulation. So I think it's reasonable to do that.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Well, there's the transmittal letter, remember, from September 28, 2011. There's also this information was represented in the CMS Blueprint, some of the recommendations.

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

Right.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

So I mean we could reference any one of those works, if we're confident that those are standards that we believe are appropriate for some of these characteristics.

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

Rob, do you recall that discussion as well?

Robert McClure, MD – Owner and President – MD Partners, Inc.

Vaguely, but I agree we should reference it.

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

Yeah, I mean it was a decision that did go to the Standards Committee and did end up in a transmittal letter, so I think that's clearly worth referencing.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yeah and I think ONC folks, I think we're supposed to – aren't we charged with using recommendations or work that has been done previously to make this process more efficient. So, that's in the context of being lean, I think. So, we should do that as well. So, any more comments on this one on patient filtering, because if that's the case, I think we've done all of the new 2015 edition issues that we need to select – that we need to talk about.

There's the 2017 edition CQM items that we might want to address, I don't know if the two of you have read through the proposal regarding electronic processing or functions and standards for certification and capture and export. I think we have some comments – I'm not sure; we did get comments from Eric Rose on capture and export?

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

I'd have to go back to those. He sent us quite a few lengthy comments. But I'll have to find that email to see if it was specific to 2017, so give me a minute.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yeah, this is electronically processing eMeasures, requiring that certified EHRs be able to automatically ingest electronic CQM specifications is a natural step in the evolution of electronic clinical quality measures. And his biggest concern is around value sets and I'll paraphrase a bit, some of the value-set developers are – have not used – the value sets are not faithful to the terminologies themselves so while the words might read one way, the semantic tag is something else. And I think that's something that he would like to note as a problem.

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

I found the email; I can share it with Rob and Floyd.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay.

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

Yeah, I also made some comments on that in what I sent yesterday and it's – so I would agree with Eric's comment. I also don't think we have, even though there's good promise, that we really haven't seen HQMF R2 or the 2.1 that's required in order to do a composite measure. We haven't really seen those used and – to be able to actually incorporate the measure, the way that wording is stated. So, I don't know that I've seen that happen.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Oh, I'm sorry. I was on mute; I was asking you a question, Floyd.

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

Oh, well, I answered on mute, no –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Did you send your comments directly to Danny and I or just to ONC?

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

I sent them to you, Danny and Alicia, last night. And right now, my email is not connecting, so I can't even find them.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay.

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

Yeah, 5:57 last evening.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yesterday, 5:57?

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

Uh huh.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Wait, these are comments on slide 7?

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

On 7, 8 and – it started with 7, because I thought that's where we were starting today.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Marjorie, would you like me to read those?

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yeah, because I am missing like a set of emails from last night, so I don't have that. I knew you sent something, but I don't have it, Floyd.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

I'll read it over here. Floyd, I will do my best to channel your essence.

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

Please feel free to paraphrase.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

On slide 7, QRDA Category II was considered as a – level when QRDA was first developed, but it has never been detailed or balloted in HL7. QRDA Categories I and III have been balloted and are DSTUs; however, no action has been taken on reported errata since at least September 2013. Category II has not been defined so it is not yet a "standard."

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay, so yes, I have that, now. Thank you Alicia for forwarding that to me again.

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

Now that's a slightly different question than document and report.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah, I agree. I mean, I have to admit, and I said this a long time ago and I'm not going to raise it as a significant issue here, because I think it's covered. But Category I data obviously has lots of personally identifiable health information – so, and we allow for that. And Category III, I think my perception of Category III is what we just talked about, which is, it's an ask of a receiver to the sender, do my work for me. I mean, there's a little bit – that's a little overstatement and that I guess it's possible that there could be a request that does an assessment of data that's not kind of typically asked for in the Cat I data that results in – that are sent in a Cat III.

This is, I think, what the original intent was and so you get aggregates that you couldn't create using Cat I data. But we're so far from understanding what we're doing at this point that that's a level of complexity that we're just not at yet. So, I would – I think we should solely focus on dealing with Cat I data for a while, until we understand what we're doing.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Right, and then maybe we could also make a comment about – I mean, what you're – what I'm hearing, Rob, and I don't know much about QRDA III, Category III, other than what you're saying is that patient filtering would generally be happening on the receiver side, not on the sender side. Is that what I'm hearing?

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah, well what I'm saying is that I think it's reasonable to assume that for now, we will – we'll make that assumption. I mean, all – Category III is a very understandable, reasonable thing to have available to us. But until we know, I mean, again, maybe I'm making some fundamental misunderstanding, but I believe Category III is essentially saying do the filtering and send it to me. And when this was originally conceived, there were, I think, in part, that's why I mentioned it, some concerns about sending all of this personally identifiable health information through this pipe, because it's a ton of it.

And so – plus, the who – a lot of the reasons for doing this were to do aggregate analysis and so Cat III was an initial take on that, says, okay, somebody's going to be doing data aggregations, just send us the results of those data aggregations. And in particular, when you're talking about quality measures, you do the analysis; here's the quality measure, you figure out all the patient populations and send us the final results. And that makes a lot of sense, we'll just believe you and then we'll go back and audit, perfectly sensible. But that other NPRM comment about – was not that, right, Cat III used to send the final results of an entire quality measure, 85%, that's – a Cat III can be used for that. That other request was I'm using a Cat III for you to do data analysis that is not the end result of – your final numbers from a measure. And that's where I think we need to not go there, if we're going to ask – if we're interested in that, we should be using Cat I data, that's what I'm saying.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay. Floyd, any other –

Robert McClure, MD – Owner and President – MD Partners, Inc.

And I admit, so the whole Cat II thing, I was always confused as to why Cat II really had value, it was kind of sub-population analysis stuff and that's why it's never really gone anywhere, because I think nobody could figure out where it was really useful.

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

Well, I – so, this is Floyd. I think it hasn't really always been clear what Category II is, and my initial understanding, back when QRDA was developed was, it was a single patient's result only, and couldn't include – and would be a result about one measure. And I think that's changed somewhat.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Hmm.

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

I thought Cat II was, if you want to provide all the individual results about all your patients – and so –

Robert McClure, MD – Owner and President – MD Partners, Inc.

Oh, that's right, yeah with like a – yeah, that's right.

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

So instead of sending many, many documents or files, send one.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Right.

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

But I'm not sure that that was ever clearly defined, what Cat II is, and that's part of the problem.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Right.

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

So when we say Cat II, I don't know what we're talking about.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah, that's right, I do remember that conversation, it was like, why send me 10,000 Cat Is, just send me something that is an aggregate of those as still one document and I agree with Floyd. This is unclear and I think when – in that conversation, people were saying, you know there's this thing called zip files, maybe that'll solve the problem.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay. So I think we have some guidance there. Floyd, you did send some comments that we – I don't think we talked about, or is it necessary?

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

Well, I was just looking at your subsequent slides and commenting on the items on there, that's all.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay.

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

If we don't need to get to those, that's fine.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

So it looks like we're not prepared, necessarily, to talk about the capture and export of eCQMs in an EHR. What slide is –

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

Well that's the one I just don't think that the standards have been evaluated well enough to say that they – we can actually import to encourage – so importing the HQMF in a sense should be just to pull out data that already exists. But not necessarily – I mean, if it's properly constructed, it's looking for data that are already there, rather than expecting you're going to from that, add additional documentation fields, that could be problematic. So I just don't think this is a mature enough process to really say that this is ready to capture directly from the HQMF and report out.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Okay. And Rob, any thoughts from you or do you want to have some time to – I mean, this isn't something – this is an item for the 2017 edition and I just thought maybe we could begin to have the discussion if we needed to have it. If we flesh through all of the 2015 items, we don't have to con – deliberating on these items here.

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

Well we've fini – this is Alicia, we've finished going through 2015, right –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yes.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yes.

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

We've got – so, the only thing that's left really is to –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

The 2017 –

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

– on 2017, so, I mean –

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Go ahead.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

This is Lauren. I just wanted to clarify that piece you were just talking about the Category II QRDA report was a Request for Comment for 2017 edition.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Yes.

Robert McClure, MD – Owner and President – MD Partners, Inc.

I mean if you were asking me if I have any additional comments, I don't. I think that there's – again, I would summarize my thoughts on this as there's no need for us to investigate Category I for 2017, full stop; I'm sorry, Category II for 2017, there's just...there's no need for this. I think that 2017 should focus on improving what we need to do around our utilization of – well, approving what goes into Cat I, and improving our utilization of Cat I on the receiving end, in terms of what CMS and ONC is interested in doing.

And that's it, I think that the Cat III stuff presumably we would continue to, I assume maybe there's – I actually don't know the details, but maybe we request Cat III in relationship to summary data on particular measures. And then I would also reiterate my comment in that, I don't think we should be asking providers to submit Cat III data that is a summary of what we can do on Cat I data. I think we should take on that burden, I don't think we should send it out to –

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

So Rob, that's helpful and your comment regarding Cat III would actually, Alicia, I think we should factor that in to the 2015 edition comment, because as we're proposing it, we're proposing to not change the first three clinical quality measure criteria and the associated standards. So what we proposed in 2014, we're proposing would hold for 2015, which does include Category III in addition to Category I. So if that's your recommendation, then we should factor in to our 2015 proposal.

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

Yeah, I agree.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay. And then Marjorie, the other two pieces we thought that this group may be interested in commenting on, depending on whether you have time. It doesn't have to be done today, as we said, we have a little more time. The first issue about the e-processing CQMs was really about the readiness of the HQMF standard. And then the second issue around clinical quality measures is sort of a general comment solicitation about going forward, what function should ONC be certifying for CQM certification criteria and a little bit of a request for comment on what about supplemental data elements. And I believe Floyd did send some written comments about both of those two, but I'll defer to the group on whether you want continue discussing today or defer to another future meeting.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

And Danny, I'll – thank you Lauren. Danny, I know we've been discussing, as it relates to the electronic processing of eMeasures, specifically HQMF R2.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Yeah.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

We've already had some discussions about that already, within our group and maybe it might make sense to have – to discuss this on a subsequent call.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

– Marjorie and I think it would be great if, two things, if number one we could reference our sort of the framework for identifying readiness and appropriateness of – standard. And then obviously if we have a couple more folks on the call.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

That is correct. So, Alicia, Michelle, Lauren, I think we'd like to take those other two 2017 items and put them on the agenda for a subsequent call, as Danny described.

W

Okay, so, why don't we internally at ONC take the notes from these three calls and distill those into what the themes are that we think would be what we would want to get agreement from the group, although we haven't had great participation during these three meetings. If that's what they want to put forth to the Standards Committee as their deliberations and recommendations and comments on what's transpired over these three meetings. And then maybe start to try to elicit on the remaining items, comments in advance of the meeting that perhaps could also be shared with the workgroup on April 24, as our initial thoughts and deliberations about the 2017 and then go from there with regards to scheduling one more follow up meeting. Does that sound like a –

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

I think that would be helpful.

Robert McClure, MD – Owner and President – MD Partners, Inc.

Yeah, if we could kind of, I agree with all of that, I think we do need more input from, and we can't do it if there are just two of us. But the one thing that we kind of might help solicit that input would be to send out another, I can't remember whether you sent out the PowerPoint or whatever it was, but that highlighted the particular items. I mean, I guess it was a Word document, too, that now would be focused on the 2017 asks. And the nice thing is that if we – I would imagine that there's a good chance that many of the other participants have been generating responses that they're going to submit. If they get that now new list that's just the 2017s, they could potentially collect the information that they were going to submit, or that they will submit separately to – in response to the NPRM, then they could submit that again and we could debate it.

W

That sounds good.

Robert McClure, MD – Owner and President – MD Partners, Inc.

That way we can collect their – because I'm going to guess a chunk of the committee members have been putting together responses and if we just got their responses, then we could del – kind of coalesce all of those.

W

Sounds good.

Gene Nelson, DSc, MPH – Dartmouth University

Hi, Floyd and Marjorie and all, this is Gene Nelson. I've been listening in since about 25 until the hour. I really have not had anything to add, but I have been on the call.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Thank you, Gene, for joining us. Okay, so are we ready – I guess it's time for public comment, unless Danny you have anything else you'd like to bring up.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Nothing else, Marjorie.

Public Comment

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

Operator, can you please open the lines?

Caitlin Collins – Project Coordinator – 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.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Thank you.

W

Thank you everyone.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Thank you everybody.