

**HIT Policy Committee  
Quality Measures Workgroup  
Vendor Tiger Team  
Transcript  
October 19, 2012**

Presentation

**Operator**

Ms. Robertson all lines are 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 as part of the agenda and the call is also being transcribed so please make sure to identify yourself when speaking. I'll now take roll call. David Lansky?

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

Yes.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, David. Mike Aswell? Chris Bontempi?

**Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Chris. Annette Edmonds? Joseph Geretz? Kip LeCrone? Margaret Lohnes?

**Margaret Lohnes – Quality Measures Manager - McKesson**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Margaret.

**MacKenzie Robertson – Office of the National Coordinator**

Stirling Martin?

**Sasha TerMaat - Epic**

This is Sasha TerMaat for Stirling.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Sasha. Ginny Meadows?

**Ginny Meadows – Executive Director – Program Office - McKesson**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Ginny and Mark Segal for Jon Morrow?

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

Correct, I'm here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Mark. Karen Nielsen?

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

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Karen. Lynn Scheps? And I believe we have an alternate for Melissa Swanfeldt?

**W**

Here, yes.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks. Okay and ONC we have Kevin Larsen and Jesse James.

**Fred Rahmanian – Principal Product Architect – Siemens Healthcare**

Hi this is Fred Rahmanian I'm representing Siemens as well.

**MacKenzie Robertson – Office of the National Coordinator**

Fred Rahmanian, okay.

**Fred Rahmanian – Principal Product Architect – Siemens Healthcare**

Thank you.

**MacKenzie Robertson – Office of the National Coordinator**

Thank you and I'll turn it back to David, briefly?

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

Yes, all right thanks MacKenzie and thanks everybody for making time again to give us your perspective. So, where we are the Quality Measures Workgroup has been working for a couple of months alongside the Meaningful Use Workgroup to develop a Request for Comment document which will be going out, I don't know in the next few weeks I'm sure, Jesse and Kevin can update us on that, and that will be an opportunity to solicit from the entire industry providers, vendors, general public a number of thoughts on how Stage 3 might be shaped to take advantage of what we've learned from the last couple of years and also of course what we're trying to achieve in overall policy goals.

So, we've got a draft now and I think this is a good time...there are a couple aspects of that draft that reflect the conversations we've had on this call before and I think we want to get some further discussion of some of the issues implied there and I'll, you know, ask Jesse and Kevin if you want to give us some other direction of what else you'd like us to focus on today.

**Jesse James – Office of the National Coordinator**

Thanks, David, today in particular we've updated the group on the draft before and we've focused previously on the architecture and features for Health IT and population management for what we see as the next generation of quality measurement and today we've really wanted to be sure that our understanding of the questions at this point are consistent with how the vendor community will interpret them and there are two issues that we wanted to dive deeply on to the extent that time allows.

And in the agenda we've listed them under the point number two as A and B, and for A we wanted to get a feeling for the current status or the current capability of vendors to capture and implement CQMs automatically. So, we've described before in Health IT Policy Committee Meetings and in previous, well in previous Workgroup meetings a plug and play approach to measure implementation and we see a long-term goal for our HQMF XML that's produced with the technical specification of measures being automatically, immediately machine readable by vendors.

What we haven't been sure of per vendor is how close we are to that capability and I imagine they're both barriers on the federal program side from the point-of-view of the standards and from the vendor technology side, but we'd like to get a feeling for that and be confident that the question we are asking will be interpreted as such.

And then for issue B we've discussed population management and clinical quality measure dashboarding and we wanted to be sure our description of that in the RFC is consistent with how vendors will interpret it.

**Sasha TerMaat - Epic**

Just a logistical question, you mentioned A and B, I downloaded the agenda here, it doesn't list either of those.

**Jesse James – Office of the National Coordinator**

There is the high level agenda that is attached, that Altarum, the contractor, puts together and then there is a detailed agenda and that document is named Vendor Tiger Team Agenda October 2012, 10/19. There are 3 attachments.

**MacKenzie Robertson – Office of the National Coordinator**

Jesse, do you want to have one of those projected now as we're going through this conversation? Do you want the detailed agenda up?

**Jesse James – Office of the National Coordinator**

Yes would you project the detailed agenda, please?

**MacKenzie Robertson – Office of the National Coordinator**

We'll have them get that up there while you continue talking, thanks.

**Kevin Larsen – Office of the National Coordinator**

This is Kevin, the question really about the HQMF is in part broad and in part narrow, the goal that the Quality Measures Workgroup and the HIT Policy Committee has had all along is a flexible platform for clinical quality measures where the vision is that quality measures are not hard coded into EHRs and so that's the sort of broad question is how do we make that happen and the more concrete question is the tools that we currently have, for example the clinical quality measures as expressed in the HQMF, what could we do to make those tools evolve to that vision of the flexible platform.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

Well, this is Mark Segal from GE, just on the first part and just to quickly comment, it seems to me that it's a reasonable goal of the Policy Committee and ultimately ONC to allow for sort of multiple ways, you know, different platforms and approaches in terms of calculating quality measures and reporting them, and I think that frankly the way the Meaningful Use Stage 2 approach took that, you know, it was a reasonable one, but I guess from a vendor stand-point, and I suspect this is shared by colleagues, but they should certainly speak up, I do find it a little problematic with the notion that particular architectural approaches to solve technology solutions and really, in effect, you know, our customers problems, I just have a concern about, you know, particular models of architecture being kind of put forward, you know, and so I'd just kind of urge a little caution there.

**Kevin Larsen – Office of the National Coordinator**

So, can you give suggestions for how we could word this question, the Policy Committee is really interested in knowing what would be approaches that would allow this flexible architecture to happen and how we would use the levers we have of policy and certification to encourage the industry in this flexible frame?

**Fred Rahmanian – Principal Product Architect – Siemens Healthcare**

This is Fred Rahmanian, I'm with Siemens, first I want to reflect the same sentiment as stated previously. I think, whatever we do it should not be, and I think this is the goal also, I'm not saying that it's not, but it should not be prescriptive in any way in terms of the technology, the model, the architecture, the architectural style or any of those things that should not be part of the specs, so I agree with that.

Secondly, you know, I think we should...I would be leery about soliciting information from vendors that may involve intellectual property in the answer because you're probably not going to get any answer in that case.

So, then the big question here is then if we're looking at HQMF, again, I'm looking directly at A and B items in the agenda item number 2, if you're looking for specs and you want to create concrete specs there are ways, and they have to be...and your goal is to be machine readable, if as stated, then there are ways well known ways in computer science, you know, you can use a BNF model for instance to define the domain specific language to me, HQMF is essentially a, what we call in computer science, a domain specific language and there are well written, you know, many books on this.

And I would say if you really truly want to be architecture agnostic but yet provide a concrete way of defining quality, how a data should be retrievable or essentially be very precise about HQMF, use those techniques, as I said, for instance defining a domain specific language with BNF then that leaves very little to ambiguity, they are context-free representations of these domains specific languages that we can use.

**Sasha TerMaat - Epic**

I have, maybe to take it up a level, since Fred I don't think I'm as technical as you are, this is Sasha, it seems like if the policy goal, I'm guessing, is speedy implementation of new measures as they're developed without the kind of lead time that vendors have previously been advocating is necessary to develop and implement new measures, it seems like maybe your question would be better phrased more broadly to say, what steps would it be useful for us to take from a policy perspective, from a standards perspective to speed the development and implementation of new measures without getting into the worries that Fred and Mark, and I share of implying that one particular technical solution of plug and play HQMF XML is already sort of predetermined, because some folks might have other creative ideas of the same end goal of being able to implement a quality measure very easily.

**Jesse James – Office of the National Coordinator**

Thanks, that's a good point. I think it's not our goal to be over prescriptive and it makes sense to step back and ask the question is it...do the vendors share the same end goal in this area? It's our understanding that the specifications have required, the technical specifications for Meaningful Use 1 required a bit of human input in areas of ambiguity and were in different systems perhaps not calculating consistently because the specifications weren't as consistent as they could be and our end goal, as we go forward, is to be as consistent in our language and the specs as possible, and across measure as possible.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

Yeah, and I would say that definitely, you know, again, I'm not as technical as Fred, but the idea of machine readable certainly is appealing, the idea of measures that are precisely defined in ways that even if they have to be manually coded are framed in ways that can be readily translated into the EHRs and their particular, you know, quality measure calculation engines make sense. I did...because I'm going to have to drop off, there were three terms that I wanted to kind of urge you to look at, you had asked the question about whether the RFC kind of communicates well to vendors and in the first item, which I think were labeled item A, where it talks about the desirable attributes, where you talk about CQMs should not be hard coded and I don't think we need to get into the detail here, but I think it's important for you to say exactly what you mean there.

Secondly, on the point on being able to configure to use data elements appropriate to local workflow, again, this is kind of a policy issue between ONC and CMS, but the question is to what extent can providers, will they be permitted to alter the certified CQM calculation capabilities to meet local circumstances and so I would just kind of take that into consideration.

And then finally, where you say, when part of the EHR...there are a couple of places where you talk about calculating scores automatically, and again I'm not sure that automatically is necessarily the right word, in some cases particular architectures of reporting, you know, are going to require...I mean, there are cost and time associated with how quickly results come back and so I would just kind of think about do you really mean automatic or do you mean...or is automatic meaning without human intervention, or does automatic mean that it sort of happens immediately, and so, I would just on those items I'd be kind of clear what your intention is so you get better responses.

**Jesse James – Office of the National Coordinator**

Thanks, automatic should not imply immediate calculation but should imply calculation without human input.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

Yeah, and I would just clarify on that.

**Jesse James – Office of the National Coordinator**

No, thanks, I appreciate it.

**Fred Rahmanian – Principal Product Architect – Siemens Healthcare**

I would add to that, this is Fred with Siemens again, I would add to that again, it should probably not...it should not imply any timing in the calculation itself, because then that would then clarify the, you know, the how immediate the results should be available or not.

**Jesse James – Office of the National Coordinator**

We haven't committed ourselves to immediate calculations and immediate results. We do see immediate calculations and results as being valuable information but right now we're not demanding that from technology.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

And the other just...

**Jesse James – Office of the National Coordinator**

And the provider and clinical I definitely see the value in that.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

The other dimension of automatic to consider, again, looking at the text here, is there is automatic in the sense of the provider let's say doesn't need to request a report to be run and then part of what I think you're getting here is really that the measure calculation can proceed totally with data that is sort of natively in the EHR and you don't require, you know, sort of abstraction or anything of that sort.

**Jesse James – Office of the National Coordinator**

Yes.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

So, I would just think about what are the dimensions of the automatic that you're really referring to, I think, having it, you know, operate automatically versus somebody requesting a query it seems to me that is less important than moving to be able to actually have the calculation sort of proceed with just the data that is already in the EHR.

**Jesse James – Office of the National Coordinator**

Absolutely. Were there any more comments on the use of automatically?

**Kevin Larsen – Office of the National Coordinator**

This is Kevin again, another, I think, great bit of input from you, we hear from the Policy Committee a desire for there to be a low cost end burden for providers to implement incrementally more measures and so part of this question about being able to take in measures is not just, as Sasha so clearly pointed out, about the speed of uptake it's also about how do we make it a low cost, low burden ability to take in more measures.

**Sasha TerMaat - Epic**

So, just at a high level, Kevin, I think that, you know, you asked do vendors share this goal, I mean, I think for competitive reasons it's advantageous to all of us if adding more measures is easy for us from a development perspective, because then we can, you know, expend development resources on other things, and it's also advantageous competitively if it's easy for our users to add more measures because that's something we hear as a desire not just from the Policy Committee but from users, and you know, it's a way to distinguish ourselves. So, I don't think your question is really, you know, are vendors deliberately trying to make this slow and hard, but I think your questions about, you know, what can happen to make this faster and easier are true.

I know that I am convinced from talking with our developers that trying to do machine readable at this point is actually going to be longer and harder than actually having a person do some of the coding and release that out. So, I mean, I think, in an RFC we could respond with more detail about why we think that, but I think, you know, phrasing-wise, obviously no one is going to sit on this call and tell you we want it to be longer and harder.

**Kevin Larsen – Office of the National Coordinator**

Yeah, know, I know, what I want to be sure is we elicit that kind of response from you that you can help us with the levers that we have, where should we invest the energy and policy to help make it faster and easier?

**Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies**

Right, so this is Chris Bontempi with McKesson, just to tail on what you just said or what you just asked about, you know, I do know that in previous discussions the question has been raised, I believe by vendors, about whether or not this is even a worthwhile goal, so I do think that's a valid question and I would agree with the previous speaker that it would be useful to us from a competitive advantage if this were easier and I think, you know, we've heard that...I've heard that a number of different times, but that's really where we're...that's really the condition for us is if this is easier and feasible, and also consistent, it has to be, as other folks have mentioned, it needs to be consistent so that we end up with the same results and don't end up with a lot of different results or at least can verify that we all have the same results, which I think the testing is going to help with.

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

And this is Karen Nielsen, I just wanted to go ahead and bring up something that is not related immediately to technology and the vendors, but it gets back to some of the things we've discussed before which is the data elements themselves. There is a certain amount of cost associated with each data element and as measure specifications or measures are being designed perhaps one of the areas to look at is again the reuse of key data elements and looking at ones that are easy to capture versus ones that are going to take tremendous changes and workflow, etcetera. So, that's just something that I want to put out there as well.

**Jesse James – Office of the National Coordinator**

We, appreciate it, we are on the same page of thinking about in Stage 3 how we repivot on our feasibility testing, how we do this in a way that considers both what elements have been captured before, what elements are captured frequently across multiple CQMs and what elements are feasible technically in EHRs, and we do intend to pull in vendor input earlier in the process.

**Kevin Larsen – Office of the National Coordinator**

So, a question back to you, this is Kevin again, how can we phrase that for the RFC, because what we want to do is elicit people's good ideas to know how do we identify elements that are low burden elements?

**Ginny Meadows – Executive Director – Program Office - McKesson**

Well, so Kevin, this is Ginny Meadows, and I would suggest, you know, one of the things that, you know, obviously you asked that question, but I think part of what we should be thinking about is how do vendors become more involved in the front end with the actual measure development and then I think, you know, you asked the question, I saw something in there about retooled measures versus de novo measures, and I think many of us have realized that, you know, the danger with retooled measures is you're kind of working from a roadmap that already assumes certain data is existing. So, you know, the whole issue of kind of thinking about the development of measures from the de novo measurement perspective and having vendors participate early on and kind of ideas around how that participation could work, we've seen some successful pilot projects. So, I think that definitely needs to come out in this RFC.

**Kevin Larsen – Office of the National Coordinator**

Do you have suggestions about how to word that question?

**Ginny Meadows – Executive Director – Program Office - McKesson**

I think I'd suggest just asking the question outright is what suggestions do we have for insuring that the feasibility of the measure is a measure being created as actually being considered by the measure developer.

**M**

And what processes would they undergo to actually assess that, you know, who should they consult with.

**Ginny Meadows – Executive Director – Program Office - McKesson**

Yes.

**M**

What question should they ask?

**Ginny Meadows – Executive Director – Program Office - McKesson**

Yes.

**Sasha TerMaat - Epic**

Ginny do you think...so it seems like there is almost two spots for feasibility the one you've identified, which is if there is at the point of developing the measure a way to use data elements that are, you know, mathematically equivalent but easier to report on, that seems like one point of input. The other point would be, in my mind, at the point of selection for inclusion in a federal program evaluating whether a measure includes data elements that are assessed as feasible or not as a second check point. Does that make sense?

**Jesse James – Office of the National Coordinator**

Yeah, it does, another thing that we've been noodling on is would there be a way that we could assign a feasibility score to individual data elements and then you could come up with a sort of equation that says, you know, the overall measure has to be below the score in order to be feasible and you could get a much more sophisticated grade of feasibility rather than a kind of yes/no.

**M**

That makes sense.

**Sasha TerMaat - Epic**

I like it.

**Ginny Meadows – Executive Director – Program Office - McKesson**

Yeah, that's a good idea.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

This is Mark, I've got to dial off, but I just wanted to leave one last point perhaps, which is a lot of the focus on this part of the RFC and from what I've seen, you know, in other Workgroups, is really new functionality for Stage 3 and it seems to me that across the board Stage 2 whether it's interoperability or quality measurement is really, you know, it's almost in some areas an order of magnitude increase in terms of potential capability that can be exploited, and the reality is that it is going take more than 2 years to kind of fully exploit that for people to work with this, you know, and so I'm not sure exactly how you frame it in the RFC.

But just as there are examples in the move from Stage 1 to Stage 2 where you increase the percentage, you know, or, you know, with clinical decision support where you broaden it a bit but it's going from, you know, one rule to 5 interventions, I would think about ways in which rather than trying to put new technology approaches in place in Stage 3 that you can really learn from the experience in Stage 2 and have people actually more fully exploit the Stage 2 capability, you know, whether it's in threshold, whether it's in, you know, guidance or refinement, because I think there is just this sense of just sort of continuing to really ratchet things up every 2 years and not necessarily building on the investment at each stage. So, just, again, I don't have a suggestion for how to frame that, but I think that thought seemed to be missing from the RFC.

**Jesse James – Office of the National Coordinator**

Thanks, Mark, we mentioned in the preamble, which isn't attached in this chart, we mentioned that we see our goal for Stage 3 as, and you'll notice we don't list CQMs as the previous RFCs did, and we did do that for a reason because we wanted to take a step back and consider the environment, the process of creating them, the testing of the measures, the availability of innovation and both the vendor and the specialty society community. So, we really want to use this opportunity on the Quality Measures Workgroup to step back with Stage 3 and refine the measures we have, that we see as our goal instead of just expanding the number of measures you have to report on and the number of measures there are. We really want to think about how we can do this in a better way, a cleaner way and produce a product that's more useful clinically and to the vendor community, and to patients as well.

**Mark Segal – Vice President, Government & Industry Affairs, GE Healthcare IT – GE Healthcare**

Well, thank you. I have to go, bye-bye.

**Margaret Lohnes – Quality Measures Manager - McKesson**

Hi, this is Maggie Lohnes, I was reflecting back on the question about the value feasibility and I'm recalling a webinar that the National Quality Forum hosted I believe about a month ago, it was a demonstration of the measure authoring tool and other tools used for measure development but also a demonstration by Yale on their use of the tools, and they had one slide that gave a very simple 3-part feasibility question that they use when they're developing measures and if I recall them correctly one was is it available technically in the system and the second was is it consistently gathered by the providers in their group, but also a third was does it work within the clinician workflow? So, there are really different aspects to the feasibility outside the technical feasibility.

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

Yeah, and if I could just branch off of Maggie's comments, this is Karen Nielsen, I know I had mentioned to Jesse at one point in time that the Joint Commission is also doing some work and they've actually come up with a way of looking at again some of the data elements just in one registry in New York and trying to figure out how much of those data elements are actually normally available in an EHR versus ones that you would never get out of an EHR, and there was a methodology that was put together to actually grade the different data elements and it had not only a yes or no kind of question but also you had the methodology of going through and if it was a yes that was fine, if it was a maybe then why is it a maybe, and then if it is a no why is it a no. And so that, again might be something that you might be able to utilize in this process.

**Jesse James – Office of the National Coordinator**

Thanks, this is Jesse again, so our Stage 3 planning is in its early stages and we are...part of our work on Stage 3 will be to take a lean focus or a lean approach to measure development and to pull in stakeholders both from the vendor, the testing, measure developer, measure endorsement communities and to review the process, pull out the redundant steps and to also identify places where errors are introduced and that work will involve two presidential fellows, presidential innovation fellows, one will be housed at ONC another will be housed at CMS and over the next quarter they'll be working on measure development and we'll have listening sessions where we'll be calling on vendors, testers, data intermediaries, providers, also measure developers to figure out how to clean up this process both to make it shorter but also to encourage eliminating some of the redundancy and a lot of the errors.

So, we absolutely get that feasibility testing has to change and we want to pull in both the NQF and Joint Commission's work. We're supporting some of the work at NQF on changing feasibility testing or at least investigating options for feasibility testing inside of EHRs in the future. One of our mid to short-term goals will be to set up innovation cells around measures where we can team a vendor, provider, developer early and build measures that can work inside of EHRs but to know that they work inside of EHRs because we code them earlier than we have been previously. Not to get too far off track, just want to give folks an idea of what we're thinking about on our end of how to do this in a different way.

Were there any more comments on the incorporation of HQMF into vendor systems? I think what would be a fairly consistent summary of what we said so far is that one to a certain extent vendors share the goal of non-ambiguous technical specifications that are machine readable but that may actually be more work in the short-term than the current state of measure specifications and that any comment on what's considered proprietary technology likely won't happen through the RFC that the vendor community is interested in really what, you know, is on the policy end or the standards and can be done to allow for quicker and more consistent creation of CQMs.

What we didn't address is whether there were characteristics of measures that made them more likely to have HQMF that was machine readable. Are there any comments on that?

**Margaret Lohnes – Quality Measures Manager - McKesson**

Hi, this is Maggie, just to build on the previous conversation about the values it would seem to me if there were no new values introduced in the definitions that might be one aspect that would make it more quickly adopted.

**Jesse James – Office of the National Coordinator**

If the logic in the value sets were the logic and value sets that were used were consistent with logic and value sets that were previously used in other measures?

**Margaret Lohnes – Quality Measures Manager - McKesson**

Yes, that it didn't introduce any new concepts.

**Jesse James – Office of the National Coordinator**

All right and some final background into this question, we asked in particular, because, I think the Workgroup has an idea of what would make the development process, the software development process around CQMs easier for vendors, but we have to be sure that our understanding of that is consistent with your reality and I think there are some places where it isn't and I expect that the RFC will get us closer to being there.

So, onto the B section, which is about the business process management software and the question we asked in the RFC which we previously put before the Tiger Team was how prescriptive or how strong a policy lever the Health IT Policy Committee should be willing to use in the area of population management and CQM dashboarding and our feedback essentially was that the Policy Committee should be willing to give the area more time for the market to develop and the technology to develop and we absolutely get that and understand it. What we wanted to ask in this question to the public was something similar where we ask are there levers that we should pull or is this an area that we should allow the market to continue to evolve?

And so, our main question here was does or do the questions in this section and that's the final part of the RFC and the chart is labeled quality improvement support CQM population management program, the question was are these questions consistent with where there may be barriers either technically or from a policy stand-point, or are there parts of the question that need to be either edited or added to from a vendor perspective?

**Fred Rahmanian – Principal Product Architect – Siemens Healthcare**

I'm sorry, Jesse, this is Fred with Siemens, can you...which section are you on again, I'm kind of lost now on the last comment you had?

**M**

Yeah, I agree.

**Jesse James – Office of the National Coordinator**

This is from the quality measure work, its labeled QMWG addendum to RFC chart. Altatum, could you post that on the webinar?

**Fred Rahmanian – Principal Product Architect – Siemens Healthcare**

Oh, I see it now, okay, that's the other document, okay, very well.

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

Yeah, and Fred it's on the second to the last page I believe is what Jesse is referring to.

**Jesse James – Office of the National Coordinator**

So, it starts at the bottom of page 6, the bottom of page 5, I'm sorry, and continues into page 6.

**Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies**

This is Chris Bontempi from McKesson, I would say that we should probably allow vendors more time on that from our perspective.

**Jesse James – Office of the National Coordinator**

And can you elaborate on more time?

**Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies**

Well, I mean, I thought the question was should policy levers be used to move this along or should we sort of be left to continue on the path that we're on and I believe we should be allowed to continue on the path that we're on.

**Jesse James – Office of the National Coordinator**

Right.

**Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies**

Are you looking for a timeframe?

**Jesse James – Office of the National Coordinator**

No, not really, just, is there a reason in particular that you feel from your company then that you should be allowed more time, is it you feel the technology isn't quite where it needs to be or adoption isn't as broad spread as it needs to be?

**Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies**

Well, I just believe that...

**Jesse James – Office of the National Coordinator**

You haven't figured it out completely yet, there is still a lot of innovation in this space?

**Christopher Bontempi – Software Architect Advisor – McKesson Provider Technologies**

Yeah, I would just say that I don't see the necessity for policy intervention at this point; I don't know that that would necessarily be constructive.

**Jesse James – Office of the National Coordinator**

Oh, that's fair.

**Sasha TerMaat - Epic**

So, I think your first sentence in that section where you say comment on the value and feasibility I think leads me down the correct path, if I were going to respond this during your RFC to sort of talk about advantages and possible disadvantages of policy requirements in this area for example I'm sure there are features that providers might find very useful correspondingly those features might be very expensive from a development perspective, from a hardware perspective and at this point the expense might not be worth it.

At the following question I think that it's also fair to say that the area is experiencing rapid innovation it might not be clear that we could write a requirement that would be broadly applicable to all the different ways that we might innovate in this area and it could be prohibitively prescriptive. So, I guess, I think some of your questions are getting at the kind of feedback you're hoping to get.

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

And if I could just tag onto what Sasha said, this is Karen Nielsen, you know, one of the things that we already have going on out there as far as policy is concerned is the policies coming out of CMMI or CMS in general and there is policy that is changing the risk structure and the reimbursement structure and as a result I think that the industry is trying to be very creative in their ways of assisting providers in the ability to meet the needs of this changing environment, and if we can...so if we look from a policy stand-point I think there is plenty of policies out there driving in this area.

I think it's a matter of letting the free market continue in trying to come up with very creative methodologies for addressing this and I know that just from the stand-point of looking around at my friends in California who are jumping into pre IPO ventures out there trying to, you know, come up with some new strategies, I don't know if we want to put restrictions on some great inventive engineering that could be on the horizon that we just don't know about.

**Jesse James – Office of the National Coordinator**

So, that's fair and it's a good point in that there are levers in place that are encouraging providers and provider organizations to think about the populations they manage and increasing their financial risk involved with those populations and therefore it might be best that the innovation is left up to the providers and the technology vendors to create solutions in that area, and we're pretty early in this area if that, thanks. Any other comments on this section?

**Ginny Meadows – Executive Director – Program Office - McKesson**

Yeah, Jesse, this is Ginny Meadows, I was just going to agree completely with Karen in that there definitely are other levers in place, so I don't really see that the Policy Committee needs to give any guidance and we all know that, you know, there is definitely some good exemplars that we can find from where the things that the payer business has learned, but there is definitely innovation as we think about moving this into a provider centric kind of model, so I really think letting the market kind of drive this will be our best way of getting the innovations.

**Jesse James – Office of the National Coordinator**

Thanks, Ginny. Are there any other comments or questions either in this area of globally?

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

Yeah, I'd love to make a global suggestion if I may? This is Karen Nielsen again.

**Jesse James – Office of the National Coordinator**

Yes, please?

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

You know, one of the things that strike's me is that there is a lot of focus on technology and not everybody who's trying to deal with this new landscape understands the technology. So, for instance, the measure developers who are going to be required to do the de novo measures it might be helpful for them to be able to have a framework to at least grow from and I'm suggesting that maybe some basic education, we've got many members of the EHRA that's on this call and that would be a wonderful organization to work through for perhaps some education opportunities.

And then additionally, you know, I'm doing a program at Hopkins and it's the clinical informatics certificate and one of the things that we had to do before the program started is we had to go through some of the curriculum that was developed through ONC funding for community colleges and those are wonderful programs that are already created, the work has been done and maybe the idea is to make some of that available to this group of measure developers so that they feel like they have a better understanding of technology before they're asked to sit down and create measures that are going to be leveraging the technology that they know nothing about.

**Jesse James – Office of the National Coordinator**

Touché, there is an opportunity with three to join the measure developers to the EHR software developers more closely and we're working on that. I think the developers are increasingly knowledgeable about EHRs, but different developers spend a varying amount of time with EHRs and it sort of developer dependant on how they test their feasibility with EHRs, some do it directly through EHR vendors others use survey CMIOs at provider institutions. So, part of our work going forward is to create a single standard feasibility testing inside of EHRs and NQF is our partner in that, but you are absolutely correct there is more that can be done to join the software developer community with the measure developer community and the EHRA is a good avenue for that.

So, we'll be thinking as we move into Stage 3, we'll be thinking more about pulling the EHRA in sooner and even having a formalized process for that, but that's something we want you guys to be thinking about as well and we would anticipate we will get some feedback from the EHRA to this RFC in that area in particular. Are there any other questions/comments? If not then I think we can adjourn at this point.

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

We have public comment to do.

**MacKenzie Robertson – Office of the National Coordinator**

We'll have to do public comment first and then we can adjourn.

**Jesse James – Office of the National Coordinator**

Following public comment of course.

**MacKenzie Robertson – Office of the National Coordinator**

Are we ready for public comment?

**Jesse James – Office of the National Coordinator**

We are ready for public comment.

**Public Comment**

**MacKenzie Robertson – Office of the National Coordinator**

All right, operator please open the line for public comment.

**Caitlin Collins – Altarum Institute**

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

**MacKenzie Robertson – Office of the National Coordinator**

Great, thank you.

**Jesse James – Office of the National Coordinator**

Thank you so much, the Tiger Team you guys have been extremely helpful on working on the RFC. Our meetings will likely be less frequent now that the RFC is completed but there will be additional work around the data quality hearing we're having at the end of November and then into next year once we get closer to the proposed rule we'll be pulling people back in again, but thanks so much for your input and we look forward to your comments after the RFC is released.

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

Thanks everybody.

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

Great, thank you.

**W**

Thank you.

**W**

Thank you.

W  
Thank you.

M  
Thank you.