

**Quality Measures Workgroup
Draft Transcript
August 27, 2012**

Presentation

Operator

All lines are now bridged.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you very much, operator. Good morning, this is Mary Jo Deering in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup. It is a public meeting and there will be an opportunity for the public to make comments at the end of the call and I would ask anyone who is speaking to identify themselves for the transcripts and I'll begin by taking roll. David Lansky?

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

Yes, here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Tripp Bradd? Russ Branzell? Helen Burstin? Neil Calman? Tim Ferris? Patrick Gordon? David Kendrick? Charles Kennedy? Karen Kmetik? Rob Kocher? Norma Lang?

Norma Lang, RN – University of Wisconsin

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Marc Overhage? Laura Petersen? Eva Powell?

Eva Powell – National Partnership for Women & Families

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Sarah Scholle?

Aldo Tinoco – National Committee for Quality Assurance

This is Aldo Tinoco representing Sarah Scholle.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you. Cary Sennett? Jesse Singer? Paul Tang? Kalahn Taylor-Clark? Jim Walker? Paul Wallace? Mark Weiner? Did I miss any other members? Joachim, are you a part of the workgroup now?

Joachim Roski – Brookings Institution

Yes, I believe so.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, I'm sorry; I just have a list that didn't have you on it, I'm glad to have you join us. Would staff who are on the line please identify yourselves.

Jesse James – Office of the National Coordinator

Jesse James from ONC.

Ahmed Calvo – Office of Health IT and Quality - Human Resources and Services Administration – Dept. of Health and Human Services

Ahmed Calvo, HRSA.

H. Westley Clark – Substance Abuse & Mental Health Services Administration

Westley Clark from SAMHSA.

Jonathan White – Agency for Healthcare Research & Quality (AHRQ)

Jon White from AHRQ.

Maureen Boyle – Substance Abuse & Mental Health Services Administration

Maureen Boyle from SAMHSA.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you. Back to you, David.

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

Okay, Mary Jo, thanks all for joining. Since we only have a few of us from the committee I'm a little reluctant to get too deep into the content without more input, but let's see where we're at and decide what we can get done today. We had three primary tasks in the materials that Jesse sent out and I apologize we sent out things in a couple of batches.

Last Thursday you got some material from Jesse with some annotated copies of the RFC questions and a refresher of the agenda document and then this morning from Altarum you got a copy of a measures crosswalk that has been updated to reflect the final rule. So, if you can put those together, plus of course I know you spent your weekend reading the final rule and therefore I think we're in a good position to take stock of where we're at.

In addition, Jesse sent out the notes from the Vendor Tiger Team call of the other day. So, I think the three things that we wanted to do today primarily were to share with everybody the Vendor Tiger Team results, talk about the crosswalk and the measures gaps that maybe remaining to be addressed in Stage 3, and update our discussion on the Request for Comment, particularly the section we just started with last time on the architecture and standards issues. So, let me stop there and see if Jesse concurs with that summary.

Jesse James – Office of the National Coordinator

Yeah, I think absolutely, I think a review of what we learned and have the group view the comments from the Vendor Tiger Team would be great. A review of some edits to the RFC to make sure that they are true to comments from last time or even since last time a few of the members were on vacation and not able to make the call, it also would helpful for them to go back over the current state of the drafted RFC and if we have the time maybe, it would have to be a sort of high level walk through of the concepts that the Quality Measures Workgroup came up previous to the NPRM and their state vis-à-vis the final set of quality measures, and then maybe a discussion about where we see us going next with the group of concepts we committed to for Stage 2 and Stage 3 and thinking about how much further we want to go with them in Stage 3 or do we want to split up on new measures. So, I think that's plenty of grits for the mill and probably will take us into this meeting the next and maybe one after that.

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

Okay, so in sequence it sounds like starting with the Vendor Tiger Team summary, which we have like about a 4 page version of in the materials and whether people have had a chance to read through it or, I don't know if Jesse you want to summarize the high points of that summary?

Jesse James – Office of the National Coordinator

Yeah, I'd be happy to and would encourage people to interrupt and ask questions if they'd like some more detail or if we have disagreement. So, this is the memo that's titled notes from Vendor Tiger Team and the call was on the 16th of August I believe.

We started with the purpose statement that we discussed previously for the RFC saying that this is the fundamental aim for CQMs and that statement says we want to promote capabilities of EHRs that capture, calculate and report measures used for public recognition and payment for the sake of improving quality of care and patient experience. And of course, there was broad support from the Tiger Team on that. There was some note of frustration around the sort of high level and minor differences in CQMs that cause vendors to have to put extra development and time into CQMs that appear similar at the high level, but once you get into the details they have minor differences that causes a need for differences in software as well.

They asked that we consider a sentences that would state the importance of measure selection and development of measures being more collaborative and this is something we've talked about in the past, we've sort of considered how do we...we've talked about how we can change testing of measures and how we can change measure development to get better input from vendors earlier, but also to get better input on what's in the software development pipeline for vendors so that we can use their innovation and also in a more innovative measures that we're planning.

And another point was that vendors really wanted us to think about how the CQMs could best fit into the training and workflow management process that comes with implementation of any CQM. And we went a bit more into detail in that later in the memo when we asked them about what they needed in particular from a vendor stand-point what would help them make measures that were more consistent and were going to be implemented in consistent ways.

So, after that discussion we moved onto the measure development pipeline and we wanted the conversation for the vendors to mirror the conversation that the Workgroup has been having and the major question for this segment of the call was, we understand that there is technology in the EHR software development space that might not be leveraged as well as it could by the quality measures and we asked them in particular what could we do, what are vendors doing with your EHRs that you think the quality measures aren't really using up to their full potential.

And after we talked for a while we really came to the conclusion that, well a few of the vendor contributors made the point that one, tying CQMs to clinical decision support was very important, but they also came to the point that more nuance measures should use patient data and the gold state for a patient, and consider the delta, the space between those two as a metric of performance and also a metric of clinical quality, and that's the point that we make and it's on the second page of the summary for point one and point two.

Point two being that sort of high level, the typical CQM for diabetes may look at a number of patients who are between 7 and 9 for their A1c or the number of patients whose blood pressure systolic is less than 130/140 and that more nuance measures might look, per patient and decide, well what percentage of patients, considering their clinical background, are at or below goal and also the most nuance perhaps would say considering this patient's preferences does this patient not actually interested, via their PHR, they said, well it really doesn't make me a difference where my blood pressure is or actually my blood pressure goal is about 145 because I can't tolerate all of my medications or my hemoglobin A1c goal, because I'm an 84-year-old frail patient is actually just let's keep it less than 9 and not necessarily less than 8 or less than 7.

So, the idea of the delta measures and longitudinal tracking of patients and their goals over time is something that the vendors were really interested in us building CQMs that take advantage of those features in a way that we haven't yet. To some extent we're moving in this direction, absolutely, with our longitudinal blood pressure improvement measure and with our TTR measure for warfarin use and INRs and for our patient's functional status assessment measures.

So, we have a few de novo measures inside of the final rule measure set that are absolutely moving in the direction that the EHR vendors were saying they would like to see CQMs go. Are there any questions on that segment or that portion?

Ahmed Calvo – Office of Health IT and Quality - Human Resources and Services Administration – Dept. of Health and Human Services

Yeah, this is Ahmed Calvo, I just have a clarifying question, was there any sense about whether the programming issues from the vendors point-of-view was related to differences in the difference vendor systems or was it an issue of the fact that it's a new measure and therefore required new fields or data fields pulled in from different places, different locations.

Jesse James – Office of the National Coordinator

From a programming stand-point you're asking when I made the point that they said that they need more consistency inside of the measures?

Ahmed Calvo – Office of Health IT and Quality - Human Resources and Services Administration – Dept. of Health and Human Services

Well, no, they said that they would like to minimize programming issues and I'm just trying to figure out whether this is intrinsic to the existence of a new measure or whether it may reflect in some cases differences in the actual operating systems or EHRs themselves? In other words, to what extent can we really avoid this?

Jesse James – Office of the National Coordinator

Right, so for that point they were saying that when you have...they think of CQMs as small pieces of software and they're given instructions on what the software should do, they're given a narrative spec and the XML spec, but these specs are not machine readable and to that extent there are some ambiguity on the developer's end regardless of if we had a single developer for the whole country or several different developers. So, the extent to which we can minimize ambiguity in our description of measures so that the human measure software developer at Epic can read this as much in the same way as the developer at GE, then we can have more consistent measures.

To some extent until this is entirely automated and machine readable there will be some ambiguity but there is probably more ambiguity than there really needs to be and also to some extent since we're moving from what was previously human readable text and human abstraction of charts to machine readable measurement and calculation, that process of understanding nuance and then minimizing nuance into computer language is going to...there is going to be some ambiguity that's inherent to it, but I think over time as we have a feedback loop both from our vendors and from our providers, and from our measure developers to pick up issues, errors or bugs and codes that we didn't appreciate as being there, this should get better over time. And, I dare to say that our way of coding these measures for Stage 2 should be better than for Stage 1 and should, of course, for Stage 3 be even better.

Ahmed Calvo – Office of Health IT and Quality - Human Resources and Services Administration – Dept. of Health and Human Services

Very helpful, thank you.

Norma Lang, RN – University of Wisconsin

Could I ask, this is Norma, could I ask, how does the standardized terminology and our goal for interoperability fit in here?

Jesse James – Office of the National Coordinator

It plays an enormous role and I'm assuming by standardized terminology you mean standardized terminology inside of the measures, inside of descriptions of measures?

Norma Lang, RN – University of Wisconsin

Yeah, well, the measure itself, it's going to be machine readable?

Jesse James – Office of the National Coordinator

Right.

Norma Lang, RN – University of Wisconsin

It almost has to have that kind of an interoperable standardized; however we call that terminology...

Jesse James – Office of the National Coordinator

Right, no, I'm absolutely with you. So, we're not yet at the point where our measure specifications are entirely machine readable, there is an extent of human input that persists, but there are a few things that the developers are doing and are working on even for Stage 2 to make more standard terminology.

So, to the extent that measures are combinations of value sets and logic, on the value set end we're making the value sets more standardized by one, encouraging developers to record their intent for the value set but also encouraging developers to use similar value sets. In a few of the measures we had multiple developers design a single value set which really hadn't been consistently done in the past, but for the sake of minimizing small differences in value sets of course at times one QIOs value set diabetes may differ from the QIO in the next set, states value set for diabetes in only a few codes.

So, NLM has done no small amount of work in identifying those differences and asking should those differences be there and sometimes asking, based on the number and the types of codes inside of a value set, asking is there a diagnosis that is missing, but also asking if this CPT code is actually not the correct one. So there were I think a couple of thousand errors that were found over the CQMs and the value sets and over the past month ONC, CMS and NLM have been working with developers to fix them, and it's been a large amount of work done and has moved this forward.

On the measure logic side similar work has been done to one identify inside the QDM places where a software engineer or two different engineers might read the code and come out with a different interpretation, and so it's an iterative process both between, MITRE is the main contractor on this, but multiple developers of measures to identify not necessarily errors, some errors, but identify better syntax for measures that would have less ambiguity to a third-party when they read the code. So, this work over the last two quarters, mainly over the last quarter has been a major focus for ONC and CMS.

All right, so the next two parts that the Tiger Team devoted their attention to, one was the dashboard, which we spent a bit of time on the last meeting discussing and two was the requirements for a toolkit.

So, we've talked before in the Quality Measures Workgroup about what type of tools for the vendors might be useful. And if you look on, I believe it's the third page of the notes under measure development lifecycle, you'll see the Vendor Tiger Team response where both they said, standardized CQMs would be helpful, and when it comes to measure requirements we listed four tools that might be helpful including a description of the intent of the measure and the measure components, a description of sample workflow diagrams that clinicians, but also developers might find use in, test decks for testing CQMs to give the developers an idea, well the EHR vendors an idea of what the calculation should be given a standard set of patients, and then mock up screen shots perhaps might be useful when they think about how to capture the data inside of the measures.

Actually, to our surprise, I wanted to be a bit prescriptive in some of these tools to see how interested they would be in us giving additional amounts of details on the measures and they really said, all of these would be useful and didn't push back on any, which, of course led us to think that there...and made it clear that there is a need for both as being as close to machine readable in our description of measures, but also for the human element involved to give them as much detail on what the measure developer was thinking and envisioning as possible.

And then in the final segment we talked about QI support platforms for population management and this was a segment that the Tiger Team said they were excited about, there is a lot of innovation happening in this section of the industry and sort of the opposite in the previous segment when we said, what can we give you and how much more information do you guys need, they were really asking for as much feedback and input from the Feds as possible.

For this segment they actually said, and we asked the question, do vendors need more guidance, is this an area that the Health IT Policy Committee or the Quality Measures Workgroup should be influencing or can we do much to influence the landscape favorably and they actually said that they really needed...it's a huge opportunity for QI, but they were concerned about regulatory bodies being too prescriptive and were cautious about "over regulation" so to speak in the area and really enjoyed the opportunity to build platforms for population management, but were cautious about the Workgroup or the Policy Committee at large putting constraints on exactly what should be on that platform or what features should be there, they really wanted the opportunity for the market sort of to figure this out.

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

Okay, thanks, Jesse for the good summary and discussion. You know, looking over the whole list of recommendations from that group and thinking about how do we internalize some of their feedback into our discussion, some of their feedback is about how does ONC and CMS improve the toolkit for shorthand, sort of implementation and administrative issues, and some of it is more strategic around what kinds of measures the EHRs will be capable of and whether we can work more closely with the vendor community to really rethink the measurement approach itself.

And their suggestion is provocative, but I'm wondering Jesse if you could react a little bit in terms of the measures pipeline and whether or not the kind of rethinking that they suggest is consistent with where the agencies are going in promoting new measure development and whether it's even relevant given the Stage 3 timeline, I guess I would probably postulate that what they're suggesting here isn't going to happen for Stage 3 unless ONC and CMS or AHRQ put out a very aggressive development work project.

Jesse James – Office of the National Coordinator

Well, I think, we asked them sort of both short-term pie in the sky, well long-term pie in the sky and also short-term realistically what they would like to see when it came to types of measures. And for the features of measures, longitudinal measures and the delta type measures, and that was without prompting really on their end, that's something we've been excited about and that they seem to be too, when the concepts for the Quality Measures Workgroup in advance of Stage 2 included several delta and longitudinal measures not only around hypertension, which we were able to deliver for Stage 2, but also on smoking cessation and improvement in hemoglobin A1c.

So, I think this goes along with a theme that they also mentioned when we discussed with them whether they would like for us to broaden our measure set or to refine the measures that we've been working on and, you know, even from a vendor perspective, of course any new measure is more development time and development time is a cost, so of course they push for refinement of measures but if we could refine measures around these features that there is pretty good agreement that we can...there are certain measures that can be done better inside of an EHR than they are human extracted, then I think we're sort of...we're almost in alignment.

When it comes to the toolkit CMS and ONC are working on developing a toolkit and a single source for that toolkit both for EHR vendors and for implementers, and we'll use implementation for Stage 2 to learn from and by Stage 3 I'm sure we'll have a much more robust toolkit than we will for Stage 2. To a certain extent we are learning a bit of this as we go and we are broadening our scope to fit the needs both of the vendor community and of providers.

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

So, what you're saying is some of the measures, even in the Stage 2 final rule, reflect the philosophy of using the patient as their own control in terms of measuring improvement over time?

Jesse James – Office of the National Coordinator

Yes.

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

Implied by what they're suggesting, yeah.

Jesse James – Office of the National Coordinator

Yes, one of our favorite measures, the hypertension improvement and also one of Farzad's favorite measures was longitudinal improvement and hypertension and that's an excellent example of looking at per patient did your systolic blood pressure improve by 10 mmHg from over I think it's the first six months, at least six months of the year. So, that's sort of our canary in the coalmine measure, but there are other measures that the Quality Measures Workgroup described previously that we planned for Stage 3.

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

All right, well, as we get to the spreadsheet we can look at the measure, matrix itself and talk a little more about that. Okay, other people on the call have comments about the vendor comment?

Norma Lang, RN – University of Wisconsin

Yes, this is Norma again; this is kind of I think a philosophical or maybe some other kind of comment, but what we're doing is driving a lot of the priorities for the vendors as they try to construct these systems and sometimes I feel that these quality measures that we're putting in are just the tip of the iceberg as to the clinical information or data that is needed and yet it drives how sometimes these things are structured to be able to get those out to meet the regulations and not necessarily to meet the content that is necessary for patients, and yet people are wanting to go in this direction because there is some reward at the end of the time.

So, this is just a part of what we're talking about when we need to get, you know, good data for patient care, somehow I need to keep saying that, because these measures are so few and really, they're important, I don't mean to underestimate that or to take away from the importance, but there is a whole other piece out there that vendors and clinicians, and others also need to deal with in an information system.

Jesse James – Office of the National Coordinator

And is that other piece patient reported data or...

Norma Lang, RN – University of Wisconsin

No, it's clinician reported data as well. They're not reporting it necessarily for quality, but if you're going to take care of a multifaceted patient and you're a physician or you're a nurse, or you're a whatever, there are lots of pieces of data that go into the decisions about that patient and including the patient's reported data. But, between these few pieces that we're putting in as quality measures and the few more that the patient puts in is only a very small percentage of what's really going on with that particular patient or family.

I'm just cautioning us not to think that this is the...and when we drive vendors priorities and I had been speaking to a vendor not too long ago, who said we're waiting for Meaningful Use 2 so we can put where our priorities will be for building, but it didn't include a lot of those things that are necessary to give clinical care, because this seems to be taking over the priority. I'm only cautioning us that this only one part of care and we can't expect vendors and people to put all their...it's like putting all our energy into the measures of quality and what's going on with the rest of the care that's required to be assessed and delivered, just a comment from working in that area all of the time.

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

Okay, any other suggestions about the vendor input? If not we'll try to capture some of the key ideas that will be appropriate to our next work process and perhaps also in the RFC itself. So, the next thing, Jesse, do you want to talk about the crosswalk, the measure gap issue and the crosswalk...?

Jesse James – Office of the National Coordinator

Yeah. So, just to ... the crosswalk is the spreadsheet and it's an update of a spreadsheet that we made in the spring of this year based on the NPRM. The original version of the spreadsheet is actually the 4th tab in the spreadsheet and the matrix was made to show the NQS high priority domains, clinical appropriateness, population and public health, patient and family engagement and so on, and then for each sub domain, I believe this was 2010 the Quality Measures Workgroup chose concepts that at the time they thought were faithful to the sub domain and domain, and were high priority, and they decided, they split these concepts between Stage 2 and Stage 3.

And for instance, for clinical appropriateness under efficient use of diagnostic tests there is a concept for lower back pain and appropriate head CT imaging. And earlier this year, after the NPRM was released and the third spreadsheet on the workbook we show in colors green, yellow and red for each concept how close at least a single measure in the NPRM was to fulfilling what we thought was the intent of the Workgroup concept and there was at that time pretty good coverage for clinical appropriateness and efficiency, and population and public health, but after we went through it we felt that care coordination and patient safety really could use more attention going forward.

And, of course after the final rule some measures stayed in, some measures fell out so this needed to be updated last week and after the notes page, the Crosswalk Workgroup read the final rule, this page shows in similar colors the green, yellow and red the proximity to the intent of the concept to the final rule measures and then some measures, the measures that are grayed out were measures that fell out of the NPRM.

And, as I went through the update I thought that it might be helpful to think about one, when we look to what we kept in for Stage 2 and also what fell out, are there concepts in particular that we think should have attention for Stage 3 or more attention, and also as we look to Stage 3 when I looked with the group for Stage 3 I'm actually pretty satisfied, but of course, it should be more the Workgroup to say are there other concepts that we need in or are we still confident that we've hit the major issues and that maybe we want to think about what types of features of measures we might be interested in particular and with that it might be useful.

I'll leave it to you David should we walk through concept by concept or on a high level get input from the Workgroup?

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

Well, I think given our small numbers today we probably should just get a general reaction, try and maybe schedule a meeting in the next few weeks when we have time and people have some preparation time to mark this up and think about it, and come back with suggestions.

Jesse James – Office of the National Coordinator

That sounds great, then I'll just walk through it and invite commenter's to interrupt me as I go. So, starting from clinical appropriateness and effectiveness and the first sub domain is...

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

Jesse, just on that one, can I interrupt you for a second?

Jesse James – Office of the National Coordinator

Oh, please.

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

I'm just thinking at the next iteration of this, because the final rule does have providers choosing, you know, at least 3 categories out of the 6.

Jesse James – Office of the National Coordinator

Right.

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

We should...I think efficiency is a separate category isn't it, in the final six?

Jesse James – Office of the National Coordinator

Yes.

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

Or efficiency or portability, whatever we're calling it; we should probably take this one apart and restructure it to match the structure of the submission protocol?

Jesse James – Office of the National Coordinator

Excellent point, we'll do that.

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

Okay. Go ahead, given that caveat.

Jesse James – Office of the National Coordinator

So, the concept the Workgroup came up with was asthma medication ratio and that being a ratio of patients with persistent asthma who had controller medications, who had asthma controller medications to their total medications and there were two measures in the proposed rule that addressed this, one was use of appropriate medications for asthma and the other was asthma pharmacologic therapy for a persistent asthma.

The grayed out measure had some issues with data capture and that was described in the final rule the NQF 0036, which is NQF endorsed and is a measure of appropriate medications for people age 5 to 50 stayed in. So, there is at least a single measure in the final rule that is somewhat faithful to the concept that the Quality Measure Workgroup previously had described.

Then the second measure, which is highlighted green was lipid control using Framingham Risk Score and the measure, which is a core measure, that's in the final rule is preventive care for cholesterol, which is tracking the fasting LDL and a risk stratified LDL, the measure doesn't call out the Framingham Risk Score in particular and I guess we could have some discussion on whether a de novo measure would get closer to this or whether the Workgroup is satisfied with the current measure in place.

On the Stage 3 end what was planned was a measure for global cardiovascular risk and measures for preventable ED visits and all cause readmission. Onto efficient use of diagnostic tests, in this area...

Helen Burstin – National Quality Forum

Jesse? Sorry, this is Helen Burstin, I joined late, can I interrupt for one second?

Jesse James – Office of the National Coordinator

Yes.

Helen Burstin – National Quality Forum

Are we going to return to the workgroup concepts when we get to the third tab, the newer concepts or is this the appropriate time to talk about them, David?

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

Well, I was just thinking we may want a deeper dive in another call. I don't know do you want to keep it at some strategy level for now, Helen?

Helen Burstin – National Quality Forum

Yeah, that's fine; I just...I think in some ways I would want to at least have us have more discussion about the readmission in the ED visit measure. I think the ED visit measure is something we desperately need; it's been something really hard methodologically to come up with a good scale of preventability. I know AHRQ is working on that, so I just wanted to make sure that Jesse had hooked up with AHRQ on that development piece.

And lastly, the all cause readmission measure is just an interesting strategy question of when do you need an EHR-based measure when claims-based measures actually get us the picture, it's just sort of a strategy question I think, just, you know, an issue of whether we really need to get to EHR-based measures for everything if claims-based measures are working for some.

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

And, I think in turn that raises the question of multiple data sources as part of this program or not.

Helen Burstin – National Quality Forum

Yes, right.

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

And certainly...I kind of read in the final rule that CMS wasn't eager to embrace that strategy at this point.

Helen Burstin – National Quality Forum

Right.

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

...feasibility, but it's almost the agency's jurisdiction starts to mitigate against a more patient centered measurement approach and we probably should have some discussion. We may have to accept that as realistic, but...

Helen Burstin – National Quality Forum

Yeah.

Patrice Holtz, RN, MBA – Office of Clinical Standards and Quality – Centers for Medicare & Medicaid Services

So, Helen?

Helen Burstin – National Quality Forum

Yes?

Patrice Holtz, RN, MBA – Office of Clinical Standards and Quality – Centers for Medicare & Medicaid Services

This is Patrice at CMS, Patrice Holtz, I agree with you, I think in some cases claims measures are probably better than EHR measures for looking at readmissions and so I would say that the committee really should give consideration to whether that would be reasonable for Stage 3 or not.

Helen Burstin – National Quality Forum

Right or at least consider measures that are more hybrid oriented where you actually are taking claims measures and clinically enriching them with things that may improve risk models, but, I just think, especially given where we are and to throw the baby out with the bath water, I just think it's something we really need to talk about.

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

Agreed.

Patrice Holtz, RN, MBA – Office of Clinical Standards and Quality – Centers for Medicare & Medicaid Services

I agree with that.

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

Good, thanks, Helen.

Helen Burstin – National Quality Forum

Yes.

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

Jesse, do you want to press on?

Jesse James – Office of the National Coordinator

Yes, absolutely, some notes about the claims-based measures versus the EHR enabled measures. I think we at ONC have come to the same conclusion that there are measures, there absolutely are measures where abstractors and claims can do a better job at capturing data and entering the basic intent of the measure than EHR-based measurement can at this point, and it would be a great discussion to have going forward, especially on the Stage 3 measures since the workgroup is a bit more knowledgeable now on EHR measure development on what features and what types of measures we should prioritize for Stage 3 and which types of measures are we satisfied with measuring via claims.

So, the next domain, well the end of this domain, is on efficient use of diagnostic tests and ONC, RAND and CMS have partnered on work in this space just since the NPRM was released and over the time between the NPRM and the final rule I haven't inserted the new measure of concepts that we're considering but it would be reasonable and helpful for the workgroup for us to talk about some of the measures, the efficiency measures that ONC, RAND and CMS are working on.

For the ones that were listed in the Quality Measures Workgroup concepts there is a measure on back pain, head CT, pulmonary CT imaging for PEs and cardiac imaging appropriateness, and I think this is getting at appropriateness for assessing risk of coronary artery disease and ruling out coronary artery disease with diagnostic cath or with CT, MRIs, cardiac MRIs or cardiac CTs.

So, the measure that was previously green but was grayed out was the low back pain measure and there was a decision, based on both the data elements for this measure and some vagueness that created difficulty encoding it for EHRs, that it was decided not to include it in the final rule, so this was a previously green measure that's now colored red. The head CT measure, there isn't one included for mild traumatic brain injury and there may be a question of mild traumatic brain injury, its level of importance from a population stand-point, its importance for meeting the Meaningful Use Program and for the development of a measure on it is reasonable.

PEs and pulmonary CT there was a chest CT using contrast, which was not close to the measure but it was within the intent of the measure, but for this measure as well there was some concerns on CMSs side about collecting data, discrete data and as I recall the issue was on finding from the radiological report whether the CT in particular was for a PE.

The next section is population and public health and this includes sub domains for a healthy lifestyle, preventative services and health equity, alcohol screening, tracking of BMI, measurement of depression and assessing undiagnosed hypertension were a few of the concepts that the Quality Measures Workgroup identified. There is yellow coloring for alcohol screening because there is a measure on alcohol screen, there is also a measure on depression, a measure on bipolar that made it into the menu for the final rule. So, we think it's consistent; it's not exactly what the Quality Measures Workgroup had described previously.

The Quality Measures Workgroup both described a longitudinal measure for BMI and a longitudinal measure for tobacco. The longitudinal measure for tobacco was more seen in Stage 3, the longitudinal BMI was for Stage 2. So, in the final rule of Stage 2 there is adult screening, adult weight screening and follow-up but that's not exactly...I don't think it's longitudinal and the intent that the Quality Measures Workgroup had in mind in particular, I think we were thinking more of an improvement of BMI over time not just follow-up of a BMI.

However, we do have, I'd say we have the ground set to move in this direction since we've been able to develop the hypertensive measure for a longitudinal measurement and also develop codes and LOINC to track blood pressure over time, I think creating a similar measure for BMI and for tobacco use, and for A1c will not be quite as difficult since we've already done work in this space.

Next coded in green is a measure of depression screening and there is a screening for clinical depression, which uses PHQ-9. There is also, you'll see, in the Stage 3 column we had planned for longitudinal tracking of blood pressure, which we previously mentioned, under that is the measure tracking longitudinal change in depression, and there were two measures in the NPRM, one at 6 months and one for depression remission at 12 months, which it really gets to the intent of the measure is to see were you diagnosed with depression, did you have improvement, that's one way of looking at the measure, another way is looking at the concept, another way is you were diagnosed with depression, have you had remission?

So, remission is more end outcome focused. So, we might discuss, going forward, are we interested in another measure that does not only look at remission but perhaps looks at improvement and patient reported PHQ-9. So, that's just...it's an idea to throw out there and for the workgroup to decide sort of if we want to go deeper or are we satisfied with the current status of that measure?

Now the two red rows under population and public health there is the concept of a measure assessing patients with undiagnosed hypertension using an algorithm and this concept was discussed inside of the Booz Allen HITECH contract, I remember earlier in the year we talked about this on a test panel, so now that we've done our work on the longitudinal hypertension I think this is the type of measure we...it's a measure that has been done before in several medical centers and one that we can think about more for Stage 3. And the measure of longitudinal assessment of blood glucose control, which sounds like longitudinal assessment of A1c, to me, that's a measure that I think we'd be excited about working on in the future for Stage 3.

Finally, under population and public health, two of the Stage 3 measures that were in gray are the measure of HIV screening based on current guidelines. We did at ONC and with our developer partners, we found some challenges to an HIV measure that was based on HAART Therapy because, HAART being Highly Active Antiretroviral Therapy, because of the frequency at which the guidelines were updated. I think the guidelines for HIV screening haven't been updated as frequently and don't change quite as much as those for the pharmacotherapy. So, there is an opportunity to do more work inside of that measure.

And that's followed by a measure assessing clinical quality for patients over multiple...fields and for health disparities there wasn't as much work on disparities in Stage 2 or Stage 3 but I think the long-term plan was Stage 2 to be more on quality assessment and 3 more improvement in population, so it fits that for Stage 3 we think about disparities and quality measurement. Any questions or I'll continue to move down the list?

So, in the next section, care coordination, care coordination was a quality priority that we previously described as being...remaining as a high priority and one we'd like to put more emphasis on in the next stage for meaningful use and for quality measurement. So, concepts we've discussed, the measure of self-management plan, a measure for documenting an advanced care plan, and a measure assessing the presence of a completed comprehensive care plan, and in my notes for the completed comprehensive care plan I listed that there are several measures that...well there are several disease areas, multiple disease areas where there are measures for a care plan but not a single measure for a comprehensive care plan across multiple disease areas.

For transitions of care there is a measure for medications reconciliation that's a core in the final rule. There is a measure for patient and family experience as a concept for patient and family experience that has previously been described that we can consider making a priority for Stage 3. Then there was previously described a concept for closing the referral loop and the closing the referral loop measure did make it into the core in the final rule.

For the final domain, patient safety, which has the sub domains of adverse drug events, falls prevention, hospital associated conditions and EHR safety. There is an adverse drug event measure wherein which we focused on warfarin, INR and time and therapeutic range, which is included in the final rule. There is a measure of adverse drug events reporting, which from a public health stand-point would be important and valuable, and FDA has put a lot of emphasis on that, and that's a concept that we can expand on deeper in Stage 3.

There is a measure of medication disease and medication interaction in the elderly, the measure that's closest to this is the use high risk medications in the elderly. We did not pursue a de novo measure in that area and I guess the Quality Measures Workgroup can consider whether the high risk medications that the HEDIS measure whether it's close enough to what we were intending or whether we should consider a new measure, and there is a measure for fall screening and this area has encouraged a lot of discussion in the past from the Workgroup on how much broader a measurement for falls risk and fall screening should be, as I recall, I think its and EP measure and the Workgroup in the past felt that this should be a measure that's expanded across settings.

The measures in gray for patient safety were the measures on high impact medication disease, that's sort of medications interaction between medication and medication or medication disease in patients. Measure for pressure ulcers there was a previous wet-to-dry wound care measure that did not make it into the final rule. And then a measure on patient identification and EHR associated hazards.

So, to sum up big picture, the vast majority of the measures that we previously identified as being consistent with Quality Measure Workgroup concepts moved from the NPRM to the final rule, a few didn't make it due to data capture and calculation issues and our work going forward will be to decide how much of these, how many of these priorities in particular we move from Stage 2 into Stage 3 after we do some more inventory on what's in place.

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

Thanks for the summary, Jesse, and one other piece of data probably when we do the more detailed dive is the status of measures in development that you guys are working on?

Jesse James – Office of the National Coordinator

Oh, absolutely, yes.

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

I think getting an update of what specifically is coming forward will help us try to populate the Stage 3 grid and then decide if there is anything else to be done about gaps. Anybody on the call have questions or additional suggestions for us to...I guess what I'm thinking is in the next 2-4 weeks we should have a call with more time devoted just to this task and have a little more data in front of us when we do that.

Helen Burstin – National Quality Forum

David, this is Helen, just one more thought, I think a strategy question for us to key up is this issue around disparities. We're actually putting out today or tomorrow our new report on how to assess measures for disparity sensitivity, i.e., not different measures to assess disparities groups but which measures should be stratified, I just think it's an interesting discussion for us to have about how EHRs play that role in terms of being able to be then engine that helps us stratify, but if you really need a new set of measures I guess is the question I'd like us to think through.

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

I agree. I think there are a couple of categories on the grid right now that look like they are thin and that's certainly one that we want to strengthen.

Helen Burstin – National Quality Forum

Yeah, and I'll be happy to send that along to Jesse to share with the group...tomorrow.

Jesse James – Office of the National Coordinator

That would be great, thanks, Helen.

Tripp Bradd – Skyline Family Practice, VA

Jesse, this is Tripp Bradd, I came in late I was at a research meeting in Charleston, so I'm a little late, but I would sort of reinforce the medication in the elderly, the HEDIS measure, that would be fine, I don't think you have to go much further than that as far as listing the medications and linking them, that would be great.

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

Any other high level comments on this grid at this point, efficacy or any other informational resources you would like to have in front of you when we do the deeper dive? Okay, well we schedule that in one of our future calls and give everybody enough prep time to be ready for a good planning session. I don't know if you think, Jesse...or what I'm wondering about is whether there is a way to take the high level review we've just quickly done in a little more detail and produce any questions for the RFC from it?

So, for example, we might identify, let's say Helen's last point about the stratification of some measures for equity analysis, is there a way we could put that kind of topic into the RFC, put enough information in there to provoke some useful feedback from the community?

Jesse James – Office of the National Coordinator

Well, I think we could for concept or we can choose concepts that we have specific questions on, we could create inside of the RFC a grid of concepts and then our questions for concept that we would like for commenter's to address.

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

Okay, well let's think about...I guess part of what I was thinking about was timing, if that's the case we want to have our more thorough conversation here in order to prepare some questions for the RFC in the areas of greatest interest or concern.

Jesse James – Office of the National Coordinator

Absolutely, I figured this call would give us an opportunity to say, you know, the final rule is out and to add the new measures to the matrix and then give folks some time to think them over and maybe on the next two calls we'll come up with the questions per concept and also a final list of concepts that we need addressed in the RFC.

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

Okay, good. All right, any other comments on that material? Then, I guess we go onto the RFC questions, especially the architecture section that we began to delve into or maybe we should start by just, if you have...let me see, what do you want to know, Jesse? I know you sent out a revised e-mail this morning with I think all the documents in it, so in that most recent e-mail have the RFC document updated August 23rd, so that has...what Jesse did I think was insert a number of comments and highlights of the areas where we've either added text or there is a suggestion of modification to the actual RFC language, and that takes us down as far as the patient centeredness and architecture section, which haven't been flushed out.

So, let me ask if people...if you had a chance to review that since you got it I think on Thursday, any particular reactions or changes to what's implied by the highlights or the comments as far as we got and then we can turn our attention to the architecture standards issue?

Norma Lang, RN – University of Wisconsin

I'm sorry, this is Norma, I'm not sure...I'm kind of going through these materials...my dates don't match up with yours, would you say again what you thought you were just referring to?

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

Sure.

Norma Lang, RN – University of Wisconsin

I'm sorry.

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

I think the most recent e-mail we got from the Altarum or this morning.

Norma Lang, RN – University of Wisconsin

And only an agenda and these comparison ones, I think.

W

Yeah, it didn't have an updated RFC.

Norma Lang, RN – University of Wisconsin

No it didn't.

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

Oh, well I had one that came...

W

I'm looking for it as well.

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

All right.

Norma Lang, RN – University of Wisconsin

I'm glad I'm not the only one.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I think one came a little later.

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

Yeah, there is one at probably 11:12 Eastern Time, at least that's when I got it.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

After the call had started I think.

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

Yeah and it had draft questions for RFC Stage 3 version 008.

Norma Lang, RN – University of Wisconsin

Oh, okay, I see it.

W

Yep, see it now, got it...

Norma Lang, RN – University of Wisconsin

I see it now too. All right, so what were you...

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

That maybe the same as the one we saw last week, but in any case...

Jesse James – Office of the National Coordinator

Right, I apologize for the confusion, it's the same document as was sent last week but we resent it this morning just to make sure you had all the documents in one place. This is a memo titled ONC, QMWG draft questions for RFC Stage 3.

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

So, if you're able to find that.

M

Got it.

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

Okay, most of this material we've discussed a couple of times and you see Jesse's comments on the margin and the yellow highlights of proposed new language or changed language. We have another month or so to come back to this, but you can just do a quick glance and see if there is anything there that deserves additional attention right now. Jesse if there are no material comments today are you able to essentially create a consolidated draft reflecting comments and changes going forward from here?

Jesse James – Office of the National Coordinator

Yes.

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

Or is that pretty much implicit in...does the yellow highlighting capture most of what's in the marginal comments?

Jesse James – Office of the National Coordinator

I'm sorry; I didn't hear the last part?

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

I was just trying to see whether you think the yellow text, the highlighted text already captures most of what was in the margins?

Jesse James – Office of the National Coordinator

It captures most of it, but I left what was in the margins just in case any other commenter's needed to be reminded of what they said before to give them an opportunity to add more detail to it.

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

All right, maybe what we'll do then is send it out before the next meeting a request that everybody do a careful read of the current consolidated draft in case they want to make additional changes and we can discuss them next time. So, hearing no particular cries of pain today the last thing we did at our last meeting was we began to go through the bullet points on architecture and standards, and that has been reflected in the...really in the agenda document, it's not in the one we just found. So, if you go back to the detailed agenda document and the outbound e-mails, which actually dated, details agenda August meeting 2, 8/23 version 2. Let me see if I have that right.

Jesse James – Office of the National Coordinator

You do.

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

And then in the agenda for the meeting there is about a half page of detailed bullet points titled architecture and standards review. And we did go through this a bit on the last call and I think we recognized some of this is more suitable to the Standards Committee Subgroup, but we certainly want to send some directional signals of what we're trying to achieve and also factor in what the vendors have given us back in feedback.

I don't know, Jesse, if you want to give us some suggestions on what we should usefully do here given the input both from the vendor group and probably the interest of the Standards Committee. Do we have enough here now to sort of characterize the direction and now we need more technical work or is there more you would like this committee to do to flush this out?

Jesse James – Office of the National Coordinator

Well, when I think how this section will fit into the RFC I'd like the committee to give more guidance on what are the questions that we want answered, is it the usefulness for the features that are described in A? Do we want a description of requirements for use cases for the features that are described? I guess, I'm not really sure in what format to add this to the RFC.

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

All right.

Jesse James – Office of the National Coordinator

Or should it be these are the following features of reporting platform, we would like comments on if they are appropriate, like should they be considered for objectives going forward? It's pretty broad in the direction we could go, so I wanted some more clarity from the group on how we want to corral our commenter's.

Saul

Jesse, this is Saul, I have a question that doesn't really answer what you just asked, but I'm curious whether the list of bullets implicitly incorporates the ability to author new measures?

Jesse James – Office of the National Coordinator

It does not and that we discussed in a separate section of the RFC.

Saul

Maybe in that case I would suggest...the thing which I thought might suggest that was the text ability to build.

Jesse James – Office of the National Coordinator

Yeah.

Saul

Or maybe execute or deploy.

Jesse James – Office of the National Coordinator

Thanks.

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

Well, let's see if people have...I'm pondering the question of how best to solicit public input on these attributes, part of me thinks it's at a policy and strategy level, essentially saying to achieve the goals of the National Quality Strategy and other various public initiatives, do we need this set of features, and another layer of it is more operational, are these doable in the timeframe for Stage 3 or what are the right incremental steps to move down this direction for Stage 3, if we pause that these necessary, and then going back to our discussion a few minutes ago about the claims data and the longitudinal tracking, essentially asking the practice community is this realistic and fair given the nature of the system in which you operate or how do we make it tractable given the nature of the system in which you operate. I guess in a sense we're asking how would you solve...how would you achieve these objectives if we put these forward?

M

I like that.

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

I'd be interested those of you in the various agencies who are on the call, staff what would you find helpful in terms of public input and the ability to satisfy your mandates? How can we build this platform in a way that provides value to your agencies? Most of these elements listed here are things that are somehow attached to what you've talked about in your objectives.

H. Westley Clark – Substance Abuse & Mental Health Services Administration

This is Wes Clark from SAMHSA, I find the features useful but I'm going to obviously need to vet them with others. We are working on a behavioral health framework and naturally we have to link that framework up with EHR issues. We've also been meeting with the vendors who work with the behavioral health community, so some of the issues that have already been discussed earlier are captured here.

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

I wonder, Wes, in that context if we waved a wand and had a set of EHR products that could do all this or any...or not just the products but the environment, HIE and registries and whatnot, how would that affect practice in the behavioral health community?

H. Westley Clark – Substance Abuse & Mental Health Services Administration

Well that's the other thing we've been working with the guild to address some of these issues and again we're still in the early stages. Maureen Boyle and other staff have been trying to communicate with our guild, so, again, we need to start to share these approaches given that this is a FACA meeting with the guild so as that if they've got any concerns they can express it early on and I think this notion of its evolving is an important notion, but there is an agreement that we need to move in this direction but that agreement of course is always subject to subsequent reconsideration.

Ahmed Calvo – Office of Health IT and Quality - Human Resources and Services Administration – Dept. of Health and Human Services

This is Ahmed, HRSA, one of the areas I've been sort of struggling with and I don't have a good yet sense of is to what extent is the health information exchange and therefore the assumption of course that other data points or information will come from other sources besides the clinical sources, i.e., the hospitals or the medical practices, etcetera.

To what extent should all of this be in an EHR, when we talk about EHR in the sense of electronic health record broader concept than just the question of a medical record, because again, from HRSA we are almost entirely talking about health homes and comprehensive health homes is the phrase that...I mean I'm biased because I coined it, but the point is that HRSA is not funding just medical care, it's funding oral health and behavioral health, mental health, it interfaces with SAMHSA a lot, etcetera.

And so we broadened the concept from not even talking about patient centered medical homes but rather to the broader health home phrase, but that's not really good enough if we talk about health as a frame of reference as opposed to just health care.

And so when we get into conversations about metrics of health care we're much more comfortable I think, but we haven't really, really begun to address the issues around the broader health information exchange kind of piece, which I think are going to be more complicated than just the questions that we're fussing with right now and are complex enough as they are related to exchange of hospital to clinical practices.

So, I would like some insight into that aspect of it, because it's not really clear if it is in our purview to fund it, but at least we should be thinking about this stuff now.

Jesse James – Office of the National Coordinator

So, for your question, Dr. Calvo, I think we've been to some extent agnostic on where the data lies, whether it should be stored in the EHR, the entirety of the data that comprehensively describes the patient's health experience, does it need to be stored in the EHR or can it, and perhaps more feasibly will be stored in an institution data warehouse from which the EHR pushes and pulls, the HIE pushes and pulls, the PHR pushes and pulls, and the EHR is better for viewing, editing and not necessarily the home for said data. And, I guess the entirety of the Health IT environment, the need is that there is someplace that that data lives but need it be in the module that is the EHR.

Ahmed Calvo – Office of Health IT and Quality - Human Resources and Services Administration – Dept. of Health and Human Services

Yeah, that I understand, but I guess my question is, maybe I just need to hear it, if it already has been said, but I still hear health data being used in the sense of healthcare data and even if the repository system someplace separate from the functional EHR for running the medical practice, isn't it true that some data points might be coming from completely different types of organizations in the community, I mean it's not just going to be in the health care delivery, because I'm just thinking about social determinance of health aspects and the fact that there are other data points that might be relevant in the future that we're really not consciously talking about nowadays yet. I mean we talk about it in general concepts but not necessarily concrete enough to say where would that other set of data fit in that future. Because, we can't just put everything into one giant, you know, database, I don't know, I don't think so.

Jesse James – Office of the National Coordinator

Yeah, I think to some extent, but I'd like to get more input from the group, we aren't there yet but it's also the challenge and part of the mission for the group to think about, besides clinical data what's important for quality and how it can be used, I mean, for the sake of innovation, that is innovation is using what has not previously been useful or capturable for quality measurement.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim Walker; I guess that's why we prefer Health IT as the category because then you're basically saying any electronic information system that has information you need to...to improve health for population. I think the problem is that the lever we have right now is meaningful use, reimbursable meaningful use and EHR certification and so we kind of, for a good reason, we have to focus there just in a pragmatic sense, but remember like you're saying at the other end reality what it is is a complex ecosystem of information systems that if we're going to provide high quality end data and convenient care to patients we have to bring all kinds of information systems together into meaningful processes.

Ahmed Calvo – Office of Health IT and Quality - Human Resources and Services Administration – Dept. of Health and Human Services

Yeah, I really appreciate that last comment, I think the Health IT frame it works well and I agree that meaningful use HITECH aspects really statutorily I think and financially pragmatically place us in the clinical realm, that's where actually many of the measures are too by history. But, my point is that conceptually we have to broaden and therefore we have talk from the point of communicating well with others that the National Quality Strategy talks about if from a health frame, not a healthcare frame of reference, in order to get to the MVP of personal and sort of population health metrics, which by implication means can't just come from the clinical setting.

And, I think the doctors don't want to be held responsible for the clinical outcomes if they wield major factors that are from outside of their areas of influence and that's where we were kind of in that gray zone I think often times in both the metrics discussions and sort of the payment and implications of strategy.

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

This may suggest a way forward for the RFC, acknowledging what you both have said is totally accurate, there are two things. We could split apart our direction as far as the specific meaningful use criteria and measurement set is one path of work, another is to communicate something as a workgroup to the Health IT Policy Committee and Standards Committee, and the Policy Committee in particular has a broader purview than just the Meaningful Use Incentive Program, so we may say to them, even though this is not part of the meaningful use program per se, we encourage you to look at the following issues around data intermediaries or registries or data interfaces or interoperability.

But, I'm also thinking the bridge between those two worlds maybe in the RFC is to invite the community to say, how can we better use the meaningful use incentive program to create the capabilities of addressing the larger health objectives that are in the National Quality Strategy and that we all share, you know, in reality, but we realize the constraints of this particular program, but we would like input on how to make sure this program does as much as it can to build us the right platform.

Ahmed Calvo – Office of Health IT and Quality - Human Resources and Services Administration – Dept. of Health and Human Services

This is Ahmed, I really like what you just said, that makes a lot of sense to me.

Jesse James – Office of the National Coordinator

So, what also might be helpful, Dr. Calvo, is as we move forward inside of concepts and exemplars for the group to be reminded of the types of non-traditional clinical data that might also be determinance of health that we should consider for capture, consider inside the measure as well, and some of them will often not be feasible but if we don't think of it then we won't be able to test it.

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

And, I guess I'm saying, Jesse, too we may be able to state an example like that to the Policy Committee, look, we can't under the purview of the Meaningful Use Program Stage 3 go very far down this path, but you the Policy Committee need to solve it by whatever other tools and approaches you have access to.

Jesse James – Office of the National Coordinator

So, would that be part of the RFC or a separate communication between...I guess when we present our RFC we can have a question aside of the Policy Committee concerns in a non-directional manner?

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

Well, I think first from the public.

Jesse James – Office of the National Coordinator

Oh, from the public too? Okay.

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

Yeah. Other reactions to the attributes list we have on the architecture and standards section on how to translate it into something useful for public comment in the RFC? I wonder if you jump down to the bottom of Section B on the data intermediary's bullet point, I don't know if there are any update, Jesse, on where we are with the data intermediary's group and whether this group is ready to give some input to that...to what we want to extract from them?

Jesse James – Office of the National Coordinator

Well, I think, we would need the...it would best to have the entire group, but so far we are combining the data integrity hearing and the data quality and quality measurement hearing into a single hearing, and that will be scheduled, we have three dates in September and have a poll out for the key contributors, but we haven't settled on a single date yet.

And the meeting last week with the Chairs with yourself and Larry Wolf, and Deven we've since then added some of the points to the agenda that you guys brought up, but it primarily will be organized around first the questions of data integrity as a whole and then taking insight from the intermediaries like the QIOs, the HIEs and individual medical centers and then asking them what where their lessons learned around the quality measures and how can quality measurement be enhanced by improved data quality, it's really a question on multisource data and the standards that are in place, what can we do from a policy stand-point to have "better standards" our early indications are that a lot of the standardized data formats aren't actually moving accurate data or high quality data and of course for the long-term goals paying for quality if you're going to pay for quality you have to pay...you would like to pay for quality that you have faith in.

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

I wonder as we get a little closer now, as you're digesting the feedback last week, if we could send out the draft set of panelist questions for that upcoming hearing to this group for comment on our next call?

Jesse James – Office of the National Coordinator

Will do, we've updated so the draft as we've combined at each level, the draft has taken on a new shape, but I'll send out the one that's previous to adding Deven's group, our section of it hasn't really changed as much as the other ones have.

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

Okay. All right, so any other comments on this architecture and standards section, and we've given Jesse some ideas on how to convert it into RFC-type questions that we could look at in draft form next time around? If you have any other thoughts voice them now or send them along by e-mail. All right, Jesse, what else did you want to try to do today?

Jesse James – Office of the National Coordinator

I think those were the main goals for today. I think for the next meeting what would be best as we're moving from our discussion on architecture to a discussion on the actual concepts, so now that the final rule has been released and we have an update of our concepts and a crosswalk between our concepts and the final rule measures, I think the next conversation we should have will be able to discuss in more detail both the priorities for the workgroup, the gaps that exist around the NQF domains, and to Kate Goodrich's previous point not just identifying gaps but also proposing how to fill those gaps.

So, I see for the RFC that would be one of our major deliverables, something that's useful to CMS and HHS would be one, identifying the gaps but also giving some strong recommendations on what the community feels and what the workgroup feels would be high quality measures to fill some of those gaps.

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

Okay, so we'll have quite a bit of work to do for our next call and we'll hopefully have the full set of materials on the measure gaps question, and we'll send it out early enough for all of you to have time to review it and be ready to flag issues that need some discussion. And, we'll hopefully have a revised RFC that includes something on the architecture section we just talked about. And is there another meeting...when's the next meeting of the vendor group, Jesse?

Jesse James – Office of the National Coordinator

The next meeting of the vendor group would be the 2nd week in September.

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

All right, so we're going to meet once before that?

Jesse James – Office of the National Coordinator

Yes.

M

Jesse, did any of the behavioral health vendors get an invitation for the second meeting?

Jesse James – Office of the National Coordinator

They did, I received...after the first meeting I received an e-mail describing a need for the behavioral health vendors to contribute and we responded back saying as many that are able to make the meeting, we'd love to have them all.

M

All right, thank you very much.

Jesse James – Office of the National Coordinator

No problem.

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

All right, any other business. I guess we have time for public comment if anyone wishes to make one, Mary Jo can we do that?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Yes, David, I wanted to mention to folks on the phone that if anyone was interested in participating in one of the upcoming webinars on the two final rules there are going to be repeats of some public webinars that were...there was one put on, on Friday and it includes both the overview of the meaningful use rule by Rob Anthony of CMS and of our standards and certification rule. Is there anyone on this call who would like to receive sign up information for those webinars or information about them? They've also been archived so you could go back and see the slides and hear them.

H. Westley Clark – Substance Abuse & Mental Health Services Administration

Sure this is Westley I'd be interested.

Tripp Bradd – Skyline Family Practice, VA

Sure, this is Tripp; I always like to have that kind of source.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Then what I'll do is I'll just send it around then to the workgroup and with apologies to those of you who don't need another introduction to the rule. Okay, operator would you please open the lines for public comment?

Public Comment

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

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

Okay, well thanks again to all of you for making time today, getting us caught up and hope you all have a good Labor Day weekend and we will enter the new season ready to tackle all these issues again in a couple of weeks. Thanks, everybody.

M

Thank you.

W

Thank you.

M

Thank you.

W

Thanks.