

Quality Measures Workgroup
Draft Transcript
March 23, 2012

Presentation

Moderator

The lines are now bridged.

Mary Jo Deering – ONC – Senior Policy Advisor

Thank you very much. Good afternoon, this is Mary Jo Deering in the Office of the National Coordinator for Health IT and this is a meeting of the HIT Policy Committee's Quality Measure Workgroup. First, this is a public meeting and there will be an opportunity for public comment at the end. I will ask all members to please identify themselves when speaking, and anyone to identify themselves when speaking as there will be a transcript made; thanks.

So now I'll begin with the role; David Lansky?

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

Yes, I'm here.

Mary Jo Deering – ONC – Senior Policy Advisor

Peter Basch? Christine Bechtel?

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva Powell on the call for her.

Mary Jo Deering – ONC – Senior Policy Advisor

Yes. Tripp Bradd?

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

Present.

Mary Jo Deering – ONC – Senior Policy Advisor

Russ Branzell?

Russ Branzell – Poudre Valley Health System – CIO

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

...? Neil Calman? Carol Diamond?

Meredith Taylor – Markle Foundation – Director of Health

Hi, Meredith Taylor in for Carol.

Mary Jo Deering – ONC – Senior Policy Advisor

Tim Ferris? Patrick Gordon? David Kendrick? Charles Kennedy? Karen Kmetik? Rob Kosher? Norma Lang?

Norma Lang – University of Wisconsin and American Nurses Association

Here. Can you hear me?

Mary Jo Deering – ONC – Senior Policy Advisor

I can hear you fine, thank you.

Marc Overhage? Laura Petersen? Sarah Scholle? Cary Sennett? Jesse Singer? Paul Tang? Joachim Roski?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Jim Walker? Paul Wallace?

Okay, and whoever's on the phone please identify themselves.

Ahmed Calvo – DHHS/HRSA – Senior Medical Officer

Ahmed Calvo at HRSA's Office of Health IT and Quality.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

This is Kevin Larson from the Office of the National Coordinator for Health IT Meaningful Use Team.

Jon White – AHRQ/HHS – Director IT

Hey, Jon White from AHRQ.

Pat Santora – SAMHSA/CSAT

Pat Santora from SAMHSA, Center for Substance Abuse Treatment.

Russ Diamond – ONC

Russ Diamond, ONC.

Jesse James – ONC

Jesse James from ONC.

Mary Jo Deering – ONC – Senior Policy Advisor

Okay, over to you David.

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

Thanks Mary Jo and thank you all again for making time to join us. We had a call, many of you were on a couple of weeks ago, March 2nd, and as a result of that call we did our first pass through the issues that were surfaced in the NPRM with regard to the clinical quality measures for Stage 2. I think today we'll stay focused on Stage 2.

In the interim I think we've all had a chance in our own context to continue to discuss some of the issues, even in the last Meaningful Use call this morning. Some of these questions surfaced again. However, I don't think we have processed all the input from the last call in order to bring back to you today a very well cooked set of draft proposals for discussion. So I think what we'll try to do today is two things; one is a probably relatively brief review of where we got in the last call and people surface any additional

considerations for now. Then, secondly do an update on some of the de novo measure development work that Kevin can catch us up on that will be germane for what's available for Stage 2 and certainly what's in the pipeline for Stage 3. I'm going to try to make this call a little bit shorter, maybe than we planned.

We do have another call in about a week and I think our challenge will be with staff and I'll certainly contribute; try to put together some major initial proposed recommendations that we would want to communicate to the Policy Committee on April 4th. So, just to refresh everyone's memory, the common period for Stage 2 is open until May 7th, the Policy Committee is intending to digest the input from several workgroups, including ours, on April 4th; that's in about ten days.

At that meeting they will probably give us some feedback as to whether what we are communicating is consistent with what the larger Policy Committee is thinking and then we'll have a chance during the month of April to continue our own thinking, take into account the input from the Policy Committee and others. Then we'll have time over the month of April to formalize our thinking and share it again with the Policy Committee so they will hopefully incorporate it into their comments to CMS on May 7th. So I hope that schedule roughly makes sense, and I hope I've got it right, Mary Jo and Josh.

So we have some time; we have five or six weeks to continue to think about how we want to express our views to the Policy Committee and certainly continue to share with each other our thinking. So with that in mind, I think what we'll try to do is again, review where we came out last time, compress that in a sense of the staff can begin to turn it into some talking points and then we will at our meeting next week review that and hopefully see that we have something we're ready to share with the Policy Committee on April 4th.

Let me see, if Josh, Mary Jo, you think, Kevin, I got that right for now?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

This is Kevin; it sounds good to me.

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

Okay. Then I think what we'll do today; let me just kind of go through the major questions CMS asked us to comment on, and how far we got in our last call. Then I think the staff will take whatever we summarize here today and turn it into something in writing that we can review at our next meeting.

So with that, we did have a good discussion last time of some of the high level reactions people had to Stage 1 and to the NPRM itself. We then dived into several of the specific requests for comment that CMS has identified. On one of the primary questions they opposed to us is the reporting options 1A and 1B, and probably as you all recall, 1A would be an approach that would let eligible professionals report 12 clinical quality measures from the long list in Table 8, but they would be required to report at least one from each of the six domains. CMS has asked for comment on those six domains, they've asked for comment on the list of 125 or so measures and they've asked for comment on 1A versus 1B.

My takeaway from our discussion earlier this month was generally a tilt towards 1A given that it provided more flexibility; it continued to encourage people to address each of the six domains. It allowed different specialists and different practice types to find themselves somewhere on the list, that was all in its favor. There was some sentiment advocating that 1B had the benefit of focusing attention on a specific comparable set of measures that would be more widely adopted. I took away from the conversation some general signal in favor of 1A, if we had to pick one versus the other. There was some requests that we look for some alternative or hybrid, but obviously that work hasn't been done.

Let me stop there and see if what I took away from the conversation is about right, or if people would like to revisit the direction that favors 1A as an approach that we might communicate to the Policy Committee.

If we were to call the question today and had to vote; 1A versus 1B, would we still as a group favor 1A?

Russ Branzell – Poudre Valley Health System – CIO

This is Russ Branzell, I think I would lean toward 1A being the way you described it earlier.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva. I think that's probably the way I would lean.

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

This is Tripp, and I'd agree.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Joachim Roski agree as well.

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

Alright. So, the main drawback of 1A as people have identified was, it wasn't very parsimonious and doesn't drive people towards a narrow list. So that may be a place we want to come back to the question; if we do endorse 1A in our comments, which is the gist of today's discussion, then we may want to suggest ways of making 1A more parsimonious and more focused to some degree without losing its flexibility. I think that's where we would come back to the long discussion we had on e-mail about what are the criteria that CMS might use to revisit the Table 8 list. So let's hold that thought and maybe Kevin, I'll see if you guys can get some more thought to how to frame a comment to the Policy Committee that favors 1A and encourages CMS to do additional work on the inclusion criteria for what's on the Table 8.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yes, we'll be happy to do that. We'll draft some language and run it past you, David, and whoever else you'd like to have us review it before we send it on to the whole committee.

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

Great. So then we did have the long off-line discussion on e-mail about the criteria to encourage CMS to use in revisiting Table 8. I don't know if anyone has digested all that, or has further comments. I think what I would ask the staff to do is look at both the notes from our verbal conversation and the e-mail thread and see if we can compress this to a couple of options for discussion next week. I don't think we had agreement, what I read in that thread I think is actually a range of opinion. I know not everybody who was on that thread like Peter and Jim are on today's call. So I think to be fair if we could try to; again I'll ask Kevin, if we could distill that long discussion to a couple of options or proposals or alternatives, then on next week's call, perhaps we can either find agreement or we'll agree that we don't have agreement and maybe it's not an area that we can make a consensus recommendation on.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yep, I'm happy to do that, I'm pulling them up here so I'll be happy to do it.

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

Let me ask people on the call, any—given the both verbal and online conversation we had, anybody want to make any further comments on the criteria for selecting measures discussion?

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

This is Tripp. One of the things that Kevin got back to me on was the concept of HIT feasibility as a concept.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yes, I'll get into that in some of my, this is Kevin Larson again, I'll get into some of that in my testing discussion for the measures. But there are some, and this is sort of pre-shadowing the, what I'm going to talk about later, some of the measures that reference things like guidelines and don't actually call explicitly out what the details are. While electronic, a measure that comes straight from the electronic medical record can't simply reference a guideline in the way that one that uses a human being abstractor can. So there are some that have some inherent issues and need for a lot more specificity in the actual measure than has been done in some of the measures that we are retooling.

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

Any other reactions or comments on how we might see what that ... of issues of criteria?

Eva Powell – National Partnership for Women & Families – Director IT

Well this is Eva. Just a general comment that I felt like a lot of the conversation by email was kind of rehashing work that other people have already done and just for us to bear in mind; I mean I appreciate the need to be realistic about what's possible in an electronic environment, but I think much of the prioritization work has already been done, and done, and done, and done. So there's that issue. But then there's also that tension of much of our quality measurement and the lack thereof is driven by an inability to collect the things that we really need to be measuring, and help IT is a key to being able to do all that. So we also need to push things, but understanding that in Stage 2 there is going to be a limit to what we can push because of the development cycle, but we still need to push. So I just would challenge us all to hold all of the tensions in mind and certainly not to redo work that's already been done by many other people many other times.

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

I wonder Eva, if the way to do that would be to maybe remind everyone of, for example the map criteria and that there's been some consensus around criteria for measures generally. But then separately I think, as suggested ..., talk about what are the additional or distinctive criteria that we want to advocate, particularly for the purposes of the Meaningful Use EHR incentive program that in effect sit on top of criteria like the map criteria that are already widely accepted. So we don't rehash things that are in general, as you say general accepted discussions, but really focus on the ones that are distinctive to this program.

Eva Powell – National Partnership for Women & Families – Director IT

Yes, that sounds good, and Kevin, I think Josh said on the last call that the ONC staff were putting together a crosswalk with map? Do you know if that's done, or if we'll have to—?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

We have an initial draft of the crosswalk with map. I don't have it on hand, but we have been doing that work. Is that something that this group would like?

Eva Powell – National Partnership for Women & Families – Director IT

Oh, absolutely. I think that's critical.

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

Okay. Can you Eva or Kevin can you clarify; you mean a crosswalk of criteria or of measures?

Eva Powell – National Partnership for Women & Families – Director IT

I guess in my mind what I mean is the crosswalk of measures between what map is recommended and what is proposed to Meaningful Use.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yes, what we have done is taken all of the measures that are under development under the contracts ONC has as well as we looked at some of those that CMS has as part of this incentive program and looked at which ones were actually map supported. So we do have that crosswalk.

Eva Powell – National Partnership for Women & Families – Director IT

David, I think that's a good question because it would also I think be helpful to have the criteria.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

I'll work on that too.

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

Good. Okay, so the next topic, which is germane, extends to this last one, was the six categories that we had developed way back with our Tiger Teams and have been carried forward during the National Quality Strategy for the somewhat rewarded. TMS asked for comments on whether those six categories from which the quality measures would be drawn are still right, and I guess I'd welcome; well obviously this group has supported those throughout, but if anybody here now who wants to make any comment to CMS that would reconsider those six categories or are we still happy with that structure?

That's the Patient Family Engagement, Patient Safety, Care Coordination, Population, Health Efficiency and Clinical Process; those six buckets.

Russ Branzell – Poudre Valley Health System – CIO

This is Russ Branzell. I think it would be difficult to change that at this point, mainly because it's become a widely accepted categorization. I would recommend we continue with those.

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva, and that seems to be the only place that CMS considered this group's recommendation. So it would be nice.

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

Any dissent from continuing to support that structure? Okay, so the next implication of that, of course, is are the measures that are available to Meaningful Users in Stage 2 within that structure sufficient and appropriate? So that takes; I know I've done it, I don't know if we've done this as a group, sorting the full list of 125 by those six categories to see what's actually in there. I think as I look at it anyway, personally, it raises some questions for me and maybe nothing can be done about that now, but it may nonetheless be a subject appropriate for us to comment on.

I'd asked Kevin if it would be possible to take the Tiger Team recommendations that we supported about a year ago, like it was a year ago last February, and crosswalk again, our recommendations for measure concepts against what is now available in the actual proposed rule, so we could essentially make a comment as a committee whether CMS has moved things along the path that we had requested in our previous work. To me it's sort of our own accountability to ourselves to see that our recommendations have or have not been satisfactorily addressed.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

I'll get that out to you guys before our next call. I needed to spend some time, as I'm new here, finding out where all the artifacts of these things live. So that's on me.

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

Sure, I appreciate that Kevin, and obviously we need to take some time to get that sorted out, but let me just ask the group if that seems like to you all a worthwhile task to burden the staff with, validating the current proposal against our original suggestion?

Eva Powell – National Partnership for Women & Families – Director IT

This is Eva, I think so.

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

Any disagreements about proceeding that way? Okay, I hear none.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

So, let me just clarify. So it sounds like what would be helpful is a list of the measures with one column that would be, where do they fall in the six categories, and another column mapped to the Tiger Team recommendations. That way we could look at them through more than one lens. Is that what I'm hearing?

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

Yes, and maybe two separate documents. I haven't in my head put them quite together, but you and I can work on that offline and sort that out.

M

So I think those are the right two products, whether it's on one page or two.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Okay.

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

The next topic was this crosswalk topic and around alignment. So we've talked about aligning; we just talked about the domains. We talked about PQRS and aligning the reporting models and everyone felt strongly that alignment was a good thing, and reducing burden is a good thing. We had some discussion last time; let me just remind everybody and see if it's still the case, but there was some nervousness that alignment shouldn't be alignment to the lowest common denominator but we should align toward the most valuable approach to these quality measures. If the Meaningful Use, so on a specific case of PQRS, two solutions were suggested.

One is that PQRS adopt the same attributes that are being used for Meaningful Use measures. If that's not feasible or too ambitious given the structure of that program, rather than sort of deeming a PQRS submitter as a Meaningful User, which is what their draft rule implies, we might reverse that and say, if you're a Meaningful User satisfying these option 1A requirements then you could be deemed to be a PQRS compliant user. So it's actually flipping the compliance strategy. Again, what I think we should do is put some kind of a proposal in writing and bring it back to this group for further discussion. But let me just first test whether I remembered our last conversation about it right, and if people have any additional thoughts about the PQRS or other alignment questions.

So, hearing no comment, I guess what I'll do is see if we can again work with the staff to develop a written summary of that discussion around the PQRS alignment and we can review it at our next call.

The next big one was this group reporting option which we last time said we liked and this morning we were subject to a very long conversation by the Meaningful Use workgroup in which partly I think because we had in front of us; is that Josh? No, I thought someone had a comment. On the group reporting option there was a long discussion today because of one of the exhibits that the staff used listed the 20 or so questions that CMS has posed about the group reporting options, and as the Meaningful Use group stared at that list, which I think is on page 242; 241, 242 of the draft rule of the proposed rule, it raised a lot of questions about whether the group reporting option was really describing a coherent clinical practice group, which if so everybody felt like it was a great idea and we did too on our last call. But if not, if it's a just a convenience tax ID number with a bunch of doctors under it, it may be that a lot of the aspirations of the clinical quality reporting would be lost.

So for example, if you have 25 or more doctors who practice under one tax ID, but are not really clinically a team, which measures do they report, what happens if some individual doctors can't report some of the measures, want to be excluded on some but not others for legitimate reasons of different practice type or so on? Is having them report as a group of 25 or more doctors a meaningful reporting of quality measurement and meaningful for purposes of assessment or improvement.

The committee this morning was backpedaled a little bit on the group reporting option as it started being impractically realized. I guess, having heard that discussion this morning; I know Eva, maybe others were on that call, do people think we should revisit our endorsement to the group reporting option or you think we want to stand pat, once we bring this forward to our next call?

Have any of you been doing it additional thinking about the group reporting option for quality measures that you want to comment on now?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yes, I can make a couple of comments. One, as we dive into some individual measures, it becomes a possibility in some of the measures to actually think about responsibility for patient outcome among a team instead of among an individual. There have been people as we've discussed these that have been proponents of that idea. So for example when we talked about the warfarin measure coming up, that one of the questions is if a patient is on warfarin and is taken care by a cardiologist and a permanent care doctor, and maybe another specialist, is it an individual in that group of people that is responsible for that patient's warfarin or is it the group of doctors that's responsible? The group responsibility option has some practical benefits to not throw the whole responsibility or accountability onto one person. That then brings up measurement questions about how do you give group responsibility, but only have reporting option for an individual.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

This is Joachim Roski. Does CMS have the ability to ... groups rather than individuals under this program? I can't remember.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Not really but that is coming, of course with things like ACOs and different sort of bundled payment methodologies.

Josh

This is Josh. Is your question about Meaningful Use, can they make the payment to the group?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Correct.

Josh

Yes. So that's the proposal that's in the ... that was not in Stage 1, and so what they've proposed is on the clinical quality measures that there's an option that they can choose that would allow them in a sense to do that.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Then double dipping, you can only do one or the other I suppose, right?

Josh

Correct.

Norma Lang – University of Wisconsin and American Nurses Association

This is Norma Lang. Since you brought up the issue of team, has there been any thought of other than MC or physicians in that team?

Josh

The list of eligible professionals, it does include on the Medicaid side, in particular some additional professionals, but that is set by statute, that's not something that CMS or HHS has the ability to change.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

That includes people like nurse practitioners and dentists, for example.

Josh

Right.

Norma Lang – University of Wisconsin and American Nurses Association

That was part of being on my question.

Josh

PAs and certain types of practices, those that are led by PAs and that's on the Medicaid side.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

This is Tripp. I have the tendency to agree with the team concept or the ease of reporting, again, getting back to the feasibility of it. A lot of practices have a designated person to do the attestation currently, not by position, and by doing it by group might simplify that process, perhaps. The idea is to get the reporting done and the easier we make it for the providers, eligible providers, the better it will be. I think the group thing just lends itself towards that.

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

So I think, Josh could probably clarify, I think there's an option for batch reporting which would make the physical, administrative work a lot easier, along the lines of what you're saying. That's different from that group reporting where 25 or more doctors, EPs, have the results that denominator pools and the numerator pools. I think the concern given the list of 20 issues CMS surfaced is it what kinds of physicians are in that cluster of 25 could the all kinds of things. So it's not necessarily coherent clinical practice team, it's a bunch of people who have a shared business contract, they have a tax ID is the only formal requirement CMS can actually monitor.

So the question came up this morning; is there any way for CMS to tell the difference between a bunch of physicians who share an office suite and a bookkeeper versus an integrated team providing care together to a group of patients for whom we would all feel good about having shared measures. There may not be any way for CMS to draw that distinction, in which case the risk of having big pluralistic groups of physicians under a common tax ID may make it really hard to know what the measures mean.

Russ Branzell – Poudre Valley Health System – CIO

This is Russ. I think where we're going to find problems with this are mostly a lot of the larger employee medical groups that are under a health system or hospital structure, in which this is very appealing for us. But all the complexities that are going to be coming out, and the amount of significant questions and variations that will be out there, then create a lot of complexity for us because it's a defined medical group. They do consider themselves a cohesive multispecialty group, but you're going to have so much variation that's going to want to be under that umbrella that I'm not sure it's going to be feasible to actually report under it.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

This is Joachim Roski. Does CMS have any solutions yet identified to administer some of its innovative payment programs and how they're sorting out who's who and under these new arrangements, be that bundled payments or medical homes or ACOs? It may provide some insight into how this could be organized here.

Josh

That is; this is Josh, that is sort of what they're trying to do, they're trying to make them as common in the approach as possible.

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

So for example, Joachim, I think on page 215 there's a proposal that another group reporting option is this here in an ACO or a pioneer ACO you can submit your ACO measures and then get credit from Meaningful Use. So I think they're trying to align and bring together the payment models with this EHR incentive program, but I think as the last conversation suggested there it's going to be easier to more coherent new programs like ACOs will make that pretty easy.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Yes, right, that's right.

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

The old stage programs like PQRS may not get us very far.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

That's right.

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

So what I'm hearing from our conversation so far in terms a comment is we like the idea of finding more efficient batch or group reporting options where we think it doesn't hide our real diversity or variability within the group. So it's a meaningful group reporting option we're in favor and we have some uncertainty as to whether the proposed group reporting option will meet that test. Is that a reasonable summary of our discussion?

W

Yes.

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

So again, I think we ought to put something in writing that expresses something along these lines for next meeting and they we'll have a chance to visit this and maybe a few ... to take a closer look at the text in the rules and especially that list of 20 questions that's on page 240, 241. Maybe we can provide a more formal set of guidance to CMS of how to make it work best addressing the multiple goals we've just talked about. Any other thoughts about the group reporting options and how we might want to respond to them?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

The only other thought that I have, and I apologize if I'm not as close to it as some of you are, is it their way for CMS to define to make it financially not attractive for "artificial" groupings of physicians who come forward under group reporting rather than "natural" groupings, i.e. under ACOs or physicians that work together quite clinically speaking, rather than in some administrative format only. I don't know exactly how to best think about that, but so for example how do you—is there are any financial incentives to come forward as an individual, because you could you reap more money than if you were to come forward under a group, or the other way around for that matter.

Because if that wasn't the case I would imagine that there's no incentive to come forward ... financial aid, why would you, other than if administratively so much easier to handle that your cost offset is—

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

They asked a couple of questions in their long list about the payment arrangements in a group model. Maybe that's an opening for us to think about your suggestion, Joachim. It's an interesting idea. Any more thoughts about that one?

Jesse James – ONC

One thought is, Jesse from ONC. The administrative simplicity in itself a financial incentive when you think about it because there's some cost, there's some financial cost that increase administrative burden. But also from a broader point of view, as someone who is in the physician job market within the last five years, the trend overwhelmingly is for small practices to be bought up by hospitals.

Everywhere I interviewed the practice itself was being bought by the local hospital and that trend makes the reality of group reporting imperative. It's something that has to be figured out, and the balance between missing individuals for the sake of the group or that that individual has an administrative efficiency, or if it's really practicing as a group I would suggest that perhaps what's more important is that if that group's payment is tied to that group's performance, the individuals inside the group therefore have an incentive to put pressure on their underperformers over time. That perhaps missing some the individual signal might be something that can be foregone for the sake of paying as a group and forcing the group itself to police itself.

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

Another wrinkle on this has been, there are some questions raised about, you can imagine the group as the kind Jesse just described; let's say 50 physicians could be on five different EHR platforms, all certified maybe more or less interoperating with each other. On the one hand they're all certified, they may be, their capabilities of reporting the quality measures, they may be all technically capable of it. I think one question we have to ask ourselves is, what do, we what are we looking for, what are we testing for in this pluralistic group environment. Is it that each of the 50 physicians can report a dozen quality measures relevant to their specialty, or that as a group they can somehow generate a denominator and numerator, but we can't really validate whether it's coming out of all 50 EHRs reliably.

I don't know the answer to those questions, but I think these groups will be very pluralistic, both by practice type ... populations, quality measures of interest, technology platforms they're using. I guess our job is to figure out what the program's interest to be looking for. The fear I think on the flipside is what we end up with is some numbers that don't mean anything. Somewhere these 50 doctors saw X thousand patients that had X thousand numerators and does that tell us anything.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

This is Tripp. If I understand correctly, though it will still fall to the individual physicians as far as attribution, won't it? So that will be tracked?

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

On the criteria, the Meaningful Use functional criteria, I think the answer, Josh can correct me, is yes. But the quality measures would be a big numerator and a big denominator.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

Yes, I just didn't want, like you were just mentioning. I didn't want to get the figures lost in the committee, so to speak, of the single practice entity or whatever.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

I mean is there a way to think about for CMS to allow different entities to rely on different measures for extra credit, or equivalent credit, i.e. theoretically speaking, those who have integrated EHRs within, let's say, in emerging ACOs may have the ability to demonstrate Meaningful Use in different ways than individual physicians who have to demonstrate Meaningful Use.

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

That goes back to Table 1A, 1B distinction in some ways you can imagine a 1B solution where there's a core set of measures that all 50 of our hypothetical physicians have to be reporting on. So you would have more interpretability of the data.

If you go to the menu and the group reports on 12 measures, but out of the 50, some of those 12 apply to 30 of them, some of them apply to 20 of them, some apply to 49 of them. It's hard to know what we have it the end of the day.

Josh or Kevin or Jesse, any other suggestions on how we should think about this and how to provide useful input to CMS?

Josh

This is Josh. The only thing I would say is, is just in terms of the Policy Committee had solicited input about a year ago, a little over a year ago, in a request for comment on the questions around group reporting more generically, not specific. It was actually probably more around the Meaningful Use measures, but some of the comments that came in were related to both measures. I think in addition to the sort of administrative issues, I mean goals around somebody's care, there also were some things that were raised related to how to assign a patient to a particular provider in certain circumstances, that there may be that sort of relates to the comment about warfarin that Kevin made, but there may be some challenges in assigning particular patients to particular providers for the purposes of measurement.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yes, so I'll just echo what Josh said as we dig into making sure that these measures all have real good clinical meaning. In some large group practices, that is distributed between primary care and specialists, for example. It may be clear in the group practice which part of them is responsible for blood pressure,

but currently the way that this measure's all being attributed to an individual, each individual then has to make sure that they're responsible for blood pressure as opposed to having the group practice having figure that out among a multi-specialty group.

W

Could somebody address so what happens if the patient is assigned to a warfarin clinic for example?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

So we can talk about the specifics of the warfarin measure; the current way that it is being proposed is that the provider that is writing the order for the warfarin is the provider that is being measured.

W

Even though most of the decisions and care is done over in some clinic?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yes, like I said, we can get into the details of that when we talk about this measure, but those are some of the kinds of individual versus team questions that the specifics of measurement bring out.

W

Yes, that's why I was raising those things.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yes.

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

Okay, well I think it we've framed it a little bit today, we'll have to think about if we should try to respond specifically to questions in the NPRM, so that we have the structure to our comments. Again, I would encourage people to look through those detail set of questions on pages 240, 242, and see its given this ... gone through if we can see a way through it on one of our next calls. It may be for the purposes of the policy committee meeting we simply want to summarize some of the things we've just talked about so that the complexity of this particular one is brought to their attention and we may do some more work during April to try to see if we can recommend a solution.

Next topic that we had talked about last time was the hospital reporting structure, which we actually felt pretty good about. Nobody had any particular concerns about it, including the shift towards this reporting 24 out of 49 measures, including one from each of our six categories. Any change to our view that we support the proposed change for the hospital reporting?

Alright, so tentatively we're going to go ahead and endorse that proposal. There's one little footnote to that, maybe Josh can comment on it. There was a request for comment from us which we didn't talk about last time. They asked about the patient population that should be the basis for the submission of the quality measures. As I understood it they asked whether we should ask hospitals to report on all their Medicare patients, all their Alpare patients from a sample of Medicare patients or from a sample of Alpare patients. There were four choices and they said they would like to end up with only one patient population as the basis of quality measurement reporting. Do I have that right Josh, is that the question?

Josh

I am not sure; I will have to look at that. Kevin do you know?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

I don't know offhand, no.

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

Alright, let's park that one to come back to another time unless someone on the call is expert on the subject and wants to comment on it.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

No, we'll look into that. I will say that we've been talking to them about how they're doing ACO reporting and that they're looking at some sample base reporting for that. So, just FYI.

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

Okay. So otherwise I think we were good with the hospital reporting questions that they had posed. Then a couple other issues that surfaced in our last call that we probably will want to keep coming back to. One was the hardwiring versus having an "engine" to compute measures, and the concern that has been raised both by users and by the committee was that many of the vendors had gotten through Stage 1 by hardwiring the list of measures.

Now that the list of measures might be as many as 125, that's an awful lot of hardwiring and it doesn't really solve the longer term problem of having a flexible platform that adapts to a variety of quality measures that different specialists or practice settings might need. Jim Walker made the point that he thought it was important from quality improvement point of view to have a quite a lot quality measures available for use within an enterprise. So the question was, is there some way in our work that we could signal to the vendors the desire, and this maybe goes to a ... with a certification and standards folks, is there a way to signal the desire to have a more flexible platform in which each quality measure specification is not hardwired into the vendor product? Then there were some other issues around certification that had surfaced during our last call. So again, I think we'll bring that forward for further discussion. I don't know if people have any further thoughts since the last call about the hardwiring question?

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

This is Tripp. I was in an advisory committee meeting for an EHR just yesterday. We were talking about that and I think you're suggesting more or less a Rosetta Stone to translate whatever data that comes out of an EHR land in some other place for measurement. Is that what you're trying to say?

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

I think there are two issues. There's the receptor site for the measurement specifications. So as people are beginning to standardize the quality data model and other tools how the measure specs are specified that the vendor product be able to accept an input of a measure specification and then generate the resulting numerators and denominators.

Secondly, there's this reporting platform question that people have talked about, which is to offload the calculations to an independent platform. So the EHR doesn't necessarily have within it all the calculating power for all the measures, especially if you look at measures that are longitudinal or delta measures or multisite like readmission type measures where all the data is not necessarily in the EHR. Should we start looking at a way to have the EHR export the relevant data to an independent platform that does the integration and calculations? So there are two issues in play there.

M

I think in the thread I mentioned research network that kind of does that through an EHR. You know individually of course each particular practice couldn't do it, but a separate entity could and did a fairly

good job and with the purposes of ultimately changing the behaviors of the individual practices with our quality measures. So, it worked pretty well. Can that be translated across different EHRs? If the level of complexity increases, but it certainly been done with one EHR in any case.

M

I'll just remind the group that we have under development this popHealth tool, and part of the popHealth tool's goal is to be able to take CCD documents and convert them into quality measures. So we do have a contract here at ONC to develop such a tool.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

So David, all you see is the ability of the HR's to generate, if you will, a CCD or in essence, an XML kind of reporting format that would be then turned at an off-site place.

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

That's one answer, right. I mean, where they split the effort, how much is the EHR ... there's another counterargument, which I think Paul has voiced, that you want to have local rapid feedback of the benchmark data for internal improvement and monitoring. So you don't want to off-source it, off-site it too far. So maybe there's a hybrid where some of these measures are generated locally for internal feedback and others are, as you say, the raw data is shipped off to a third-party site.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

Would the popHealth information, this is Tripp again, be available to those practices via web or whatever?

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

Currently popHealth in a kind of alpha testing phase and the software is being built as Open Source. So we don't have any places live, but we have tested against real data and the vision is that it would be available on the web and that with some frequency, as determined by the group that was using popHealth, the data from that group's practice would be sent to popHealth for that group to see. So yes, it's web-enabled and my understanding of the tools, it could take any number of frequencies of data being loaded into it daily, weekly, monthly, yearly, quarterly.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

I would say, this is Tripp again, since we've had experience since '95 with it, I will tell you how much the individual practices have really improved their care as a result of that. As you mentioned David, fast feedback, so I think having access to the data really makes a big difference, certainly enterprise wide places have a lot of infrastructure to push the quality. But when you're a private practice out there on your own, it's valuable to have this kind of resource.

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

This would be a really appropriate area for us to make some comment, especially as we look toward Stage 3 and we want to make sure that Stage 2 is a way station toward something with even greater value and robustness. So let's again put that on our agenda, Kevin, for the next discussion. What can we appropriately do to avoid this hardwiring and fairly narrow approach that might be a short-term temptation?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

I'll make one more comment if I may. This is Kevin again, about the first of your two items, which I thought were nicely articulated. This idea that the vendors can take in new measures and fairly quickly have them be live in the systems. We're working on that as well with the standards group under Jacob and others, trying to figure out how our measures have more consistency across measure to measure.

So, for example, the value sets may have more consistency and we're hoping that with some more consistency across the measures, we help support the vendors being able to do this kind of more modular work as opposed to each one being a fresh creation.

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

Good. That's very encouraging. Okay, let's see how are doing on our list. I think we've covered most of the topics that have previously surfaced and that are in the CMS request. There are a couple of technical areas we haven't talked about much. For example, the reporting methodology, portal ..., all of those kinds of questions we haven't come back to, and maybe we'll hold on them until we get through some of the heavier lifting in the next few weeks.

Let me just ask everybody if there are any other topics on the quality measures in the NPRM that we haven't at least identified in the course of these calls and that we can now start honing in on our comments on. Anything we're missing that you want to make sure we comment on?

Eva Powell – National Partnership for Women & Families – Director IT

David, this is Eva. I know it's not in the rules, so I know that we can't get it into the final rule, but just the whole notion of patient experience. I know there's the debate about these measures need to be able to be generated by the EHR. But it seems to me if you kind of just step back and say are we meaningfully using health IT or not, there has to be a patient experience component there, and how are we going to get at that? So maybe that's more of a discussion for Stage 3 and we should table that, but I guess I'm just troubled by the fact that there's still really nothing in this rule in terms of quality measurement from the patient perspective.

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

In a related topic there, I think as you've all seen, there is the proposed measure that's not yet final that Kevin can talk about regarding functional status. For several functional status measures proposed in the rule, including one for pre- and post total knee replacement. They raised the question of what the expectation of the data field in the record, is it a yes/no field? A yes, a functional status assessment was done, yes/no, or is it the score for a structured instrument? If so any instrument or certain instruments, and if you are capturing a preoperative score for, say, pain level or functional level then you want to capture a postoperative score then you may compute a delta measure between those two scores.

If we don't get the data fields supported in the Stage 2 certification criteria, then the data may not be there for Stage 3 when we want to actually compute a quality measure. Similarly for the patient experience, should we be proposing that certification criteria accommodate these kinds of data fields so that they're there for internal use and quality reporting? It raises a lot of questions. Eva, do you have any suggestions or thoughts of how we should tackle it for Stage 2?

Eva Powell – National Partnership for Women & Families – Director IT

I don't really know, but I think that's a good extra example and it just makes me think again back to the conundrum that we're in and a big part of why our quality measures are so limited is because we don't have, or we haven't had in place the means of collecting more youthful measures. Yet, if we're tying the actual quality measures in Meaningful Use to the ability to collect those, then we're kind of in this vicious cycle that we're never going to get out of and I'm wondering if maybe there needs to be an effort, kind of a split effort to recommend more from a standards perspective or, I don't know the best way to do this, but to get it exactly what you said is we're not proposing actual measures to be collected in this area but in Stage 2 we must see or however best to do this, which stage we really have to have the field to collect X, Y and Z data. I can name tons of examples of data elements that I know we're going to need for future quality measures that are nowhere in an EHR, at least not to my knowledge. So I don't know what the

best way to approach that is, but it seems to me like there may need to be a dual effort; one specifically focused on the measures themselves, and then the other, specifically focused on the data elements, and that would have a direct tie I think to the work that ... is doing with the QMS or the; I forget—

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

QDM.

Eva Powell – National Partnership for Women & Families – Director IT

Yes, thank you.

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

Eva, what you're really talking about; this is Tripp, is a patient ability to respond back to both the communication, coordination satisfaction, right? How about a web portal that would allow that to happen dually, if you will; one communicating to the practice, but also to CMS?

Eva Powell – National Partnership for Women & Families – Director IT

Yes, that could be one way, and I guess it was in this specific area of patient experience I see it as two different things. One is are we going to go down that path of trying to collect for ... patient experience data through the EHR in some way? So in that way the quality measure is a measure of the functional capacity. But then the other way to look at that is just from a more global way to measure whether or not technology is being meaningfully used, is just to ask patients. Are you experiencing better communication? So in that way, I don't know that that needs to be tied to the EHR at all, in terms of the functionality of collecting it, it's just a matter of having the perspective of the patient on are their tax dollars making a difference for them?

W

Would you clarify is this patient experience with the information technology or is it patient experience with the process and outcome of the clinical care?

Eva Powell – National Partnership for Women & Families – Director IT

I think it's the latter. Or at least that's in my mind what I'm more interested in and getting at. My understanding too of the CAP surveys that ask; I'd have to go back and look at this specific questions, but for the health IT module and for the new medical home module, they focus on not so much functionalities of the technology, but on how has the impact that that might have on the patients. Then again, I guess the things like, did you feel like you were communicated with effectively, did you understand what you needed to do, and that kind of thing and that really then I think puts health IT in the place of being a tool and not an end unto itself.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Eva, are you aware of any organization that's doing that today, that may serve as a template or best practice for how to think about this?

Eva Powell – National Partnership for Women & Families – Director IT

Doing what?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

To capture this information in their EHR.

Eva Powell – National Partnership for Women & Families – Director IT

No I don't, and I guess that's part of the problem I think is, and then that there are a lot of methodological issues to this. I'm certainly not an expert on that, but in my thinking, when I first brought this up, I was

thinking more from the perspective of just getting at, are we using health IT meaningfully? Certainly there are lots of ways to figure that out, but we shouldn't forget about the patient's family and let's ask them. Are they experiencing noticeable positive differences in their care because of health IT? Again, I don't think that needs to be necessarily collected by the EHR, and that's the bigger issue I think probably better suited for a Stage 3 discussion, but it does get at; are we making advancements in Stage 2 that direct us down a path to better quality measurements?

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

I think it actually goes back a little bit back to the discussion I had a minute ago about platforms. It may be that the capture of probes, functional status or patient employed measures happened somewhere outside of the enterprise and then data gets fed back to the enterprise for use and improvement. But where it goes and how it's stored, there's a much larger discussion and we're going to deal with at this stage except maybe to surface it.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

This is Kevin Larson. You could also mention an adaptation component to something like this. In the state I came from, Minnesota, where the patients in a medical home and we were required to have patient advisory councils for each clinic that was a medical home, and that was an attestation reporting. So that there was some things that were important and qualitative, but didn't actually have a measurement in the classic sense.

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

Well I know our time's running a little short. Now let's see, I think we've identified quite a few good issues that we'll try to summarize for you in writing before the next meeting. Some of which we have agreement on and some we have to have further discussions, and then staff will do some additional work on some crosswalks we've listed today. So with that I think what we'll do is turn to Kevin to catch us up on the current status of the measurement development work and then we'll have a couple of minutes for public comment, if we have any. So Kevin?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Great. This is Kevin Larson, thank you. I'll highlight just a few issues that we're running across in a couple of specific measures. As most of you know there are a number of measures that ONC has on contract to develop, and those measures are all on target except for two, and we'll highlight those two specifically. There are a number of other measures that are being developed by CMS, and in discussions with them, they appear to be on target as well. One of the ones we've been spending the most time on is the adverse drug event measure, and I'll turn it over to my colleague Dr. Jesse James to give you an update about where we are on that one.

Jesse James – Office of the National Coordinator

Thanks, Kevin. So when last we presented this measure to the workgroup, we talked about the measure as either an outcomes measure or possibly a process measure, an intermediate outcomes measure or process measure. In the time between, we've been focusing on three things around the measure. One we wanted to pursue a retool of NQS 555, which is process measure for checking roughly every six weeks for an INR for patients who are on warfarin. We actually found that there were some unique issues with the measure, which was previously a claims-based paper measure. There were some issues with changing it to an electronic measure.

So we decided to jettison that strategy and to look more either for a measure that was in place, live, ..., feasible, validated and reliable, and to also think about what the measure would be going forward to the end of finding a measure that's live in a medical center and outpatient setting that's already speced and

that has already been tested for reliability and validity. We found a measure used by VISN 21, it's a Veterans Administration measure. There is an entire suite of them that they've been using live on a dashboard inside of EHR for the last three years, two and a half to three years.

So where our thought process is currently is deciding between a couple of the measures. One of them is the percent of patients on warfarin with an INR that has been checked within the last 42 days. So this is similar to having an INR checked roughly every six weeks, and they look in particular for the previous six weeks from the point of view that people who are getting their INR checked roughly every six weeks will be more likely to have their INR checked with the most recent six weeks. That's also the point of view, taking with the HEDIS controlling your blood pressure measure where you look at the single final blood pressure for the year, as opposed to averaging every blood pressure over the entire year.

Another measure that we like that they've implemented and they're confident in is percent of patients with their INR supratherapeutic, for which they placed their threshold for supratherapeutic at 4.5, which is reasonable. Their threshold for the time or the percentage of INRs that are greater than 4.5 is 60%; I'm sorry it's 10%. So the range for that measure, the supratherapeutic measure, once they implemented it is they found that 4% to 10% in the first year of their sites, and there were seven medical centers in which it was implemented, 4% to 10% of patients were supratherapeutic over first year, who were supratherapeutic for greater than 10% of the time. The range for the previous measure, the INR check within the last 42 days, they found the compliance to be ranging from 59% to 94%. So it's a fairly wide range.

However, over the last two years of using that measure, they found that the performance improved from a range of roughly the 60s. So the 90s more in the range of the 70s to the 90s. So what we would like to get from the workgroup is thoughts on the measures, the more recent in the last 42 days, have you had your INR checked versus the pure supratherapeutic INR over the measure period.

What also would be helpful is that as we form this measure from what was rather vaguely described in the NPRM would be what would be a compelling case going forward for staying with warfarin. The way we've describe this it's medication that's commonly taken, more than two million people, roughly that's estimated because of course were not exactly sure at the national level exactly how many people are on any one given medication. It's commonly prescribed, it has a narrow therapeutic range, and it's commonly cited in literature as causing injury and contributing to hospitalizations and ER visits.

So, just to summarize, there are two main measures at this point that we're thinking of: that's INR checked within the last 42 days, and patients who are supratherapeutic, have greater than 10% of the time that they're on warfarin. Both of these measures are used in an EHR, so there's code, both for calculating the measure and for reporting it. What our thought process is and what our next steps are, are describing the measure in more detail and we're waiting to get specifications from VISN 21, and we're also concurrently thinking about, as we described, this measure more fully, we're making sure that we have a strong rationale to present with it.

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

This is David. The problem with the measure is I don't think they get us as far as the Tiger Team wanted us to go, and my worry more is that it testifies to a shortcoming in the pipeline in measurement development, though we can't test the domains and the Tiger Team report more thoroughly. One of the things on the list was warfarin monitoring, so good. But the real burden of the Tiger Team report was around ADEs, and I think this doesn't get us as far as we want to get. So my question really is what can we look forward to towards Stage 3? Maybe that's not the topic for today, but are we doing enough to populate the pipeline in measures to address these other domains?

Dr. James

Yes, I think that's exactly the same question that that brought up to us as well and we are at some point in the future really interested in talking to you guys about how we can make that pipeline better, and how we can really find a way to get measures in from where they've been deployed and live and actually built to be e-measures, as opposed to retooling currently existing measures.

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

The second thing I mentioned to you earlier, Kevin, is just wanting to validate that we have sense given the number of physicians who are managing patients on warfarin that we'll have a good uptake of EPs reporting this measure. I just don't know what the numbers are across the physician population.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Yes, we haven't had a chance to do that. But we'll reach out to CMS and see what we can find out about how many of the EPs are likely to be warfarin prescribers.

Dr. James

At the VA they found that this applied to a large number of their providers.

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

Other comments people want to share about this proposal?

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

This is Tripp. This is a common drug with a, like you mentioned, a narrow therapeutic range that I think any physician who's practiced long enough has seen a bad outcome from warfarin, and just starting this process is a whole lot further along the line than what's been done before. I think it's great what the VA's done and would like to see it implemented.

Dr. James

One of the other things we found appealing is in our discussions with the VA, they actually have a whole toolkit for practice about what you can do with your results and how you can undo some diagnostics about which particular strategies you can put in place to improve your score.

Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice

Right. This probably follows along the American College of Chest Physicians guidelines, and I think that's generally thought of as the gold standard for the safety measures.

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

Okay, let's continue with the other updates.

Dr. James

So the other one that we have as an, in read development is the measure for potent antiretroviral therapy and what we found is that the NQS #406 calls out as a reference to current guidelines for antiretroviral therapy, but doesn't actually put them out and doesn't list out all the different drugs and all the different codes. As our vendor developer, a very sharp physician, was starting to do this he brought to us the issues that there are thousands and thousands of combinations and permutations to build to make this an executable code in the EHR, and that this is likely going to be really changeable through time.

So as this measure would get put into the final rule now in 2012 to be executed in 2014 and beyond, there is likely to be new drugs on the market, but the way the current rules are written as far as we can

tell, we would not be able to add new drugs to the code specifications of this measure. So this one is one that we are really have not found a way through yet. There is a sister measure to this one that looks at the amount of viral load suppression, which is really much more of an outcome measure versus this; are you on the right drugs process measure. So we're going to focus our energy on the outcome measure of viral load as opposed to focusing on a lot of energy in developing this whole long list of drug names that may change through time.

Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice

Could it just be that you could; this is Tripp, just having a number of antivirals as a way of measuring it; for instance two or three to help you with that process? Not necessarily caring about the names or the—

Dr. James

That's a great thought and that's what a lot of organizations have done as a way to do this. In our discussions with the people that have used this in programs already, typically Medicaid and HRSA have already used some kind of HIV measures in their programs, and they said that there are times when it's appropriate for a patient to be on a single drug regimen. There are times it's appropriate for patients to be on two, and there are some three drug regimens that are not appropriate. So there could be some inappropriate clinical care that would get marked as appropriate, and vice versa in that kind of a measure.

If there aren't any other questions about that I'll move on to a couple of other items. Measure testing is coming up; that's something that we're doing and really want to be sure that measures are well tested. One of the concerns is that we're finding that across the contractors that are doing our testing, they're not doing it all exactly in the same way. Partly that's because this world of doing formal testing and electronic health records is new and emerging. So we're working to coordinate with CMS and with our vendors to really figure out how we can make the testing across all of those places the same.

A specific issue that we've identified is really a certification versus e-measure issue. So what is happening with these measures is they're getting tested for feasibility. So for example this warfarin measure; a vendor would take this out to three different hospitals, using three different EMRs and say can these EMRs do this, and then they would get a feasibility score. However, these will be tested for feasibility against Stage 1 certified vendors, but we're asking for these measures to be in Stage 2. So it's very possible that something like a patient reported outcome may be feasible in a Stage 2 certified EHR, but might not be feasible in a Stage 1 certified EHR. But because all of our testing is being done in Stage 1 certified EHRs, we may run the risk of the measures not scoring very well in feasibility testing.

So this is something that we've identified that the vendors and CMS are very well aware of. We're all planning to be sensitive to this and potentially then having a two-stage feasibility is it feasible currently, does it seem feasible in a Stage 2 certified EHR, but that's then more of a guess than it is actually a certainty.

I just wanted to alert this group to that because we might start getting some comments about that or some feedback about that.

Then, similarly related, the definition of feasibility isn't really clear. So for example, in this warfarin measure, it's up and live in six hospitals and has been so for a number of years, so it would therefore seem feasible. But under current feasibility testing structure, it would have to be tested at three different sites with three different vendors. So it might get a score of one out of three, and that might be a score to say it's not feasible because although it worked well in one place because it hasn't been working in more than one place, it might not be scored as feasible. So I don't know if there are any comments about those testing issues?

I'll move on then. There are a couple of quick updates; value sets is something we're actively discussing again across in QS, CMS, ourselves, and our measure developers, as well as we've been looking at the National Library of Medicine for some help on this as well. We have a vision to try to create value sets that could be reused across multiple measures. Currently a value set; let's say the definition of diabetes is created only in the context of one measure. So we may have five measures on diabetes, but they've re-created the diabetes value set five times, and nobody in the whole process thinks that that's ideal. We all want to get to a different place, so we're in the middle of figuring out how to get to that different place but we don't have that figured out yet.

Finally, automated testing of the measures is something that we're pursuing and we have under development the Sequoia tool to do automated testing for vendor certification, but we have just, with John ... help tested our popHealth tool as well with real data and that may actually have a role for testing our measures, both for individual practices or for vendors or for HIEs, so it's a way that they could get some validation. So its goal is really for a practice to use it to drive their care, but we found that it has this secondary ability that could also test the measures for you either as a double check or as a first pass test. So those will be some nice tools we hope to have available for people.

Other questions on the quality measure development or the other kind of quality measure work that we're doing here at ONC?

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

Alright, well thanks very much for the update. Thanks for that how the work everyone's doing to move these initiatives along. I think I'll see if there are any other last questions or comments from people on the call then we'll turn to public comments.

I guess Mary Jo, can you remind us when our next call is?

Mary Jo Deering – ONC – Senior Policy Advisor

Yes I can momentarily. Your next call is the 28th from 10:30 to 12:30.

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

We'll probably have a pretty full agenda if we're able to—

Mary Jo Deering – ONC – Senior Policy Advisor

That's right. Then you have one on April 6th, which is, of course, after the Policy Committee meeting. So, the 28th is your last one before the Policy Committee meeting.

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

I really encourage everyone to think about what issues they want to bring to the Policy Committee on April 4th, so that we can make sure we discuss them next week.

All right, thanks everybody for your help. Mary Jo, is there any public comment?

Mary Jo Deering – ONC – Senior Policy Advisor

Operator, would you please open the lines for public comment.

Operator

(Instructions given.) We have no comments at this time.

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

Alright, well thanks everybody for your time today; we'll talk again next week.