

**HIT Policy Committee  
Quality Measures Workgroup  
Data Intermediaries Tiger Team  
Transcript  
May 3, 2013**

**Presentation**

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thank you, good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup Tiger Team on Data Intermediaries. This is a public call, there is time for public comment built into the agenda and the call is also being recorded so please make sure you identify yourself for the audio recording. I'll now go through roll call. Marc Overhage?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**  
Present.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks, Marc. Eva Powell?

**Eva Powell, MSW – Evolent Health – Senior Director**  
Present.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Eva. Micky Tripathi? Francis Campion? Can I just ask everyone who is not actively speaking to please mute your lines or just make sure you turn your computer speakers off because we're getting a bit of an echo. Francis Campion? Jim Chase?

**Jim Chase, MHA – Minnesota Measurement Community – President**  
I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks, Jim. Mylia Christensen? Richard Cramer? Peter DeVault? Prashila Dullabh? Jonathan Keller?

**Jonathan Keller, MBA – Central Utah Clinic – Director of Data Analytics**  
I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks, Jonathan. Brendan Mullen?

**J. Brendan Mullen – PINNACLE Programs – Senior Director**  
Good morning.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Good morning Brendan. Janice Nicholson? Steve Ornstein?

**Steven M. Ornstein, MD – Medical University of South Carolina – Professor, Family Medicine**  
I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Great, thanks Steve. Chris Queram?

Christopher J. Queram, MA – Wisconsin Collaborative for Healthcare Quality (WCHQ) – President & Chief Executive Officer

I'm present.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks Chris. Alan Silver?

Alan L. Silver, MD, MPH – IPRO – Medical Director

Good morning.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks, Alan. Walter Sujansky?

Walter Sujansky, MD, PhD – Sujansky & Associates – President

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Great, thanks, Walter. Daniel Green?

Daniel Green, MD – Centers for Medicare & Medicaid Services

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks, Daniel. Molly MacHarris? And if there are any ONC staff members on the line if you could please identify yourself?

Jesse C. James, MD, MBA – Office of the National Coordinator

Jesse James from ONC is on.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Thanks, Jesse.

Kevin Larsen, MD – Office of the National Coordinator

Kevin Larsen from ONC.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Great thanks, Kevin. Okay with that I'll turn the agenda back to you Marc.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Sorry, MacKenzie this is – sorry it's Micky Tripathi I'm on too.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act  
Program Lead**

Oh, great, hi Micky, thanks.

Micky Tripathi, PhD – Massachusetts eHealth Collaborative – President & Chief Executive Officer

Hi.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Great, thanks for getting on. So, welcome everybody this is Marc Overhage and I want to start off by apologizing for our relatively slow out of the gate here, I think many of us have been distracted with lots of things and have been less effective about getting us organized and moving in the right direction than we might have been.

Fortunately, our colleagues at ONC and the Quality Measures Workgroup have not been slow out of the gate and have been giving this topic some thought and consideration and pulled some materials together that they are going to review with us today that really reflects sort of the Quality Measure Working Group, and Jesse you can correct me in a minute if I'm getting this a little bit wrong, represent out of deliberations of the Quality Measures Working Group a variety of I'll say dimensions that they identified related to data intermediaries and in particular in respect to this fairly recent regulation describing the possibility of, if you will, substituting data submission to a data intermediary for data quality reporting which I know Jesse is going to hit specifically or to those like Meaningful Use.

So, what I hope we do today is use the work that Jesse is going to share with us to help begin to shape our strawman that we said last meeting we're going to create and give us some additional feedback but secondly and at least as importantly is provide during the discussion as much feedback as we can about the topics that Jesse is going to hit on and I think the discussion will be very helpful informing and framing the ideas that we want to take forward in terms of strawman.

So with that Jesse if you're ready we can launch through the presentation, that's the bulk of our agenda today we'll discuss this and then hopefully reinvigorate our efforts the first of the week to get ourselves moving down the road on this. So, Jesse?

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Thanks, Marc, and thanks again everyone for calling in. You can see the presentation that was attached or sent out yesterday afternoon and also that is part of the Webex. So the Quality Measures Workgroup and Marc was right on the Quality Measure Workgroup over the last two months has been spending time thinking about the description in the American Taxpayer Relief Act of 2012 that describe qualified clinical data registries and both the Health IT Policy Committee and the Quality Measures Workgroup have been interested in the role that the registries might play.

And to Marc's point since the release of the Act there was an RFI from CMS that added questions for thought on the issue of how a registry could give – submission to a registry could give a provider credit for participating in PQRS and for the EHR incentive program.

And of course the interest in the Health IT Policy Committee is that the measures, I'm sorry, the measures that are used in the program are of high quality, that the data are of high quality and that the registries themselves play a useful role in reporting back to physicians and perhaps back to the public as well from the EHR incentive program stand-point. The Quality Measures Workgroup and the Health IT Policy Committee seem very interested in both pushing innovation of measures but of course there is some tension between pushing innovation but also keeping the measures and the data consistent with the standards that are in place and I'm hoping to get good feedback and to encourage discussion on all of these topics. So, I'll walk through the slides and I'd like to encourage folks to ask questions and to make comments as we go along.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

So, Jesse, sorry...this is Marc, just a clarification. So, the way that it was intended to work, if I understand it and I flip flop how I think I understand it at various times is that let's say a cardiologist who is participating in the cardiology registry that is operated say by the American College of Cardiology, just to make it somewhat abstract, and then the question is what that registry – the intention is they will submit measure results to CMS or other organizations but those measures aren't necessarily or are necessarily the same ones that the provider would have submitted under say PQRS or Meaningful Use?

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Well, the Taxpayer Relief Act in itself was vague as to whether the measures should be the same and in the RFI CMS asks what types of measures should be allowed in particular and so you could imagine one of two scenarios where the program could be built so that it strictly requires the measures to be consistent with PQRS or EHR incentive program measures but that of course would not be as big of a boom to measure innovation or allow the very specialized registries or data intermediaries that serve the sub-sub-specialists.

So the electrophysiologist cardiologist that submits data for cardiac devices or defibrillators that are important to measures that perhaps CMS or ONC or AHRQ hasn't thought of, or had time to put resources into to the very specific and specialized measures, those measures, as I understand the intent of the legislation, was to draw in groups of physicians that might not have found measures that would help them to participate in the past and that might be more amenable in the PQRS realm for the EHR incentive program realm.

Some of the feedback from the Quality Measures Workgroup was that we would both of course like innovation but a greater emphasis might still be on standardization so having the capability to of course start with the data captured in the EHR and submit it from an EHR to an intermediary and perhaps starting with a measure set that's in place and then compelling the entities that build the measures and accept the data to build measures to the QDM and use HQMF on the other hand –

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**

Right.

**Jesse C. James, MD, MBA – Office of the National Coordinator**

To export via the standardized files for that. So, it could go either way and since it's early and there hasn't been rulemaking release, there hasn't been a proposed rule yet, there is still time to consider what the priorities should be and for the Health IT Policy Committee and the Quality Measures Workgroup and the Tiger Team to discuss that.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

And, I thank you for that because that was something that I was not clear about early on is that it has implications for what you want the intermediaries to be able to do or be required to do if they are potentially a measure developer in a completely distinct set of measures from those that others are dealing with and I was just confused about that early on and I appreciate you making sure we're all clear on that.

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Absolutely that's fair and I think for the purposes of this group, Data Intermediary Tiger Team and of course the Health IT Policy Committee the EHR incentive program would probably be of higher priority than PQRS for this group since we focused on Health IT and e-Measures, but any correction from – I'd like to encourage the group from CMS to correct me anywhere that I go wrong of course.

**Daniel Green, MD – Centers for Medicare & Medicaid Services**

Jesse, I don't know that – I wouldn't say that that's incorrect exactly where, you know, this is Dan by the way from CMS, you know, CMS and ONC are working together to, you know, try to align our programs in an effort to reduce the burden of reporting on eligible professionals and at the same time make the information and the data that they are submitting more meaningful to them in their practice specifically and as Jesse was mentioning before, you know, you may have the electrophysiologist that may not have your generic measures, if you will, in the ACCs current registries.

So, you know, there is some discussion in terms of providing more freedom, if you will, for these super subspecialists to, you know, identify gaps in care and report measures in that respect but it's an evolving process again as Jesse mentioned.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Great, well, thank you both for the clarification. Jesse, you want to move on here?

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Yes, on that note we can move to the next slide. This is a description of what appears in the Tax Payer Relief Act of 2012 and it uses the wording satisfactory participation for those physicians who are satisfactorily submitting data on measures to registries that might be considered as satisfactorily participating in a payment program.

And then the third bullet goes to some of the work that the secretary will have over the next year is to determine mechanisms for data transparency and specifications for elements some requirements around data submission, the expectation of timely performance reports to the participants, to the physicians and supporting quality improvement initiatives for participants.

So the Secretary of HHS has been given a mandate of delivering this path to the Quality Measurement Programs within HHS and will have a role over the next year to decide exactly how the data should move and what the attributes of the entities or intermediaries should be. Next slide, please.

So, in the RFI that CMS released there were three major roles described and three major sets of questions around the EHR incentive program one being what should be the requirements or what should be the definition of an entity or a registry. At some places in the RFI they use the term entity I think purposefully to perhaps move the discussion to be more broad than our understanding of what has been the common understanding of a registry to this point.

And our feedback on the first call from the Data Intermediary Tiger Team earlier this year, and also from the Quality Measures Workgroup, has pushed in the same direction of saying we should probably not limit ourselves to our classic understanding of what a registry is but there may be some entities that have not acted in a manner that we consider being consistent with a registry but have played a role in collecting data from EHRs, managing that data, analyzing it and providing value back to either payers or to providers as well. The next slide.

There are some questions in the RFI also on how measures should be selected; how we can be confident that the measures are of high quality and that they are both meaningful to the payer and to providers. And the next one on this slide is that there should be some criteria around reporting their position. Well, one train of thought describes it as perhaps providers who engage in this program should have to report on quality measures across the six NQS domains or for the quality of the measures whether those measures should be NQF endorsed. Next slide.

And this brings us back to the points that the Data Intermediary Tiger Team were charged with addressing in our previous work. So, we started that for a data intermediary – we started under the premise that data intermediaries are playing a role in moving data from EHRs to payers and providing value back to providers either on analytics both describing the quality of the those data but also describing quality of care performance and that there are some basic roles that the intermediaries play that the Tiger Team wanted to spend time thinking about and describing attributes further on.

So, one would be there is – of course there is a role to ensure and maintain privacy and security. There is a role to ensure, maintain, describe and improve the quality of the data, the completeness, accuracy, the timeliness, etcetera. There is a role in maintaining or designing to the standards that are in place in the EHR incentive program and the standards for certification criteria.

And finally, there may be a role around business rules for sharing of data or selling of data, but of course you could imagine that, to attract entities to the program if your business rules are too strict for them to maintain a profit motive or to sell businesses and it might be less attractive and might create tension with innovation. The next slide.

So, the Quality Measures Workgroup took the angle of thinking about what were the guiding principles sort of for quality measurement and how that might guide their recommendations for data intermediaries or the qualified clinical data registry and four of the main points we came to were that we'd like to define registries broadly and that is to the goal of pulling in as many actors as possible to let all flowers bloom.

We'd like to maximize interoperability of course that's data exchange interoperability are important features and goals for the EHR incentive program. And important role would be that intermediaries should be able to manage data, to manage, to store and govern it. And finally, we'd like to encourage innovation on e-Measurement to make measurement and the quality measures more meaningful or as meaningful as possible at the point of care.

I'm going to pause to allow for any questions so that I'm just not droning on going through slides. So, to give anyone an opportunity, are there any questions from what we've been over so far?

**Walter Sujansky, MD, PhD – Sujansky & Associates – President**

Hi, this is Walter Sujansky, I have a brief question, perhaps this was covered last time at our initial meeting. Is the goal here for the intermediaries to pass through raw data, if you will, from the EHRs, which is then compiled by CMS and so forth into the quality measures or is the intent and/or is the intent for the registries to compute the measures and submit the measures on behalf of the providers?

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Thanks, Walter. So, the current state is that through the standards for certification criteria ONC has described in our rule that you can have a module that is certified that sits between an EHR and a payer and that module should be able to accept the EHR export of a QRDA Category 1 and to calculate measures based on that.

So, the situation you described where an EHR would submit data for calculation is closest to the current state of what an intermediary that was a certified module would do. In the program in its loosely defined program you imagine either state where an EHR could export data either in a flat file or in a CCD, or C32 and an intermediary in between could calculate quality measures based on those data and then send those data, send reports to CMS and also back to the provider.

From the conversation of the Quality Measures Workgroup it seemed that the goal for the program to be as consistent with what is in place, that ONC and CMS have already established in the EHR incentive program, the goal would be for that intermediary to accept the standardized export, the certified standardized export from the EHR and to send data in a similar way that is consistent with the standards that are in place but either role would be valuable.

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

This is Kevin Larsen we're also dealing with a really heterogeneous group so as many of you know some these – many of these registries are already PQRS vendors and so they fit sort of neatly into the certification and the sort of interoperable pieces that we know about. But a number of them actually don't do measurement in the classic sense that we do performance measurement, they take a minimum dataset and they take a minimum dataset from a chart and then augment that minimum dataset with supplemental data and then that dataset is actually sent onto national aggregation, and that national aggregation may or may not result in performance measurement for the individual practice.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

This is Marc, just to clarify – make sure Walter's question got answered, Walter I think I heard your question that are we expecting that the data intermediary will compute measures and deliver those to CMS or whoever as a requirement versus will they be a pass through for data and what I think I heard the answer is they will compute measures and deliver them to say CMS rather than passing data through, but clearly they have to get raw data to compute those measures.

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

This is Kevin again, because this is still an RFI I think that's an unanswered question.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Okay, good.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

This is Brendan Mullen, as I heard the discussion I was thinking that it seems like and I think this falls on Kevin's point that we might need to try to break these into categories. So, it seems to me that there could be a very different set of criteria for the PQRS submission than there is for the EHR incentive program and I don't think, I mean, my personal opinion would be we shouldn't allow every registry that's collecting data to get folks the EHR incentive benefit if that data is not being generated out of the EHR because that seems to be what that incentive program is designed to do.

But on the other hand, we shouldn't cut off registries that are not based out of EHRs from the PQRS incentive because that's my understanding of the intention to allow more innovation and just to give you a tactical example of that, I'm looking at the dataset of our CathPCI registry now which has been around for 15 or 16 years and I don't think there are EHR specifications for example for the percent stenosis of a non-native graft in the left arterial descending artery of the, you know, of the coronary anatomy, which is actually pretty essential if you're trying to do risk adjusted in-hospital mortality rates and really important measures. I've never seen in an electronic medical record how that data would be captured or structured it's a very custom field.

So, I think to the extent that we can start compartmentalizing and breaking out this conversation it's going to be helpful, because if we kind of leave it all together it's going to be really difficult to provide any sort of reasonable advice on the standards for anyone of these programs.

**Jesse C. James, MD, MBA – Office of the National Coordinator**

That's fair and reasonable and to my earlier point that perhaps our focus should be more on Meaningful Use EHR incentive program but I'll defer to Marc and Eva on where our focus should be in this discussion.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Yeah, I've captured that as a dimension for us to get it in our thinking, thank you. Jesse, you want to forge ahead from here? I think this is – I have trouble wrapping my head around this every time I come back to it, so I think this has been very helpful level setting. So, do you want to move on through what you've got prepared?

**Jesse C. James, MD, MBA – Office of the National Coordinator**

So, the next slide, please. So the next slide defines the definition of a registry as AHRQ has previously defined it and that was to F.X. Champion's point on the previous call, but also mentions that that definition is likely more restricted than we'd like to be that the entity should probably be described more by its ability to perform tasks as opposed to only the type of data it receives more what it does with the data. Next slide.

So, into the roles we started with an important role that an entity should be able to ensure data is of high quality, there should be some checks for accuracy, credibility and timeliness. The entity should be able to prove compliance and pass audits perhaps for data quality and measure specifications should be consistent. If they were new measures in this program and the program was focused on Meaningful Use, in particular, that the specifications of measures should be consistent with the health quality measure format which is our standard used for describing measures in the Meaningful Use Program. Next slide.

So, an additional initial role in the data flow would be that – these are comments from the Quality Measures Workgroup and was submitted to provoke discussion and reaction that the entity or data intermediary should be able to accept outputs of certified EHR technology consistent with 2014 standards for certification criteria. There was, on previous calls, discussed that there is a need on the EHR end as well to automatically export the relevant data for registries and that there remains significant work done on the EHR outputs for quality metrics calculated by registries today.

But, also for the sake of the program and perhaps its simplest form registries would need to be able to accept the standards in place for 2014. They should also, one, attribute that was desired by the group was an ability to accommodate multi-source data and as Kevin spoke to and David Lansky spoke to on the Quality Measures Workgroup there is a need for – and there is also some – there is expertise on the current state of registries on handling multi-source data so not only EHR generated data but data that are very specific to clinical subspecialties.

There is, to the next point, there is a dearth in patient reported outcome measures so the Workgroup decided that a desirable attribute would be that the registries or entities are able to incorporate patient reported data into their measures and that perhaps there could be a requirement for the sake of measure innovation that at least one PRO-type measure was included in the analytics for an entity.

There is a need that a registry be able to pass audits for security we described that and then there were questions on how to balance both standardization and innovation, and how to handle measures that don't really fit to our current concept of measures, so that aren't as cleanly defined in numerator and denominator measures that might be on data quality and in particular are measures that might be based on population health characteristics.

**Alan L. Silver, MD, MPH – IPRO – Medical Director**

Question, this is Alan Silver, the first under the bullet there is this phrase EHRs must allow automatic. What does "must allow" mean? Does that mean must be capable for the certification or it's you can get this? What does "must allow" mean?

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Yes, must be capable. So, in the early discussions of the Quality Measures Workgroup the point was made that this continues to be a manual process for finding, mining, extracting and sending clinical data to registries and the need was described for a more automated process for extracting the data and sending those data to the registries.

**Alan L. Silver, MD, MPH – IPRO – Medical Director**

Thank you.

**Francis X. Campion, MD, FACP – Vice President for Clinical Affairs – DiagnosisOne, Inc. – Harvard Vanguard Medical Associates**

Hi Jesse, this is F. X. Campion; this is a great slide, just a quick comment. The need to have interoperability with CDA or QRDA is really key here that's a high bar to set but I think a reasonable one. I worked for years with the American Heart Association Stroke and Heart Failure Registries and we just tried to automate the data intake from Cerner and Epic systems and really had a very hard time, because they weren't committed toward interoperable CDAs at the time. So, we need to keep that pressure on.

The issue regarding patient reported outcomes is noble but I think it's probably a couple of years down the road, it's a good direction to head in but I probably wouldn't put that requirement on, you know, out of gate, just if you had the sequence things.

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Thank you, that's really helpful. What we also have been thinking about is that we could imagine short-term realistic near-term attributes and then sort of more ambitious longer term ones. So, it's useful to have feedback on what would be short-term reasonable and what is also more longer term 2016/2017 versions of the program.

**Alan L. Silver, MD, MPH – IPRO – Medical Director**

So, this is Alan Silver again and I apologize for my ignorance, but in terms of collecting, structuring and exporting data out why is a patient reported outcome potential element like a functional status metric so much more complicated than anything else? Once you lay it out isn't it the same? That's my question.

**Francis X. Campion, MD, FACP – Vice President for Clinical Affairs – DiagnosisOne, Inc. – Harvard Vanguard Medical Associates**

Well, you're right the actual physical movement of the data may not be hard it's really the sociology part of actually connecting say a large; I'm thinking something like the American Heart Association Stroke Registry where we have 1800 hospitals now the data comes essentially from the hospital to the registry. If you're going to put a requirement for PROs on there, you're talking about just a big increase in cost, you know, that particular registry was designed around the inpatient phase of care with the clinical questions and the quality improvement goals that it has it doesn't actually require PROs.

If you want to expand the mission of that registry to include say the post phase of – post hospitalization phase of stroke care 180 days post that would change the current mission of the registry, it would be a noble direction to go in but you're talking about a big issue, rise in the cost, that particular registry doesn't require, you know, patient – it's a quality improvement registry there is no PHI in there today, but if you were going to PROs you're going to have to put medical record numbers in, it's just a different animal, the scope of the quality improvement activity if you're engaged with PROs is different, a different kettle of fish.

So, I just think it's a good direction to go in and it's the aspiration of a lot of registries is to move in the direction of PROs, patient reported outcomes, but it's technologically, as well as just the cost of managing it, is a whole different scope of work.

**Alan L. Silver, MD, MPH – IPRO – Medical Director**

So, is the issue for you capability versus requirement or even capability is too far for now?

**Francis X. Campion, MD, FACP – Vice President for Clinical Affairs – DiagnosisOne, Inc. – Harvard Vanguard Medical Associates**

Well, I guess the point is that there are a lot of good quality improvement activity that can and needs to go on that doesn't require PROs at this point in the evolution of what we need to work on as a health system. There is plenty of work inside the hospital for hospital associated care registries as well as, according to these registries, that don't at this moment require PRO, you know, the hand offs, you know, for the stroke registry for example a lot of the work was around the time to thrombolytic therapy and that was a very successful registry for a number of years for that, a lot of the MI and angioplasty registries you don't really need PROs to do good work around what has to be done to improve care there.

So, it really depends on the mission of the registry, you know, why it's conceived, why it's placed and PROs are really something we need to move toward and in some registries it's an absolute have to have it just depends on the purpose of the registry.

**Eva M. Powell, MSW, CPHQ – Senior Director, Quality, Improvement & Innovation – Evolent Health**

This is Eva, kind of along these same lines, I understand what is being said about this and I'm just wondering if this might be another place to consider some – maybe a couple of different categories, because what I'm – I certainly would be concerned about requiring something that truly is a 2016 goal for existing registries and therefore discouraging their participation, but I'm also concerned about ending up with kind of same thing different day and in terms of encouraging innovation I think there is a lot of stuff going on and just generally speaking in the market with ACOs who are going to have to combine some of these things in new and different ways.

And we should figure out some way to rewards those who are headed there and can get there sooner rather than later. So, I'm just wondering if that might warrant kind of what was mentioned earlier not necessarily a requirement for all registries so that we could be consistent with the mission of existing registries and reap the benefit of the good work they are already doing and the new and different work that they've got slated consistent with the current mission, but also encourage non-traditional registries or registries that aren't quite yet in existence but certainly well underway in terms of being formed and reward them for doing these kinds of things because that then can drive the rest of the market maybe a little more quickly.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

I think if you're trying to reward people for doing stuff you should be rewarding them in the direction that is going to have the maximal scientific and clinical, and operational benefit. So, if you're worried about outcomes I would be structuring rewards about registries being able to link to CMS claims data so you could create true longitudinal datasets and really assess outcomes, it's cheaper, it's easier and I think, at least from the view of our conversations with the regulatory agencies and the scientists it's much more reliable at this point than PROs and it's much less variable.

And that's something that if you're going to put dollars in trying to get to outcomes that is sort of a universal potential solution set that I would think that CMS could work towards by lowering the barriers to the complexity of accessing that data and working to create the regulatory environment that would support that and would be a much larger contribution to the community, to the science and to the ACOs than focusing on PROs.

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

This is Kevin Larsen, what do you mean by outcome in that process? How would you define that outcome?

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

I mean, you know, from my point-of-view and I know that there are others that take more of the patient point-of-view that would argue differently and others probably a joint point-of-view, but I'm interested if the patient has, you know, 30 days after a procedure, you know, if they've stroked, if they've hemorrhaged, if they've had an MI, so basically you're major events, which you can measure very, very effectively by matching for example registries, inpatient registries with CMS claims data and you can understand the long-term impact.

I mean, the fact that everyone survives the CABG or the PCI essentially in the hospital is a very different economic and social question whether they should all be getting that than how they are doing 3 months, 6 months and 3 years later and I think the linkage is a much more efficient way of getting to that answer, that essential answer around value than a PRO where you may not be able to follow-up with the patient 6 years later.

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

That was a registry that you know actually do outreach calls after discharge so the surgical quality improvement registries would come from this clip.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

Yeah.

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

Because the routine 90 day call to get patients to report on their functional status and whether they are alive or dead and if they had an infection.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

Yeah, I'm certainly not arguing that that should be excluded. I think that's fantastic and we do that with some of our registries too. But, I would hate to see all of – in the dollar cost per follow-up that you have to do in that direction versus facilitating linkages with large scale administrative claims data that the dollar per outcome assessed is far lower if you can – and I would think probably more accurate over the long run if you do the linkages.

But, I wouldn't want to exclude either one I just wouldn't want to put all of our chips on PROs when there are more direct routes or at least equally direct routes to meaningful assessment of outcomes and values.

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

And who is making that statement?

**Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology – Health & Human Services**

This is Kelly Cronin with ONC what we've thinking now for years is that we really want to be moving to longitudinal claims and clinical such that you'd have clinical data across EHR systems or multiple electronic data sources so you could get, you know, 30 day, 90 day outcomes and, you know, perhaps be linking to claims for utilization rates or other measures too.

But really what where this intermediary concept is going and where we'd like criterion policy around it to encourage, you know, clinical data being exported from information systems across settings of care to get to that longitudinal picture. So, I think we really need to be focused on how we create that environment.

**M**

Isn't this a question really though of what measures are going to be supported and whether certain measures require, as shown on the slide here, entail or require patient reported data as opposed to other sources and that – I think the only requirement here is – potential requirement is that if measures entail patient reported input then the registry be able to capture that and incorporate that into computing of the measure as well rather than necessarily talking about making any statement about whether patient reported data should be part of measures or is part of any particular measure.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

This is Marc, this strikes me as on the right thread that, you know, the requirement, somewhere there is a set of requirements for the measures reported by these registries and that the requirements will ramp up and as you say that set of requirements might be somewhat – and certainly is consistent with the requirements for some of these other programs like PQRS and Meaningful Use. So, that strikes me as the right way to think about it.

**M**

The other thing to note about, to the extent that patient reported data are or maybe part of measures in my experience registries are in fact potentially a very good way of collecting those data, in other words, the registry can itself solicit that type of input from patients, especially, you know, through electronic means and surveys and so forth, and really relieve the individual providers from collecting those data and it could be a value add of the registry as an aggregator not just of data but also of the effort to collect patient reported outcomes.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

Yeah, no this kind of poses an interesting policy question, because my understanding, based on the current PQRS regulation if you had a registry that was largely based on an electronic health record but then you had some of your data coming in through say a faxed in form from a patient or from an electronic form that actually wasn't "part of the electronic medical record" that could actually put you into a different category of submission flipping you back and forth between the exclusive categories of a DSV or a registry.

So, and these are the types of things that when they get written in a regulation can cause a lot of heartburn for a lot of players because you're forced to jump one way or another. I might have that wrong, but I'm kind of – so I want to be careful about that.

**M**

No you have that correct.

**Micky Tripathi, PhD – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

This is Micky Tripathi and I think you're right about that.

**Daniel Green, MD – Centers for Medicare & Medicaid Services**

You are right about that this is Dan.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Well this has been a good rich discussion on this topic but clearly does not resolve things but clearly is on our list of topics to spend more energy on. Should we move on through to the – I mean, we're sort of getting through but there's a variety of other topics that I think we can get some input on.

**Jesse C. James, MD, MBA – Office of the National Coordinator**

All right and I think the consensus is that there is an important – the important attribute is the ability to use and analyze multi-source data whether those multi-source include patient reported data the priority of patient reported versus claims extracted and other types of data we can continue to discuss off line or on a follow-up call.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Yes.

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Next slide, this is slide nine. Describe needs around measure quality. So how can we be confident that the measures that are used in the program, if the programs are allowed to create and contribute data from their own measures for credit for EHR incentive program, how can we be sure that they are good and high quality measures. Should they be NQF endorsed? Of course NQF endorsement has time/resource costs to itself.

Should they use value sets and logic that are consistent with the MU2 measurement, the measure set for instance to be confident that these are consistent with standards that are in place for describing time and dates and clinical activities. The next point, should we use certification to ensure that the entities are able to import, calculate and export as defined by ONC's rule. And should we to be confident in the ability of the entities to risk adjust or should we require some ability for risk adjustment and this grew out of a belief and confidence that many of the registries that exist today have developed – they've developed strategies and algorithms for risk adjustment that are near standard for the industry and to take advantage of it but also to be sure that the quality of good risk adjustment is ensured.

And to the second set of points on this slide recording of data and results, so what might be a final role for the registry would be to report to CMS and report back to the physicians or providers that participate. These data, the Quality Measures Workgroup previously has defined that the data should be consistent with standards in place. There perhaps should be public reporting on measures and the question should all measures be publically reported to get credit into EHR incentive program. We haven't been publically reporting measures in the past.

Should the provider be afforded an opportunity to review all reports prior to publication? Should there be some standardized format for the reports back to providers for, you know, the sake of a standardizing how the information appears but also to the benefit of other reporters or public entities that wanted to make websites for the public to consume.

Finally, how should feedback on the quality of data be reported to a physician, should there be some standardization in that space or should we really leave that up to the market of entities to define and another role that has been or an attribute has been described or requirement, should the registry be able to report directly back to the EHR and that of course would create a requirement for certification for an EHR to be able to accept that report from a registry and to present that report to a clinician and I'll pause for reaction to this slide.

#### **Kevin Larsen, MD – Office of the National Coordinator**

This is Kevin Larsen, one of the specific questions that data back into EHRs and registries sometimes create information for example risk adjusters a number of different things that could be really useful for a point of care decision support so that is really the question is should we do that here.

#### **J. Brendan Mullen – PINNACLE Programs – Senior Director**

Just to throw out at least according to our IRB if you move to actually directly inflecting care by putting calculated clinical data back in front of a provider that may inflect the trajectory of care being provided for that provider you may lose your waiver of informed consent and thus have to consent every patient that is coming into the registry if you start doing that. I think that's a crazy rule because I think I agree with probably most others that decision support is going to be important but I just wanted to share at least the interpretation of our ethics team on what that might mean for registry participation.

#### **J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

So, just to make that even more fun and that may, depending on how things evolve, become a medical device.

#### **J. Brendan Mullen – PINNACLE Programs – Senior Director**

Yes, yeah.

#### **Walter Sujansky, MD, PhD – President - Sujansky & Associates**

This is Walter Sujansky, I would propose I guess kind of bluntly, to remove the – unless it's part of the PQRS or the CMS programs for quality measures to remove the requirement for publically reporting any data because – although there is certainly value in that there is also great risk in providers simply opting out of using registries that have a requirement to publically report data, especially if the risk adjustment models are not – even if the risk adjustment models are of high quality and trusted there is, you know, for obvious reasons there may be a lot of reluctance to participate in that registry, but often the risk adjustment models are difficult to get right and depend a lot on quality of data as well as consistency of quality of data across those submitting. So, I think, requiring that just would be fraught with difficulties and risk.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

And Walter, this is Marc, I think you've hit on one of the dual-edged pieces of this obviously is that what you said is absolutely true. The other side of the question I think is that if we're saying that by reporting to this registry an eligible provider is satisfying their requirements for quality reporting under the HITECH Act for example and you don't allow that sort of reporting or require that sort of reporting are we fulfilling our sort of obligations to the public for the use of those funds.

**M**

Hey, Marc this is –

**M**

Yeah, certainly if the measures themselves require or entail public reporting the program if you will whether PQRS, CMS or anything else entails public reporting than that needs to be allowed by any data intermediary that is going to be participating, but if the idea is for the data intermediary to be doing the public reporting in addition to what the requirements are of the program then I believe that's a different story.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Well and I think there is a question here of, you know, would they do the public reporting or make the data available to other organizations, CMS or other entities that might expose the data and do the actual reporting.

**M**

Right.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

You know, that you could work through, but, you know, what I heard Walter asking and I think it's a fair question is, you know, if you're the electrophysiologist and you've got these specialized measures you can do quality improvement without any public reporting and so on but are we then, if we don't require public reporting by the data – or the exposure of data for public reporting or something like that are we fulfilling our obligations –

**M**

Yeah, this is –

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

For the public to understand what is going on with care and so on that we're aspiring to with other parts of the work.

**M**

Right.

**M**

Hey, Marc, Marc?

**Christopher J. Queram, MA – Wisconsin Collaborative for Healthcare Quality (WCHQ) – President & Chief Executive Officer**

This is Chris Queram I'd like to align myself with your comments and maybe there is a way to balance the very legitimate questions and concerns about use of data reported to these types of clinical registries for public reporting with a requirement that that be allowed at some point in time. Personally, I would be concerned with setting the criteria for this program in such a way that would allow specialty societies or other organizations that sponsor these registries to continue to shield the data from public release, we need to move in that direction.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

And that's not to say they couldn't do that the question is if they did that does it satisfy, could they be deemed as fulfilling the requirements under this. I mean, you know, it's not like you're saying they have to do it, it's just if you want to do A then B is a requirement.

**Micky Tripathi, PhD – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

Right, this is Micky, I think as long as there isn't sort of regulatory overreach in this maybe there is a, you know, sort of a middle ground here that if it is decided that public reporting of measures that are a part of the HITECH Program or any other federal programs that require it, you know, that seems to me to be fair enough as long as the regulatory overreach isn't such that it says that if you are a DSV you're required to publically report any measures that you calculate on behalf of anyone because a number of intermediaries could be doing a wide variety of measurement activities for their customers and you don't want to get caught in that trap.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

So, I think that sounds like a good compromise I would say if there is overreach for example there is a potential like mine the ACC would pull from every participating in every one of these things if there is an overreach there and we are actually working with CMS and...to publically report on a select number of appropriate measures. So, there is a political component but I think the leaning towards public reporting is the way our organization is going but it needs to be done carefully.

There is a technical component that I still really worry about here and that is – 25 or 30 different EHR systems that depending on how folks document you can swing performance rates 10, 20, 30%. So, if you just use the coronary artery ICD-9 diagnosis as specified in the EHR as your inclusion criteria for a measure versus whether you actually look and say "oh, they had an MI and they had a PCI" so by definition they have coronary artery disease. So, those two different types of calculations can swing these rates 15-20%.

And so that raises to me still serious questions whether at scale the data coming out of EMRs is sufficiently structured and consistently captured and submitted by the EHRs for this to be viable in the immediate short-term or you're going to create more chaos than you resolve.

**Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology – Health & Human Services**

This is Kelly Cronin and I think Kevin or Jesse might be able to best address that but I think part of the reasons for thinking through this criteria so carefully is to address that issue particularly in the short-term where there will be increasingly an amount of structured data through Stage 2 and Stage 3 certification of EHRs and more how we specified QRDA messaging standards.

You know, I think in the near term we need to be really careful about that and part of the role for the intermediary or the registry is to make sure that the, you know, mapping and normalization happens such that you have comparable numerators and denominators.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

Right and so our experience as a DSV for example is that if we had just taken the CDA that had come out of these EHRs they would have been performing in our calculations at 30% below what we ultimately calculated their performance rate is because we had to go back in and find all the things that the EMR didn't structure right or wasn't cross mapping or the physicians had customized their workflow and thus was being stored in different locations.

So, you know, until that matures, and I think it's probably 2, 3, 4 years away, again I'd be leery because I think we do have momentum towards public reporting including from the doctors and specialty societies like ours but if we overreach I think that could blow up pretty quick and we would do more damage than benefit, especially since we've seen the public reporting say in the New York environment going on for 15 years it's important but it hasn't been a game changer if we're going to be honest about quality and cost.

**Walter Sujansky, MD, PhD – President - Sujansky & Associates**

This is Walter Sujansky, I think another very important related issue was just raised and that is of the data, the data quality and the example just given that the data electronically reported from the EHR to the registry is not necessarily of high quality and who should be responsible, because this question will probably come up from the registries.

Who is responsible for the quality of those data for the accuracy of the computed measure when the data are of variable quality? Is it the responsibility of the registry to go back to do chart audits to confirm quality to go back and verify every single datum that is collected or is it the responsibility of the provider to submit complete and accurate data to the registry?

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

Or is it the responsibility of the EMR to be able to actually capture that, that's what I worry about, if the providers are documenting the way they worked with their implementations but they don't really understand how the databases are structured on the back end nor should they be asked to and the big gap I see is some of the EMRs being able to close that. I'm sure those that are vendors would have – I know are dealing with a whole different set of challenges, but that worries me too. Whose actual responsibility is that?

Because – certification in our view does not seem to be correlating very highly since everyone essentially is with the cleanliness and well structuredness of the data in the electronic record itself.

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

So, this is Kevin Larsen, I would really be interested in the group's idea about how this particular new approach could help us all with that highly important activity? You know, what would be some things that we could use this opportunity for to make the data better?

**Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology – Health & Human Services**

Yeah, Kevin, I would just add that I think, you know, some of what we've been thinking in the past is that in the near term there is sort of the business case for the intermediary registry to take on a certain amount of the responsibility for the data integrity and the data quality, while it's clearly a shared responsibility the vendors have to get better over time, the field and, you know, the providers have to work on their workflow and make sure the data is being captured appropriately.

You know, and if this model is to scale the registries would be held accountable if they're reporting into payers for valued-based purchasing or for other, you know, shared savings arrangements or incentive payments.

So, I think there is probably a sharing accountability but there be some explicit role and criteria around data quality and data integrity that, you know, the intermediary would be held to.

**Jesse C. James, MD, MBA – Office of the National Coordinator**

I think also the intermediaries play this role already and that's what we've heard and we're hearing and also they are uniquely capable of describing the quality of the clinical data, the gap between the data they are receiving from the EHR and what they would expect and uniquely qualified to describe a change in this over time, a change that we expect to come with the changes in certification that start with the 2014 standards for certification where the EHRs are tested for their ability to capture, calculate and to report to the standards of the QRDA.

But, I think that it's a very good point and it would be good to get feedback from the actors in this space on the role that the intermediaries, the registries, the entities can play in describing data quality and describing that both to payers and to providers, and managing it.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

I'd make one final comment on here just in terms of the rulemaking I'd be very careful of is I would caution you to not think about data quality the way data quality and the randomized control trial is thought of and that is largely driven by this concept of a human audit.

So, if we're going to be going to big data, which I think all of us are, we're going to have to be using system engineering techniques here and that's for two reasons, one is the source data is a legal medical record. So, the question is what are you going to audit if the legal medical record is the same as your source data, which is a different question of whether that legal medical record is correct.

Number two is simply a matter of volume, so at our relatively small ambulatory registry in the grand scheme of things we get 100,000 plus encounters a week, I'm sure the EHR vendors are much bigger. So, you can even – I mean what kind of – you have to do to do a statistically meaningful audit, so that's relevant for some actors but I would encourage the policy makers to think bigger about what are the systems engineering techniques that are going to be used to validate quality and not simply think in the traditional audit mechanism, because I think it is outdated or getting outdated pretty quickly.

**Alan L. Silver, MD, MPH – IPRO – Medical Director**

And a sideways point, this is Alan Silver, there is still, I perceive there is going to be, well stating the obvious, there is going to be a role of adjudication from for example the CMS side, because our experience in the QIO realm we see orders of magnitude actually different in metrics and different EHR vendors work with clients and they define I'm calling the field this, this is what I meant and they say "okay" and someone else says "well, no you really can't call it that you've got to call it something else." And so at some level like there used to be and still is for inpatient measures there needs to be a role for someone to review who is saying what is okay when you collect this, the data that is and transmit it to CMS.

**Walter Sujansky, MD, PhD – President - Sujansky & Associates**

Yeah, this is, again this is Walter Sujansky, this is a very challenging area that can't be underestimated, you know, obviously and at the limit, you know, data quality comes down to – at the level of, in my experience at the level of individual measures and what are the data that need to be of high quality to compute each individual measures, you know, there are different kinds of exclusion criterion and so forth that are difficult to discern and rely on very specific data and the completeness and accuracy of very specific data and that varies from measure to measure.

So, it's very challenging to present – to raise the bar such that the registry is responsible for the quality of all the data for all the measures that it is the data intermediary for. So, I think there needs to be – one needs to bear that in mind and I think one needs to move perhaps more slowly and otherwise to assess whether this model of collecting data directly from EHRs and through intermediaries only electronically without chart audits results in high quality data and for which measures perhaps it results in high quality data and for which measures the state of the art does not yet allow it to.

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

This is Kevin Larsen I think there are a couple of different domains of data quality and one is the sort of semantic quality but the other is something a bit more technical which is, is there data degradation as it flows through interoperability. And I'm wondering if there some opportunity in that space.

So, for example when we've talked to Surescripts, Surescripts sends data between lots of different organizations and they actually do monthly reports to each of the parts of their exchange to tell organizations when they are seeing changes in the data or where they perceive potential errors, it's part of their business of operation to send this feedback to all of their exchange partners "hey, you've got a number in a text field" for example.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

So, this is Marc, it sounds like, you know, obviously this is A, a critically important topic for us to spend a significant amount of energy on, B, listening to the conversation this is just an observation is that it sounds like people might be leaning towards the notion of some kind of a process requirement, in other words you may not be able to say, you know, that these organizations might need to have a process which meets certain criteria which is judged to be good enough because each of these are so variable and how things happen and so on. So, that might be one way that we address that. But that this is a topic that we need to have a lot of focus on over the next weeks and I just want to do a little bit of time check here with Jesse, you've got a couple of more topics to at least put on the table right?

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Yes, this is one of the final slides, the 10 slide is just asking if there are additional rules or concerns and the 11<sup>th</sup> slide is just a diagram. So, I think we're just at about the end of the talk and so there is time for open discussion or planning for follow-up calls. The next call that's on the books is I believe the 20<sup>th</sup> of May.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Great, so and yeah, I don't want to cut off discussion but on the other hand I do want to make sure we get that on time and that we have time for public comment here, which we do.

So, are there thoughts about, given this discussion last time we talked about the idea of organizing our work by sort of putting together a strawman and then soliciting broader input on it, looking at the work that the Quality Workgroup has done it strikes me that what in some ways what we've just gone through is one strawman which is professional society registries.

I mean, I know it wasn't that specific but that's the flavor that I get out of this anyway. So, there is a strawman of a professional society registry that is focused on quality improvement in a specific area. I'd be curious how the group feels like is that a good enough strawman for us or do we need to do, as we had originally planned some time to look for a broader set of strawmen or women to make sure we're covering the ground. So, for example the discussion here to some degree applies to the PQRS registries we mentioned along the way that might raise a different set of issues it strikes me then the sort of professional registry strawman.

**Steven M. Ornstein, MD – Medical University of South Carolina – Professor, Family Medicine**

This is Steve Ornstein; I do think there needs to be a broader set like the practice-based research network type registry that I don't think works for either the traditional PQRS registries or the professional society registries.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Okay, others?

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

This is Brendan even though I of course represent one of those professional society registries I think we should consider some other strawman too. I mean, we generally want to be more inclusive and if the PBRN is one example the other one I can think of is some of the companies that I've mentioned before that are really doing some amazing sort of business intelligence data mining in a largely for profit even venture-backed capacity and their data and their analytics are breathtakingly good and I would hate to not give that some thought as to what role other folks could play in solving these problem so we keep the innovation door open.

**Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology – Health & Human Services**

This is Kelly, I would second that but I'd also add maybe having a look at the qualified entities that are also piloting on e-Measures the acceptance and reporting of e-Measures.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

So rather than trying to develop a strawman generic model maybe it sounds like our goal should be to create a list of sort of candidate strawman, you know, that are – types that we might draw of the types that we were just listing and then take the dimensions that have emerged out of the Workgroup discussions that we just went through of data quality and so on and work through maybe that sort of matrix rather than trying to create some more generic description. Would that make sense as a modification to our way forward?

**Micky Tripathi, PhD – Massachusetts eHealth Collaborative – President & Chief Executive Officer**

This is Micky; I think that makes sense Marc.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

And so – might be to create that list of – types of data intermediaries that we at least want to think through and then begin the work of flushing out that matrix. Any other thoughts about that or candidates to add to our – type list?

**Kelly Cronin, MS, MPH – Health Reform Coordinator – Office of the National Coordinator for Health Information Technology – Health & Human Services**

This is Kelly again, one idea to sort of get a little more definition around sort of where the responsibility lies for data quality and how that might change as data moves, you know, through the system and onto payers and back to providers, maybe we can be specifying not only what we think the role of the registry or intermediary might be and how that would translate the criteria and maybe process criteria but also sort of what are the core responsibilities the providers and the vendors have in that process. So, if it starts with them, you know, clarify what the expectations would be for them so that there be sort of a level playing field with any kind of, you know, business arrangement around this.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Yes.

**Jim Chase, MHA – Minnesota Measurement Community – President**

Marc this is Jim Chase the other – type that you mentioned is probably a reasonable health improvement collaborative – you know, legislation as well. I think that is where it's running through is what criteria might there be there.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Okay.

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

How about a –

**M**

This is –

**J. Brendan Mullen – PINNACLE Programs – Senior Director**

How about HIEs?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Yes.

**Jonathan Keller, MBA – Central Utah Clinic – Director of Data Analytics**

This is Jonathan, would you define the registry by who they are or what type of registry they are or would you define it by the capabilities and what, you know, what data they can handle, receive, what they can push out, I don't know?

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Yes, no that makes sense and I think people were throwing out ideas for, you know, sort of candidates to think about, but yeah that's certainly an important way to look at it.

Well, let me ask folks to, if they have additional – I've captured these, if they have additional ideas, you know, you're sitting with your iced tea over the weekend or whatever and have a thought shoot it off, as I said I will try to be more diligent over the next week and getting us moving in a focused direction. And with that let me ask if we can open up for public comment the lines in our last few minutes here? MacKenzie or operator I don't know who does that?

## **Public Comment**

**Caitlin Collins – Project Coordinator – Altarum Institute**

If you are on the phone and would like to make a public comment please press \*1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

While we're giving people a minute to raise their hand I want to thank everybody for this discussion it frankly exceeded my expectations given sort of the short notice and appreciate the hard work that Jesse and others have done to pull some of this together to help us along our way, so thank you all for that. And operator do we have any public comments or questions?

**Caitlin Collins – Project Coordinator – Altarum Institute**

We do not have any comment at this time.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

Great, thank you. MacKenzie anything else that we need to do?

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

No, I think we're all set. The next meeting is May 20<sup>th</sup>.

**J. Marc Overhage, MD, PhD – Siemens Healthcare – Chief Medical Informatics Officer**

And we will have some work in between then. So, thank you all and have a pleasant weekend.

**Jesse C. James, MD, MBA – Office of the National Coordinator**

Thanks Marc, thanks all.

**W**

Same to you.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead**

Thanks everybody.

**M**

– bye-bye.