

**HIT Policy Committee
Quality Measures Workgroup
Vendor Tiger Team
Draft Transcript
August 17, 2012**

Presentation

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you, good afternoon everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup Vendor Tiger Team. This a public call and there will be time for public comment at the end and the call is also being transcribed so please make sure you identify yourself before speaking. I'll now take roll. David Lansky?

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

Yes.

MacKenzie Robertson – Office of the National Coordinator

Thanks, David. Kathleen Aller? Mike Aswell? Chris Bontempi?

Thomas Ryabin – McKesson Provider Technologies

Thomas Ryabin for Chris Bontempi.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Thomas. Annette Edmonds? Joseph Geretz? Kip LeCrone? And Stirling Martin? Sasha TerMaat?

Sasha TerMaat - Epic Systems Corp.

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Ginny Meadows?

Ginny Meadows – McKesson – Executive Director, Program Office

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Ginny. Jon Morrow? I know Jon is on the line. Karen Nielsen?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Karen.

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

I'm sorry, I was on mute, I'm sorry.

MacKenzie Robertson – Office of the National Coordinator

That's all right I got you.

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

Thank you.

MacKenzie Robertson – Office of the National Coordinator

Lynn Scheps? And Melissa Swanfeldt?

Melissa Swanfeldt – Meditech – Associate Vice President

Melissa is here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Melissa. Are there any ONC staff on the line?

Kevin Larsen – Office of the National Coordinator

Kevin Larsen.

Jesse James – Office of the National Coordinator

Jesse James.

MacKenzie Robertson – Office of the National Coordinator

Okay, thanks, David I'll turn it back over to you.

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

Great. Thank you, MacKenzie. Thank you for joining, everybody. This effort has actually had a precursor 6 months or so ago when we first, very informally convened a number of you and others representing different companies to help advise the Health IT Policy Committee and the staff at ONC with perspectives that you've all developed over time in implementing the early phases of meaningful use and particularly the quality measures functions that are associated with meaningful use, and I think we've certainly heard a lot of input from the vendors and users both in the hospital and physician side about the challenges of the current quality measurement model that was developed in supporting Stage 1 and it's really implicit in the draft Stage 2 proposed rule.

So, I think we got some really good input over the last few months about that and we tried to reflect that in some of the changes to Stage 2 and definitely in how we are thinking about Stage 3 and so as we've done that in the Quality Measures Workgroup Committee we've really felt that we could use a more regular channel for getting input from people on the front lines of building these quality measure systems and using them. So, what we've done is ask you all to get together on a fairly regular basis as we get into the serious work of developing the Stage 3 proposals to advise us and give us the best feedback possible in how we can do this better and really look toward a longer term, sustainable framework for producing quality measures.

I think we all understand that the National Healthcare Reform Program, however it evolves, is going to include changes to payment and changes to healthcare structures and there is going to be a lot of expectation that quality measures will be used to support those changes and we certainly see at CMS and elsewhere that there is going to be payment, physician and hospital payment, and ACO payment tied to these measures. So, it's extremely important that we get this right and we build a long-term foundation that's both stable and flexible and can respond to changes in what people begin to see as the opportunities to deliver value in healthcare.

At the same time, for this to be credible it has to be really high value to the people on the ground delivering care so that nurses and doctors, and managers are getting information they need to improve what they do. So, it's a very, very challenging environment to build both policy requirements and the actual tools that both support healthcare reform and payment change, and support people delivering better care and that's where you guys all come in.

And so, we obviously can't do this without you. So, the idea here has been to identify a set of issues and topics that we think are going to be critical to doing a better job of building these tools to support both external accountability and internal improvement and get input from you as we go on how to do this as well as possible and as efficiently, and affordably, and consistent with the national goals as we can.

So, it's an interesting hybrid of public policy and private marketplace dynamics and I think as we talk through these issues we'll just have to keep going back and forth to try to get it right. So, in terms of context, that's what I think we're about, so we've asked you all to start joining us on a regular basis and advising us as we wrestle with these issues.

In the agenda materials for today you see kind of the first cut at 3 or 4 big categories of issues that we think we are going to face in developing the Stage 3 requirements and we would love to do that with the benefit of your input. At a high level I would say that the Quality Measures Workgroup and the Health IT Policy Committee are trying to come to a complete package of proposals by late spring 2013 so that we are well ahead of the curve in developing the Stage 3 proposals and the ideal actually is to get that done early enough that the industry is able to start designing, implementing, coding with much more lead time than they have had for the previous cycles.

So, to achieve that goal of a spring 2013 draft rule or at least draft letter from the Policy Committee describing their recommendations, we've got to work back quite a ways and getting your input early, that is now, is really critical to this. So, it seems like it's far away, but actually from a planning point-of-view we need your input quite soon.

Specifically, the Quality Measures Workgroup is going to be putting out its own thoughts along with that of the Meaningful Use Workgroup to do a Request for Public Comment about early November of this year, that's only 2 months away really, 2.5 months. So, in the next couple of months starting to draft the kinds of topics that we want public input on, so starting with today's call we really want to get your perspective on some of those themes so that as we draft a Request for Public Input, Public Comment, we have the benefit of some, you know, reality testing from you all.

So, without yet getting into the substance of the issues we have at hand let me see if Kevin and Jesse from ONC have other sort of context points they want to make before we jump into the details.

Jesse James – Office of the National Coordinator

No, I think that's a very good way to explain what we're looking for and from the detailed point-of-view there will be weekly meetings either in the first or second week of each month and we'd really like to keep a conversation going between the Quality Measures Workgroup, which has some questions of vendors in particular, and we'd like to move the responses back and forth and let the Vendor Tiger Team advise the Quality Measures Workgroup on the questions that the Workgroup eventually decides to place inside of the Request for Comments.

Kevin Larsen – Office of the National Coordinator

So, this is Kevin Larsen from ONC, we realize that the timing of this is a little bit unusual in that the final rule isn't out and so it's not very straightforward for you to comment when you don't see what's...it's hard to comment on the intermediate term when you can't see the more short-term thing, but it's the world we live in, we'll just kind of put that on the table that we know that that makes it less than ideal to do this discussion but we...as David mentioned, we have to start now.

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

Thanks, so let me just see...given that a high level purpose statement, if you like, any questions or reactions from people on the call about what we're trying to accomplish?

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

This is Karen Nielsen; I would just like to commend you for doing this. I think this is a great opportunity for the communication to start and it's always best to start early instead of late, so thank you so much for doing this.

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

Good, well we really appreciate your time and the insight that we've gotten already from many of the companies working in this space. Any other comments or questions about what we're trying to do? Okay, well, maybe I'll see if Jesse or Kevin want to start teeing up some of the specifics that are on our plate, or maybe, do you want to start with the program purpose and just go on from there?

Jesse James – Office of the National Coordinator

Yeah, I think that's the best place to start. So, we've split the Quality Measures Workgroup's major question areas into 5 items on the agenda which are under two and they're lettered A through E and we started with what we've drafted so far on the Quality Measures Workgroup is a statement that explains how we see the goal, the aim for the EHR Incentive Program CQM measure set and we wanted to see if this is in alignment with the vendor understanding of EHRs and the place where CQMs within EHRs in the program, and to see if there are any granularity you guys would like to add to what we've come up with, is this exhaustive of where our aim should be or are there directions that you think we should go in that aren't captured within the statement?

The statement is essentially we understand the fundamental mission of the EHR Incentive Program CQM set is to promote the capabilities of EHRs to capture relevant data and to calculate, and report measures used by public recognition, and payment programs as efficiently, and reliably as possible in order to improve quality of care, and experience of care for providers, and patients. And we wanted to build in with providers and patients, but also capture that this should make care simpler, it should make quality improvement more assessable and approachable, and should do so in way that is as seamless as possible within the user experience of an EHR. And I'll just open to questions or comments on that statement?

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

This is Karen Nielsen again, real quick question for you, both Ginny and I are on the National Quality Forum eMeasure Learning Collaborative Committee, is this also the appropriate forum to share some of the insights from that particular program?

Kevin Larsen – Office of the National Coordinator

Yes, certainly, this is Kevin; I'm on that as well, but certainly.

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

Okay, great.

Jesse James – Office of the National Coordinator

So, is there something from the eMeasure Learning Collaborative in particular that is relevant to this mission statement or program purpose that you would like to add?

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

No, not particular to this statement, I think just in general there are other comments that I'd like to communicate and I'm quite frankly not sure when to do it, so, they are more high level though.

Ginny Meadows – McKesson – Executive Director, Program Office

And, thanks, Karen, this is Ginny Meadows and I agree with this purpose, but I think the other really critical piece I think that we're missing a little bit in this purpose is the understanding that, you know, we are still in a very new area with determining the best ways to implement and utilize EHRs for quality measurement, so, I think that's where some of the findings of the eMeasure Collaborative come in, because we're really trying to address those best practices and how we can really make this work as well as possible and really provide that improvement in the quality of care and the experience of care for providers and patients.

So, I think the understanding that, you know, we're all in a learning process and I've very much appreciated the efforts of all the stakeholders in starting to work to work more collaboratively in this whole area.

Jesse James – Office of the National Coordinator

Absolutely, that important to capture and it's something that the Workgroup has talked about as using the measure set for meaningful use not only to capture data on clinical quality but also to encourage innovation and spread innovation and quality improvement throughout healthcare. So, I guess, my question back would be, at the high level of the program purpose how could we or what type of wording would be useful to express that notion that this is that we're early in dissemination of EHRs and we're early in the use of EHRs for quality improvement, what type of wording might be helpful to make that point?

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

Perhaps you can add an additional sentence at the end stating such and that the goal is to work together through this to ensure that, you know, the pace is correct and to ensure that the point of care is enhanced in the process. I know the...in our meetings, the NQF meetings, there has been a lot of discussion as far as workflow and obviously, you know, the goal is to ensure that this is, you know, the capturing of data is the byproduct of doing quality care, but as we move from chart abstraction into eMeasures that our workflow changes at a point of care that need to be worked in from a timing stand-point.

So, for instance, you know, we've had some different wonderful presentations from organizations that have gone through Stage 1 and they've commented about the changes in process and the implementation of using lean six sigma as well in those changes, but again, the changes were designed to ensure that data was captured and it didn't disrupt the point of care, that takes time and it's an iterative process where you have to sometimes go through a trial and error timeline that perhaps needs to be acknowledged in all of this.

I think that there is great desire out there to do it right. I think though that there needs to also be an acknowledgment that there is a significant amount of education internally within organizations to make this happen and not only the education but then also the process changes that also have to be done. So, I think that's just one of those nuances that are being captured by NQF that perhaps can be applied to this particular discussion.

Melissa Swanfeldt – Meditech – Associate Vice President

This is Melissa Swanfeldt from Meditech, and I would just add to those comments by saying, you know, we want to ensure that we do enhance workflow and we don't put the burden of data capture on the provider unnecessarily, you know, and I think that probably just adds to what was just said.

Kevin Larsen – Office of the National Coordinator

This is Kevin Larsen from ONC. A question for the group, there has been a lot of public comment about aligning measurements across programs, however, the Meaningful Use Program is a paid for attestation program and most of the other programs are a pay for reporting or a pay for performance, and so that desire to use the meaningful use measures for multiple uses adds higher stakes to them and gives us less flexibility for trial and error and for innovation. What are the thoughts of the group about that particular tension? It's kind of called out in this purpose.

Melissa Swanfeldt – Meditech – Associate Vice President

This is Melissa again, I'll say that in general I think it's good that the measures are being aligned across different CMS Programs because as you start to look at workflows for these clinicians if you can embed one workflow for all the reports, for a stroke for example, you know, you're going...or at least the hospitals or the physicians will get benefit in being able to use that data for multiple purposes. However, again, it doesn't necessarily give us time to do the testing that we may want to do to really, you know, fully push these measures out to include workflow enhancements and not just the burden of documentation.

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

Kevin, its Jon Morrow from GE Healthcare, am I off mute?

Kevin Larsen – Office of the National Coordinator

Yes, you're off mute.

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

Yes, good. Your point is very well taken, I wonder what your perspective is from, you know, from where you sit at ONC, in terms of where meaningful use...the evolution of meaningful use from a paid attestation program to being essentially pay for performance or at least, you know, once the CQMs in Stage 3, as we expect, you know, will have thresholds and it becomes more of an outcomes measure or outcomes actually come into it I should say not that it becomes more of it, won't that solve this dichotomy that you just described?

Kevin Larsen – Office of the National Coordinator

Well, at least what I've been seeing is that it's really in the alignment that we see the targets and thresholds as the Meaningful Use Program continues to focus on the CQMs as a way to get infrastructure for quality measurements in place.

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

Okay.

Kevin Larsen – Office of the National Coordinator

But that the alignment...other programs are really about performance.

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

So, then let me ask you this, that makes a lot of sense and I think it's understandable that the goals or the missions of the different programs might be different between meaningful use and the...pay for performance programs, but I don't think that precludes using the same measures which is what we're trying to, I think, get at or at least standardizing the measures across, you could, for example, have different thresholds. You could have lower thresholds if it is about the technology and about the measurement, but from a vendor perspective the frustrating thing is the differences, not on the threshold, because that's easy, that's just, you know, one variable, it's the differences in the way that the performance is measured, the nuances, if you will, between the criteria. I think that's really where, at least from where I sit, vendors want to see standardization across the different programs.

Kevin Larsen – Office of the National Coordinator

Yeah and we definitely heard that as overwhelming from vendors and organizations, but what I'll say is that that adds an inherent conservatism.

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

Yeah.

Kevin Larsen – Office of the National Coordinator

Using measures that were already developed and matured in other platforms.

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

I understand, I wonder though if there is a way that the measure...maybe the distinction is that what's important to us, you know, I guess I can't speak for all of us, but what's important for us, for me as a vendor, is at least the framework of a measure and a particular therapeutic area or in a particular outcome measure, that the framework be constant and perhaps parameterize so that it can be adapted to the different purposes of the different programs either by varying thresholds or even varying the criteria in a standardized structured way that maybe if one program is looking for 17-year-olds and the other is looking for 18-year-olds or, you know, up to 18-year-olds at least there is a parameter of maximum age that I know where to expect it and I can build a measure once with that expected parameter and not have to guess what might vary so that I can hard code the framework, but parameterize the things that might vary between programs that have different either evidence behind them or different goals and not have to reinvent the wheel.

I'd like all the cardiac measures to look similar, I'd like all the pediatric, asthma or I'd like all the asthma measures to look similar with expected variations among programs in places that I can parameterize. I guess, we're sort of getting there, but that to me would be how I would articulate this goal of standard criteria.

From a clinical stand-point, I'll put my clinical hat on for a second, yeah, I would like to have measures that are exactly the same so that I know when I'm seeing a 64 or 65-year-old woman that this is what is recommended I need to do, but I could tolerate as a clinician some variation and then just sort of understand what the minimum performance is that and sort of the least common denominator among or not even the least, I guess the greatest common denominator among all the measures so I hit that I know I'm going to hit everything.

Jesse James – Office of the National Coordinator

Right and there are multiple statements you just made that we are nodding vigorously in agreement with, but we do need to move on ...

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

Okay.

Jesse James – Office of the National Coordinator

But to make a few points, our background, both of us are from both provider implementation and EHR software or quality improvement software.

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

Right.

Jesse James – Office of the National Coordinator

So we see this...when we look at the measures we look at the measures that exist and we also look at the measures we would like to exist and we completely get and understand the measures we would like to exist would be a cleaner set that vary in predictable ways and when they vary in predictable ways of course it's easier for a software architect or engineer to build that hard code that will allow you to tweak certain parts of the measures but there are expected parts of the measures and those...

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

Exactly.

Jesse James – Office of the National Coordinator

The metadata around those parts of the measures will be easier to find and of course that means that there needs to be a tool set that's available and single source of truth that's available for any user. So, there are multiple great points in there that we'll be passing onto the Quality Measures Workgroup, but a few in particular that you mentioned that will help us move to a segue is what we've been wondering, and we'd like to hear from vendors, what capabilities and what technologies are you guys working on that you think the quality measures aren't really taking advantage of. So, when the...in the ONC proposed rule we talked about data capture, calculation and reporting an export for capabilities that a CQM should have, but outside of those four basic functions and even deep inside of those four basic functions, what are you guys working on that you think we should be leveraging more or leveraging in a better way inside of our CQMs?

What we've talked about inside of the Workgroup is that we'd like to focus on patient reported data capture, longitudinal data capture and tracking, and also cross sectional, of course cross setting data capture and calculation, but are there other basic areas or are there other basic functionalities that we could be using inside of measures?

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

Well, since there are so many people...answer I guess I'll take a crack at it if no one else wants to speak.

Jesse James – Office of the National Coordinator

Please?

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

Yeah, so, it's Jon Morrow again from GE Healthcare. One thing that comes to mind is that many of the CQMs, I think actually at this point all of the CQMs give, you know, there is a threshold, they are binary, and as I think all the vendors look toward the future and toward predictive or even prescriptive modeling and quality improvement not as a reporting function and a retrospective function but more as quality improvement as an active function and a forward looking function, it would be very nice to see CQMs evolve to not just a binary but also an ideal state or recommendations built into them so that we can use them, yes for reporting, did you meet this measure, but what is the true desired outcome? What are the recommendations that are sort of implicit in the measure as treatment goals?

So, perhaps by including in a structured way ideal states or recommended protocols that go beyond the binary, did you achieve this particular outcome, you know, there is always the statement at the top and there's always this sort of longer statement that gives the evidence behind the measure and why this is important, and if there is some way to quantify that and capture it within the eMeasure or within the CQM I should say, that we can build toward as we build tools that help providers achieve better quality, you know, it's very nebulous, but I think that is really where we would like to see this go and mostly...I guess the bottom line is the first thing I said, taking it from a retrospective reporting tool and a retrospective reporting toolkit, and adding forward looking recommendations, and ideals, and goals into the measure.

Kevin Larsen – Office of the National Coordinator

So, let me reframe that and make sure that I have this sort of correct in my head. An explicit statement of the care goals as part of the measure, so, for example, the national health goal is to have all patients with hypertension achieve a blood pressure below 140/90 could be an explicit care goal that is put out there that kind of frames that measure and gives it a place to aim, is that correct?

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

That's correct, but I would take it a step further. So, a blood pressure below 140/90 would be the goal, but ideally does that mean I'd like to get 135/85 as ideally that I'd like to have my patient down to 110/70, are there age and gender criteria built into that so that I not only have this binary switch that, you know, you hit 139/89 and you get a point, but I'd like to take it beyond that and be able to not just measure that 80% of my patients have achieved that goal, but that my patients who have achieved the goal that they are 80% better than that and obviously it's not a linear curve so I can't just do the math, but what is the minimum goal and what is sort of the ideal state, what's recommended for the big picture and that's sort of an integrated care holistic kind of question.

It's not just how do get my patient to check off the boxes that I've done and my patient has done the recommended things, but that we've achieved an outcomes that meets the standards but that is actually the best for the patient or, you know, so give me more than just a cut off, unless if the cut off is the ideal, you know, if it's a binary question have all Rh negative women receive RhoGAM, you know, that's easy, so you check a box and you move on.

But with something like blood pressure, with something like hemoglobin A1c with something along those lines it's not a binary state, you know, sure it's a binary state for the incentive, but for really providing the best care to the patient there is a continuum there and I would like some indication of how well the continuous goal is not just achieved but how well it's been accomplished in, you know, more of a scale and there is a difference between recommended and ideal, and I'd like to get more of a sense in a measure of what the true quality outcome is.

Kevin Larsen – Office of the National Coordinator

No, that's a great point, thank you. We're also curious are there features of EHRs that we should be leveraging more?

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

Oh, okay, so maybe I misunderstood the question.

Kevin Larsen – Office of the National Coordinator

Yeah, problem list, should we be referencing audit logs, are there...what are some of the features, because right now we're taking measures that were created for a paper-based or a claims-based work.

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

Oh, okay.

Kevin Larsen – Office of the National Coordinator

...

Melissa Swanfeldt – Meditech – Associate Vice President

This is Melissa from Meditech, I would say, you know, using...being able to take what's in a measure and make it part of clinical decision support. So, you know, being proactive is part of that care process, embedding the goals within a measure into the clinical decision support that's inherent within all of, you know, the vendor systems in one format or another, to be able to, you know, use that to, you know, drive that care process but at the same time making sure we're capturing what needs to be documented for the measure, that we're again moving care in the right direction.

Kevin Larsen – Office of the National Coordinator

That's...

Melissa Swanfeldt – Meditech – Associate Vice President

Citing, using the measures to help guide care.

Kevin Larsen – Office of the National Coordinator

Absolutely, so what format would be helpful for you for us to deliver those measure related CDS artifacts? Is that a paragraph? Is it pseudocode? Is it a Wiki of sharing different people's alert logic? What would be helpful artifacts for that CDS?

Jesse James – Office of the National Coordinator

And that may be a question that you circle back with your developers and get their input on or their opinions on. What we'd like to be ever aware of is how we can be helpful, how we can drive and encourage innovation but without being hyper prescriptive on that innovation so we don't want to say exactly how CDS has to be done, we would like to find ways that we can encourage it and make it easier, simpler for vendors to take part in it and simpler for vendors to tie...

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

Does it then become a functional measure though?

Kevin Larsen – Office of the National Coordinator

That's not our goal.

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

Yeah, because that's not your goal, right? So, that...

Kevin Larsen – Office of the National Coordinator

So, here's an example that we think will likely be concrete and many of you know that there's a new value set authority center at the National Library of Medicine, which will deliver the value set through an API for all of the Meaningful Use Clinical Quality Measures. Those value sets and the APIs from those we anticipate will have a secondary use for clinical decision support. We're just making them available, we're tagging them that say this is the definition of diabetes for this meaningful use measure, but no one is prescribing any way that they are used; we're not measuring in any way how they're used for CDS.

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

There is one particular comment that I wanted to share. This is Karen Nielsen again. Just recently I saw a presentation from an organization that used some of the sort of procedures, workflows, etcetera to try to focus the clinicians on one particular group of measurement, although they went ahead and they really did focus in on some of the key features which would be improving quality, which was what it was all about, there was significant alert fatigue and great pushback as a result from the clinician community. So, there is this balance obviously that we all know about that has to be reached so that the data is collected but we don't overburden or overtax the system of providers that are actually providing care.

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

This is Jon; I fully agree that's very important.

Kevin Larsen – Office of the National Coordinator

So, is there a way that when we construct measures or when we think about policy for measures we can encourage the right kind of behavioral around alerts and discourage the wrong kind of behavior around alerts?

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

Oh, boy.

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Yeah, that's a tough one, because, you know, sometimes it depends on the care setting, because an alert in, you know, nephrology could be, you know, very much alert fatigue if you have patients who are, you know, have nephrology issues, however alerts...those same alerts for a different population of patients can be, you know, super important and not considered alert fatigue. So, you know, the care setting in the population of patients or the type of provider are the complex things that come into play when we think about alert fatigue.

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

Here's some place where you might be able to leverage, just back to your earlier question, tying it together, you may be able to leverage some of the unique data that we have in an EMR that didn't exist in the paper chart. They both have the what, only the EMR has the who and the when and so we could see where you can measure the appropriateness of an alert and the action that has taken on the alert based on who does it and when it happened in proximity to the event or in proximity to the outcome and that's a place where we don't really leverage in the CQMs the unique features of an EMR, and I think that also plays into the extension of care beyond the physician and the larger care team, the balance though is that you wind up getting very prescriptive there.

And, you know, who's to say if it's appropriate if a physician acknowledges an alert of a nurse practitioner, or a receptionist, you know, I think there's a big spectrum of how people see that, but there could be built into some of the measures criteria regarding acknowledgment of alerts or even just achievement of outcomes and interactions with patients based on who, in other words, what kind of a provider and also the when, proximity to the event, proximity to the outcome. So, that's some food for thought I think.

Jesse James – Office of the National Coordinator

Yeah, no that's a very good point and it ties in two of the goals for this question where we wanted to discuss both what technology is in place that we haven't used as well as perhaps we could for perhaps a lack of imagination, but also, what's down the line, what's in the EHR developers pipeline that you guys are thinking about using more that we should be aware of and talking on both the time and when an action happened and who has that action but also how that's a response to CDS that ties in both to CDS that we mentioned before, and ties into your view of how we can measure quality not just in a binary way but how we measure over the spectrum of care.

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

Yeah, the challenge though there that I see is that you have to...if you're going to do that you need to be careful that the quality measures don't all of a sudden impose new functional requirements because each EMR is going to have a different set of capabilities and I think there are some things like who signs something or who dismissed an alert box at what time, that's pretty universal, but just be careful that as we try to come up with leveraging the technology that it is either universal technology or it is technology who's functionality is specified elsewhere. So, I don't think that...it shouldn't be the purpose of a CQM to mandate functionality; I think that comes from somewhere else.

Jesse James – Office of the National Coordinator

Yeah, honestly, I think the who will probably be, in a good measure of this type, the who would be less important than the what, there was an alert that this is a dangerous drug dose and whether the nurse or the physician made corrective action isn't quite as important that the corrective action was taken and that that was documented.

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

Well, although, I would...I guess this could be debated a bit, but I think with something...an example that you just gave, what is important is was an alert shown to somebody who could understand it and act upon it and if a clerk sees that alert it doesn't do much good if the clerk's response is "Oh, Dr. Jones wouldn't make a mistake because Dr. Jones is perfect." I want to make sure that that alert is seen by Dr. Jones or by a nurse who can understand it and that's a bit hard to figure out what the criteria should be, you know, so...

Jesse James – Office of the National Coordinator

That's why we sort of had to stick with the big and dangerous things.

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

Yeah.

Jesse James – Office of the National Coordinator

The corrective action not just being a clerk saying something should happen, but the corrective action would be a change in dosage.

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

Or a physician saying "never mind, I know and I acknowledge and I dismiss."

Jesse James – Office of the National Coordinator

Oh, yeah. And the place that we've been thinking, at least across government, about where we want to go is not to measure to the detail of an alert and who responded but to measure did a patient receive a dangerous drug or not and then that would be the measure, and we could provide some kind of help about tools that might work but that we really want to commit as government to measure, did the patient get the dangerous drug or not.

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

Yeah, and I think...

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

Or more appropriately, did the patient get the dangerous drug without the explicit consent, knowledge of someone who can make that decision. If a physician says “I still think this drug is appropriate for my patient.” The physician shouldn’t be dinged for having given the patient a governmentally designated dangerous drug.

Jesse James – Office of the National Coordinator

Yes.

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

Because, you know, hopefully the physician knows better than, you know, the standard label. We have to...we can’t just enforce the FDA label because there is nothing wrong with off label use.

Jesse James – Office of the National Coordinator

Yes, got it.

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

Okay.

Kevin Larsen – Office of the National Coordinator

Somebody else had a point I think?

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

Hi, this is Karen Nielsen, this is a good discussion. I think though going back to...I’m going to bring us back up a couple of thousand feet in the discussion and get back to what you had said, which is let’s not be too prescriptive as far as these quality measures are concerned. I think this gets back to what HHS is trying to do overall and that’s to refocus the attention on the six domains, right? And trying to move the nation into the direction of at least really providing high quality care in an efficient way.

And, I think when we also look at the changes that are going on right now, especially in the ACO type of framework we are going to be asking the community to start doing things very strategically with data to begin with that’s going to be making this even more challenging for them. So, for instance, if you have a population that you are at risk for and you’re going to have to know all of the care that is given to that population whether they’re in your system or not there is a new challenge as far as accessing all of this data, then bringing it in, normalizing it, de-duping it, cleaning it up to the point where you can go ahead and get the output on the quality measures that you desire or even to go ahead and to be able to drive workflow.

And so there are other things going on right now in the community that’s a great challenge to our providers as they try to deal with some of these new nuances of working with data that they haven’t had to in the past and perhaps we need to weigh that in addition to where we want to go with the measures, because we might need to get through this first, this whole data discussion and the normalization of data before we get too aggressive as far as what some of these measures are going to be able to do based on that data.

Jesse James – Office of the National Coordinator

That’s a very good point and that’s a very good segue into our next question which is...we’re on the second page now, and this question it’s 2B2, we’re asking the Quality Measures Workgroup has been thinking about what should be some of the major goals for Stage 3 and one of the overarching questions is should we go deep into the measures or should we go broad?

Should we try to fill wide measure gaps with more measures or should our goal be to look at the measures we have and try to refine them or make them better to think about the data that goes into them and think about the results we get back and I imagine, when I put on my vendor hat I would think probably well more development time would be spent on more measures as opposed to developer time spent on the measures that we have, but we’d also like to think about how we reconcile that balance.

So, we would love to get your input on what our focus should be for Stage 3 should we go deep in the measures or should we continue to expand and add additional measures to the measure set?

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

It's Jon Morrow from GE. So, I'll put on my vendor hat, I agree with you that there is more development time to doing more measures so I would go deep and then broad, but I would go deep first, I think there is a more of an impact in my clinician hat, I would also go deep. If you look at the experience with sentinel events and with hospitals focusing on particular outcome measures or particular performance measures like DVT prophylaxis and antibiotic use prior to surgery and you pick a few measures you improve the quality of those and you generate better physicians who follow evidence-based practice and everything else just sort of happens. So, I think on both counts I would say deep and then broad.

Ginny Meadows – McKesson – Executive Director, Program Office

Yeah, this is Ginny Meadows, I agree with that.

Melissa Swanfeldt – Meditech – Associate Vice President

This is Melissa from Meditech, I would say deep as well, you know, I think it's to use measures that we already have and really go deep and define best practices around those and better workflows around those allows, I think, collectively the nation to move in a direction to get better data for those things and then obviously once lessons learned from those we could then apply them to other measures in the future.

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

Exactly, so particularly if you're doing it proactively with an eye to eventually going broad and if you're doing the deepness and you're doing it in a way that's reusable to use the lessons from it in a reusable manner to develop other measures, I think it will become easier as you broaden after you indefines, whatever the word is.

Sasha TerMaat - Epic Systems Corp.

This is Sasha, I would agree with the others about going deep. I do say though that we need to be cautious about it. I know we hear from physician specialty areas feeling that if they are overly affected by specific quality measurement requirements that aren't what they consider relevant to their practice that that can be frustrating. For example, pediatric hospitals that capture, are required for meaningful use to report on measures that are for adult populations. So, I think with some thought to exclusions or minimum population requirements and so forth that can be avoided and I definitely endorse going deep.

Kevin Larsen – Office of the National Coordinator

So, this is Kevin Larsen, I will add another nuance to this, all of the measures we have now that we would deepenize are built based on a paper platform. Meaningful use, because it's an attestation only without needing to hit targets or thresholds is the place we could build on an EMR platform being workflow sensitive, sensitive to what tools and systems exist. So, new development under the meaningful use rubric is an easier place to develop and test new measures and design for this platform. If we continue with the current ones we have they will continue to retain their legacy of claims and abstraction.

Ginny Meadows – McKesson – Executive Director, Program Office

Yeah, Kevin, this is Ginny Meadows, that's a really good point. I was going to mention the fact that we should really think about focusing on de novo versus the retooled measures and possibly even start thinking along the lines of, you know, CMS has been very vocal about saying that they want to start transitioning the measures for their other programs to electronic clinical quality measures, so how could we start looking at those other programs and start picking some of the measurement requirements in those programs but coming up with potentially the best way to implement those measures as not just retooled measures but really looking at them from the EHR perspective.

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

And this is Karen Nielsen; I just want to reinforce that comment, because one of the things that...again, we don't know what the final rule is going say for Stage 2, but it did appear that there were going to be some of the value-based purchasing measures in there and wouldn't it be wonderful for an organization to only have to report their value-based purchasing measures through the eMeasure format instead of the chart abstracted format, now with that comes the nuance as far as, well is that going to...are there enough changes in the measure specifications that you would have to start over again as far as if you started to report your value-based purchasing measures through the eMeasure format do you zero think out and do you start from scratch again, I mean that's obviously a question that would have to be investigated, but I think, whatever we could do to harmonize and to reduce the reporting burden I think everybody is interested in that not only on this call but in the medical community as a whole.

Kevin Larsen – Office of the National Coordinator

So, if we did...if we went deep, which a lot of you said, what would that look like? What would you want?

Jesse James – Office of the National Coordinator

And that also brings us to an agenda point and there are certain things you've mentioned already as a set of QI tools to use inside of measures or better descriptions or a different type of technical description or a code that's closer to machine readable would be useful to you, but if you look at point D as where we're asking what as a vendor do you need or what would be helpful as a vendor when you're working with your providers to push them along or to push along your development inside of these measures and would it be workflow diagrams, would it be test decks of patients to use after you've completed your measure to see that you're calculating it correctly. What types of things would be helpful to you that we could produce and we could disseminate nationally?

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

This is Jon from GE Healthcare, yes and yes.

Melissa Swanfeldt – Meditech – Associate Vice President

...

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

Go ahead...I'll wait, go ahead.

Melissa Swanfeldt – Meditech – Associate Vice President

This is Melissa, I'll say that when looking at the list in D all of those would be helpful, if I had to rank them I would probably say number one would be top for me in my customer base probably two being, you know, the second, a test deck of patient data certainly helps from a certification stand-point. So, you know, I actually think the order that these are in probably would be how I rank them, I don't know if that helps?

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

And it's Jon, I can't see the screens, but, I think one thing that...our biggest pain point, I've said it before, has been provider patient attributions. So, some guidance either in the form of workflow scenarios or something built into the measure so that it's clear which provider is able to qualify for a measure based on interaction with the patient or which provider is required to do something or can do something, how do you attribute the patient and the provider. And then the second thing you said just escaped me, sorry, workflow diagrams what came after that?

Kevin Larsen – Office of the National Coordinator

Workflow, yeah, test decks.

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

Test deck, yes, test deck that would be...that's really important to make sure that we've got it right, it's something I know the AMA has been working on but we really very much I think need a standard set of criteria against which we can run measures to make sure we've got it right. Now, the question then with that is do you provide an exact number to the decimal point of a performance, whether it should could come out of that test deck or is there some tolerance based on how you interpret the measures, but I think that's a discussion for another call.

Jesse James – Office of the National Coordinator

Right and interpretation we would like to minimize, at least the way we tend to look at it, good software should minimize the amount of ambiguity and interpretation that a developer has to do.

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

Right, so then removing that ambiguity would be important.

Jesse James – Office of the National Coordinator

Right.

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

Because it's in there, a lot of it.

Jesse James – Office of the National Coordinator

Absolutely.

Melissa Swanfeldt – Meditech – Associate Vice President

And this is Melissa again, from a workflow diagram stand-point, I think this was just brought up, it is important to understand who can do certain functions because that was I know a struggle with many of our customers for Stage 1 is that the eMeasure concept didn't really specify who, you know, could a nurse capture it or a physician, but where other reporting programs actually specify this particular function must be performed by the physician or by, you know, a minimum of a nurse, where the eMeasures don't necessarily do that. So, it would be important to understand, you know, who can perform a specific function or intervention on a patient.

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

And of course the noun that goes with who performed is also the verb, what does perform mean? Is it a co-signature, is it supervision, you know, all that stuff comes up. When you have a resident, you know, that kind of stuff I think really is something we need to see as these get more...as we go deep, who performs and what does the word perform mean?

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

Which actually is a wonderful transition, because one of the things that we've talking about extensively is the fact that in the measure maintenance world we have QualityNet for chart abstracted measures, it's a phenomenal system, more people think about it from a data transmission stand-point but the important thing about QualityNet is that it has all the measure specifications there so that you can see what is the current specification, what the former specifications are and then more importantly there is a place where you can actually have formal Q&A.

And what traditionally has happened is that the questions come in through QualityNet, they are then distributed to the right measure developer and then the measure developer provides a response within 3 calendar days, now the reason I know this is because I used to be a measure developer and it's a very organized methodology that works for everybody and I think we need to transfer this type of protocol over to the eMeasure space so that we have a much more organized fashion so that some of these qualifying questions can be asked and answered in a timely manner.

Jesse James – Office of the National Coordinator

And you've also implied that you need a single trusted space.

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

Absolutely.

W

Absolutely.

Jesse James – Office of the National Coordinator

So, we are at about the end of the hour and we'd like to start and end on time. There is a quick question that has been vexing the Quality Measures Workgroup that we have a couple of minutes for anyone to speak on, we've been talking about how much work should we do in the area of dashboards and we've heard from some of the clinicians that it would be useful to have Health IT enabled population views for their CQMs. What we'd like to know from this small group is, is this a space that the Policy Committee should move into or should we sort of leave it alone, big picture and I'll let you talk from there.

Ginny Meadows – McKesson – Executive Director, Program Office

Well, this is Ginny Meadows, I mean, I think, that what's happening is part of a lot of our initiatives, I don't know that it's something that as an ONC initiative needs to really be promoted because I feel that it's part of the natural progression and innovation of using an EHR to do some of these things.

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

I think, with Ginny, there is great opportunity there, but at the same time I think we all agree that we don't want to be too prescriptive in anything that is put forward because we don't want to stifle creativity.

Jesse James – Office of the National Coordinator

Yes.

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

But there might be a different view beside the "dashboard" that a genius comes up with that actually is better. So, let's encourage it, let's encourage the use of data, but let's not limit and...

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

This is Jon, I wholeheartedly, wholeheartedly agree, I think, yeah.

Kevin Larsen – Office of the National Coordinator

So, this is Kevin, our time is up and we'll have plenty of time for these later. I just want to leave this open that if you have things you want us to talk about please e-mail me or Jesse and we will be happy to prioritize and put some things on the agenda that you have generated. So, the door is always open, let us know what you think we should talk about.

Jesse James – Office of the National Coordinator

It's hard to express our gratitude, we really enjoyed this conversation and we're looking forward to other calls in the future. So, thanks to the entire group, thanks for your time.

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

Thank you, this was great.

W

Thanks.

MacKenzie Robertson – Office of the National Coordinator

Operator, before we all go can you open the line for public comment too?

Public Comment

Rebecca Armendariz – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue.

Operator

There are no questions at this time.

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

Thanks, everybody for your time today.

MacKenzie Robertson – Office of the National Coordinator

Thanks everyone.

W

Thank you.

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

Thank you very much.