

**HIT Policy Committee  
Quality Measures Workgroup  
Data Intermediaries Tiger Team  
Transcript  
June 4, 2013**

**Presentation**

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

Thank you. Good afternoon everybody, this is MacKenzie Roberston in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Quality Measures Workgroup, Data Intermediary Tiger Team. This is a public call and there is time for public comment on the agenda. The call is also being recorded so please make sure you identify yourself when speaking. I'll go through the roll call. Marc Overhage?

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

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

Thanks Marc. Eva Powell? Micky Tripathi?

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

Here.

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

Thanks Micky. Francis Campion? Jim Chase? Mylia Christensen? Richard Cramer?

**Richard Cramer – Chief Healthcare Strategist – Informatica Corporation**  
Present.

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

Thanks Richard. Peter DeVault?

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**  
Here.

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

Thanks Peter. Prashila Dullabh, I'm pronouncing that wrong probably. Jonathan Keller?

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

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

Thanks Jonathan. Brendan Mullen?

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**  
Here.

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

Thanks Brendan. Janice Nicholson?

**Janice Nicholson – Co-Founder, President & CEO - i2i Systems**

Here.

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

Thanks Janice. Steven Ornstein?

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

Present.

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

Thanks Steve. Chris Queram? Alan Silver? Walter Sujansky? Daniel Green? Molly MacHarris? And Jesse James from ONC?

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

I'm on.

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

Thank you Jesse. Any other ONC staff members? Okay, I will turn the agenda over to you Marc.

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

Thank you MacKenzie and we're going to have work on the end of the alphabet here, we were going great on attendance until we got to the last half of the alphabet, we'll have to work on that. Thanks everybody for joining today. Hopefully everybody received the materials that were sent out a bit ago, meaning a couple of days ago as opposed to minutes ago, as I sometimes manage, and had a chance to look that over. But what we wanted to do today was, based on some of the previous discussions and a variety of online and off-line dialogs with the co-chair and chairs and those sorts of things, we've kind of cobbled together something for all of you to react to, that we were going to go over in a somewhat structured way. In the sense that as we went through this framework, it struck us there were a couple of the things that were more controversial, could benefit from a broader discussion. And we thought we would try to lead us all through a discussion of those topics. Of course welcome either if we have time towards the end or offline through email or offline phone calls, any other commentary, follow up or ideas that folks on the team might have to help improve this framework.

Just to remind everybody, what we're really trying to get here, sort of the overarching goal for us in the near term, is to help include a broader variety of clinicians in the quality measurement process and to facilitate that perhaps by allowing them to report through intermediaries of various kinds. And we sent out the deck from our May 20 discussion in part so you could refer to it and some of the recent regulations that have been promulgated around satisfactory participation in Qualified Clinical Data Registries as a reporting vehicle as well as some summaries of comments from other of the working groups that ONC has had. So we've gone through those and that's really for your reference.

The second thing that we sent out, which we're going to walk through next, is entitled Recommendations for a Qualified Clinical Data Intermediary Role in the EHR Incentive Program. I think that spells something really cool, but I don't know what it is. And what this is, is an attempt to list in the roles and attributes column, so each row in this table, represents a topical area, if you will, that seemed worthwhile to discuss and address related to data intermediaries and quality reporting. And within the row, we had the four columns, what is the role and attribute, a version of what does that look like today, then where might we be able to get in a 1-2 year timeframe and then a future state or sort of ultimate target goal.

So if it is okay with everybody, what I thought we'd try to do is walk through each row, just to briefly discuss what I think at least as we put this together we thought those roles and attributes might represent and why they were important. And then specifically spend some real time on three of them, looking at what you all view as the current state, were we semi-close in what we wrote down here or way off; the near term state and the future state. So that was the bulk of the agenda for today's call, if that makes sense to folks. I'll take that as a

**Janice Nicholson – Co-Founder, President & CEO – i2i Systems**

Works for me.

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

Okay. So if we could go ahead to the framework document, whoever's driving the slides here, actually we're going to skip that and go to the framework document. Perfect.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Marc, this is Brendan. Can I just ask one quick clarifying question before we get into here? So I was going through the slides and then I'm looking at the framework document, and we spent a little bit of time with it beforehand and actually, it's very impressive and well thought out. One thing that when we were trying to think through it is, we were getting a little bit confused, and this may be my own lack of knowledge, for which I apologize, is this just for the EHR Incentive Program under Meaningful Use, or would this also be the framework that is associated with what we were talking about on the last call with the 2013 – or the 2012 legislation that would deem registries for PQRS? Is this the same or is this separate?

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

So let me take a crack at that and then Jesse can tell me what the real answer is. I think the Tiger Team charge was the broader charge of data intermediaries.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Okay.

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

We have the both opportunity and challenge that there are specific issues that CMS and ONC are required to deal with which are, if you will, a subset of that. So in other words, some of those intermediaries could be qualified registries. And so, in my best of all worlds, we would have a common framework for data intermediaries that would include registries and address topics that registries might raise in that way. And in that way, hopefully serve both our broader charge, but also provide – make sure that we've thought about them specifically. And when ONC and CMS look at the reports that we produce, they can say, "Ahh, I see how that applies to our near-term issues of how do we deal with registries in this context – qualified registries in this context." Jesse, does that capture it roughly as you see it, or –

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

Yeah, yes. I think so, just one thing to add, to remind us. On our previous call, the group described in a bit of detail how the intermediaries might work with both PQRS and Meaningful Use and we shifted – of the thinking more on Meaningful Use. I think another point that came out of the previous call was that there are probably goals for the short term versus goals for the long term that we might want to call out separately. And that was the goal for this document, to separate sort of long term goals from short term goals and to use the Fiscal Cliff Act as perhaps inspiration for how a data intermediary, as the group saw it, might act inside of that framework, but also more broadly in that framework. But sort of aiming for Meaningful Use was previously described as the goal to keep us from getting too broad and perhaps too distracted, having something to aim at and having a model within to work with. I hope that was helpful.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

That's great. Thank you, I apologize for the clarification and –

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

No, no, don't apologize. I think we've all struggled with that. And one of the ways I thought about it as I went through these was, think about it broadly and then come back and say, okay, now how does this work for a registry.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**  
Yeah.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**  
So just a little bit of increased focus on that option to make sure we've thought about it well.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**  
Right, and I think that's kind of where we came down sort of critically – that there was sort of a critical junction there where a lot of this for Meaningful Use absolutely makes sense, because it's predicated on the use of an electronic medical record, largely in the ambulatory environment, but not exclusively. Whereas the whole point of the specialized registries, at least as we interpret it, is they might be functioning in multiple environments where no electronic medical record exists to solve that specific problem. And so we were trying to separate out thinking about those things, so one doesn't inadvertently preclude or screw up the other one – struggling with.

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

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**  
Thanks so much. Sorry to derail you from the get-go.

**J. Marc Overhage, MD, PhD – Chief Medical Informatics Officer – Siemens Healthcare**  
Wasn't derail, that was a very – I think everybody has struggled, and I go back and forth, whenever I come back to it, I have to kind of refresh my thinking. So, great question. Any other questions or comments before we walk down the list of roads, just to make sure we have common understanding of the role or attributes? Okay.

So, these roles or attributes are not necessarily completely baked, so don't hesitate if they don't make sense, to sort of challenge or try to describe, and in particular the last couple are sort of concepts that aren't fleshed out well enough or maybe need to be eliminated or whatever. So the first row, accept EHR and optionally other relevant data for clinical quality measure calculation. This is just to the point you were just making, I think, of these data may well come from EHRs, but may come from other sources as well, but if you're going to be an intermediary, you've got to get data from somewhere. And I'm going to just sort of walk through these and if folks have questions, just hop in and I'm not going to pause a long time, otherwise it'll take too long to go through them.

The second, the notion was that there's some obligation of the intermediary or role of the intermediary to ensure the quality of that data. So, the scope of that is something we'll obviously talk about in the state discussion, how far back does that extend to validating or assessing the integrity of the data as it was received? And then there's another piece of it that is sort of, okay, did you transfer it right, did you store it right, did you manipulate it right going forward?

The third row, security of patient data, and one could argue it should say security – or excuse me; I was missing the first part, privacy and security of patient data, that's what I was just going to add. I don't think needs too much explanation. Attribution was one that we added in and some folks might want to argue against this, but the notion that for some intermediaries anyway, depending on the model and the process, all intermediaries have a mechanism for deciding which patients would get reported against "which providers." Now that may be as simple as whatever patients Dr. X submits get reported against Dr. X, or it might be more elaborate, but it seemed like that was a topic at least worthy of discussion.

The next one down is one that we will turn to some deeper discussion on in a moment, is the design of meaningful and valid innovative eQuality measures for Meaningful Use and perform analytics. Unwieldy names that can clearly be wordsmith yet, but I think the question here is what are the measurement requirements of these data intermediaries? In other words, if it is simply to reproduce a certain subset of Meaningful Use measures, that's perhaps less interesting, but may be a necessary criteria. Is creating innovative measures that are actually used in quality improvement and demonstrably improving the quality of care that beneficiaries receive, that might be a good thing to do. But it's just really the question of what is the role of intermediaries in developing and implementing quality measures of various types. And you can see by the length of that row that that has gotten a fair amount of attention and thought so far, and will get more.

The next series of three rows are reporting to the public, reporting to CMS as a payer, if you will and reporting to providers. So this is from the perspective of the intermediary, is there a role requirement goal for them to make the results of these quality measurements available to the public. I think it goes without saying that there's probably a requirement to report data to the payer, CMS and then, what might be the role and responsibility of a data intermediary in reporting data, meaning the summary quality measure data in particular, back to providers. I guess I distinguish this from the things that they might do in terms of reporting data back for the second row, which is ensuring the quality of data. That might be a different kind of a feedback process, so I think of this as being primarily around feeding back the results of the quality measures to providers.

And then these last two, as I said, are a little bit fuzzier, that were a notion I thought we might spend a few minutes discussing at some point, or folks may have thoughts off-line. So commit to sustained level of measures over time so as not to strand providers. Now that was elegantly crafted language, I know, but I think the thought here was that when a physician licenses or purchases or whatever they do, some electronic medical record software that provides certified HIT technology for quality reporting, they probably get some kind of guarantee, whatever that means, in their contract that – from their provider that says, we will or will not add new measures in the future. We are committed to this business and will be around in five years and what got me just thinking or worrying about this a little bit is I can imagine that a whole variety of intermediaries might jump in to something like this. But how do we want to see their commitment or what would be necessary so that providers were not left stranded when this say registry that thought, wow, it would be cool to do quality reporting. And then they realize what a pain it is and next year they say, sorry guys we're not doing that anymore, it of strands the provider. So that was the thought, I don't know that it belongs on this framework in the long run.

The other sort of related thing was scale. And what I think we were trying to capture there is the notion of, and this relates fairly closely to the development of measures. So if you've got this registry and it's my three buddies down the block, and we create our own quality measure and we're only reporting it for the four of us, that's not terribly useful to the payer or to the public. So is there a requirement of size or scale or percentage of providers in a particular specialty or something like that, that really gets at the issue of how do you make sure that this data intermediary is going to produce something useful to the payer and to the public. So those were sort of the dimensions or attributes that came out as we worked through this. Are there things that we might have missed that jump out, or things that folks want to talk about, should not be on this list or why they're on this list?

#### **Richard Cramer – Chief Healthcare Strategist – Informatica Corporation**

This is Richard. The question I have is the data set that would be used to support this function and how that data set is defined. And I'm thinking particularly in the area of the intermediaries coming up with new and innovative measures, that if they are limited to a defined set of data versus what all may be available in an EHR that may artificially limit their ability to innovate. So, where's the data set definition?

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

I guess my assumption had been, but it's open to challenge, is that's really up to them what the data set would be. And they would specify what data set is required to be part – or to be an intermediary – to act with them as an intermediary, and that data set presumably would be driven by the measures that they were reporting or developing. And of course if you picked a really onerous data set, many providers might go, "Uhhh, don't think I want to do that." If you picked a very lightweight data set, people might go, "Wow, that's great," but then not much comes out in terms of the quality measures and you can't meet the quality measure requirements. So that's how I would kind of think about that, but does that make sense? Or –

**Richard Cramer – Chief Healthcare Strategist – Informatica Corporation**

It does make sense.

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

I'd also add, another way –

**Richard Cramer – Chief Healthcare Strategist – Informatica Corporation**

Go ahead.

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

– to think about it is to, in the – I think it's important to think about the data set and the data that's available for measures in both the short term and long term frame. Because in the short-term frame, there's – measures are certified, or EHRs are certified for their ability to capture, calculate and report only on the measures that are part of meaningful use. And for 2014 technology, the data intermediaries from a meaningful use standpoint would be limited to those measures. But in the longer term, you could imagine a program where we could remove the goal as being standardization and fitting to the model in place now, to the goal being allowing innovation on measures and expanding that data set. So there's perhaps a short-term limitation to the data set that – for measures that are used in meaningful use and then a long-term flexibility around what that data set looks like.

**Kelly Cronin, MPH – Office of the National Coordinator**

Jesse, this is Kelly. Related to that, I wonder if there could be some reference to the quality data model as something that would evolve over time and could be maybe perceived as a minimum data set that could help set a bar for intermediaries but that it would be expected that it would evolve over time as innovative or new longitudinal or patient-centered eMeasures get developed.

**Peter DeVault, MS – Director of Interoperability – EPIC Systems Corporation**

This is Peter. It seems to me that we should probably keep as separate as possible the plumbing of how the intermediaries work with providers and other agencies. Keep that as separate as possible from the sort of payload questions about what the data set might look like, not that we shouldn't address those, but to make sure there are no dependencies between those two sets of interests.

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

This is Jim Chase. The other area that strikes me as capabilities or attributes we'd want from an intermediary that's going to be improved, it says some of it in scale, but maybe there are some other dimensions of that of does the entity have the infrastructure necessary to actually deliver this over time. And rather than setting up your commitment to sustain a level by a guarantee of a number of years, which would be hard, it may have more to do, are you – we need to have some criteria, I would think about are you an organization that actually has a Board, has financial wherewithal to do this. And I don't want to make it too restrictive that we don't get new players and some innovation, but it seems like you want to have some standards around. It can't just be somebody who set up shop in their basement and is going to start recruiting providers and all the purchasers are waiting for them to actually be able to deliver something.

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

Marc, this is Walter Sujansky. I wanted to add another comment or clarifying question perhaps regarding the items about design meaningful and valid, innovative eQuality measures as a criterion or requirement, as well as the one about sufficient scale to provide meaningful analysis and adequate comparison and I'm struggling with how that fits in with the role of these envisioned registries as data intermediaries. Those two items sound like they go beyond intermediaries surreally doing the full job of collecting data and analyzing it and doing the comparisons and coming up with the measures and computing the measures and really doing everything. Is that the intent or if not, and this notion of being an intermediary implies between the providers and something else, what is that something else that they're intended to be the intermediary between and what is the role of the something else relative to the intermediary, specifically in the context of these two items.

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

Right. So let me take a crack at that and others can chime in, but I think when the group chartered this Tiger Team, the notion of an intermediary was for quality reporting, so an intermediary between the provider and the payer, CMS, in this example. In the sense that in today's world the model is sort of, I'm exaggerating here, you push F7 on your EHR and out comes your quality measures that go – get directly reported by your EMR to the payer. I know it doesn't work that cleanly and simply but that's sort of the mental model. And what this really contemplates is an intermediary that could, when you push F7, gets the data and does all the stuff necessary, including all those things you listed, and reports those quality measures to the appropriate parties as we define them here, including the payer or CMS. So I think that's who the intermediaries between is the provider and the payer and does embody all of those functions that you described.

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

Okay, thank you. That helps. I guess the follow up question to that would be then, imagining a world in which there are multiple maybe competing or alternative data intermediaries or, in my mind I kind of think of it more as quality measure intermediaries –

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

Yup.

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

– because they're really more intermediating the data – quality measure interme – they're quality measurement agents in a sense, that there's a variety of them out there. If they're each innovating and having different quality measures and also it's up to the providers to decide which ones they want to use, the question comes to mind, how all that will be managed so that the payers, when they're getting different quality measures on different cohorts of providers from different data intermediaries will be able to compare and make sense and use that information? I think that –

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

Absolutely, and that was what I was trying to get at with this last item with scale. Like you said, do you have enough to matter, and maybe the answer is you've got to have everybody reporting the same. But –

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I think the scale – first of all, it's kind of – that last comment I thought was actually really, really important. Because one of the reasons why we, at the ACC and we saw this, though hey, this makes a lot of sense, is because now I realize in retrospect you're describing a full-blown registry in your categories. And I can understand how others who think about more of the transfer and organization of data as opposed to the reporting and the analysis of data may have had a different response to this sort of framework.

But when you talk about scale, I just want to clarify. You suggested that 50 percent of all providers of a specialty, I don't think 50 percent of cardiologists do anything, except maybe practice cardiology. So I mean, that seems like an incredibly high number and our understanding from some of our epidemiologists is that actually, if you're really trying to measure quality, you can get pretty darn close to a providers actual performance rates by a 30 chart random audit. And so, that is actually a pretty low statistical bar, but has been shown to be reasonably meaningful, at least as meaningful as some of this huge data aggregation in some cases. So, I'm kind of curious if you could explain a little bit more about the scale and register on the comment that 50 percent –

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

And again, obviously that number was made up to be provocative, but this is a provider. So it really got at Walter's point of, if you were a payer and you're getting a quality measure, and you're only getting it – you're getting one quality measure of cardiac care from 10 percent of providers and a different quality measure of cardiac care from another 12 percent of the cardiologists in the country, what do you do with that? Because you're going to have 10 cardiologists in the community, all of whom are reporting different quality measures.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I'll be – I mean, my feeling on this, if the point of this exercise is really to allow CMS to make apples to apples comparison, then the whole idea of going through intermediaries where we're all going to be, even using e-specified measures and calculating this for our different customers and competing for customers and trying to do that, it's the wrong approach. I think that approach actually sparks innovation and will drive a lot more potential for responding to actual provider incentives and quality improvement, but I think by definition you thereby limit actually the comparability, if you're CMS. And a better route would have been to specify, you know what, we need a QRDA level 1 on everything, and it would be an enormous amount of data, but then the calculation and the algorithm engines would actually be set up and managed at CMS so that they were doing consistent analysis. Essentially the way PQRS works right now for the data submission vendors. So I think again, there's sort of a dichotomy there. If you're looking for real comparison at the individual or group level from the payer perspective, at least based on our experiences, this is not the route to get you there.

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

I think you're describing the tension that we appreciate, and we call out a bit in the create innovative measures row. But of course the 50 percent of providers is not there to describe central limit theorem, it was more to, I think, the individual that added it was aiming at an organization should be large enough and established enough to convey confidence. But it was not necessarily there to say that you must have half of all practitioners reporting to bring value or to allow for statistical comparison. But there will – the tension between measures that are meaningful and data that are meaningful to the Fed, and measures that are useful at the point of care and useful to clinicians will – is almost unavoidable if we are to allow innovative measures. And perhaps there's some way to modulate that tension or minimize it, and one you mentioned would be to have some way of measures that are part of the – the innovative measures have a pathway for them to be described to CMS and have a standardized way for those data to move through the intermediary and towards the Fed. And that may well be the QRDA and the process for the measures to be described might be in NQF or similar organization endorsement, but that bar also might be high and it may be as simple as describing a numerator denominator and a data dictionary for the measure.

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

So in a lot of ways I think we've already moved into the discussion of our row, design meaningful and valid innovative measures, because that's exactly the discussion I anticipated anyway, around this of what we need in terms of measures and the tension that I think we've appropriately identified between innovation and comparability. So I wonder if we really want to start talking about specifically the near term and the future term state in that regard, if that would help us, what is there in that one or two year timeframe and then what our ultimate goal for these measures and data intermediaries might look like.

So in the one to two year timeframe – so again, it helps me to think of concrete examples. So if you think, let's take the thought experiment of an existing clinical registry that's being used for quality improvement by its participants and is reasonably large scale, let's say. But clearly today they are not probably performing or reporting measures that would be consistent with the meaningful use measures requirement. But if we're going to have an intermediary that is going to be adequate as a qualified clinical data intermediary, what – is that good enough or what bar of measures do we have? Do they have some subset of the meaningful use measures that they must report and when? Or is it okay that – and so I'm parsing out the problem a little bit here, I'm taking out all the issues about variation and so on and saying, okay, they've got most of the providers participating and they're doing good work, is it okay to not have any of the standard measures because they're doing that? Or do we need to have a base set of those measures that any qualified data intermediary would have to provide?

**Janice Nicholson – Co-Founder, President & CEO – i2i Systems**

This is Janice and I – Janice Nicholson. And I guess I, as being one of those systems that does the clinical reporting, what we had to do was we had to get certified through ONC to be a modular electronic health record and we are certified for each and every meaningful use measure. I think to – so I think that you really have something in place already that is looking at systems, including electronic health records, that are sizing them up and saying, what really can they report and what they can't report, including in a part of that certification is that you actually can create the data electronically in the PQRS format. So there's really something already in place for those systems.

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

Right. So in that case, there is the equivalent, it seems to me, of saying that the intermediary has to report the meaningful use measures – I guess the question is, what are the measures that they've got to do and report?

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

This is Alan, I want to – I heard it turn slightly on its head that you're not certifying an intermediary, you're certifying an intermediary for a given measure and hence, that's what you're certifying. So, as opposed to this entity that has to do a bunch of stuff, it's for each of the stuff that we're interested, are you certified? Is that what was stated earlier by Janice?

**Janice Nicholson – Co-Founder, President & CEO – i2i Systems**

I was actually speaking directly to the measures. I mean it seems to me like they're – as we're – it's pretty clear that you look at all of the types of reporting that are going on, you have HEDIS, you have UDS, you have – everything is very – it's getting more and more aligned. So it's falling much more where UDS is falling in line with NQF and HEDIS is falling in line with NQF, so really the question is, can you report those measures because I think to say to – to be an intermediary that says, "Hey, I can give you measures, but none of them are meaningful to anyone else." I agree with Walter or whoever said, I think we're kind of headed down the wrong road.

We want to standardize the measures, maybe those measures get looked at a reviewed, but we want to standardize the measures because across the board in our country, we want to be able to compare them to each other. I mean, that's what ultimately is going to make changes for us. We can see data in silos right now, but we have to unleash the silos. I have many organizations that have measures that are not meaningful use measures and they look at those measures internally for their health plans or whatever. But they still can do all of the meaningful use measures that fall into their primary care or their inpatient care, whatever those measures are that they're doing.

So I think there is a set that everyone should be able to do so that we can compare apples and apples and eventually Granny Smiths to Granny Smiths. But that there – that having measures that fall outside of that is no problem if those are measures that you need within your own org or your own health plan or your own group of. But I think that we have to have a standard set, I think – and it seems like it's all falling in line with NQF, I think that's important.

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

This is Jim. I – for the intermediates data, I think it's reasonable to ask for at least a minimum number of measures that are meaningful use. I think it would be nice to be able to allow a process where you can substitute out some measures that you might be doing that could be in test phase or more valid. So I don't think in the intermediate phase we want to have everybody doing the exact same lock step set of measures, but I do think we want to have at least something that's standardized and maybe an ability to choose out of those and substitute where it makes some sense.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

This idea, this sort of concept of a minimum data set or a minimum set of measures as the core and then a larger circle around that where you can innovate seems to have come up a couple of times. And that seems like a – seems to me like a pretty good compromise position. It would reflect, for example, how we think about PQRS, so, we report back on 27 ambulatory measures to our doc, 9 of which are versions of PQRS measures and thus we can submit. And we have more than we need to submit and we're happy to keep doing the PQRS because it's valuable, but we also want the ability to submit more things back to our physicians. And so that seems like a framework that makes sense, as long, and the caveat I'll add is, we're talking about the EHR Incentive Program, which would be different than again the fiscal cliff language where you're talking about specifically about registries that are designed to operate in areas where data does not exist in EMRs necessary to do the complex risk adjusted measures there. So again, requiring a sort of separation and thinking between the two programs.

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

Who was that speaking for the sake of notes?

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

That was Brendan at the ACC.

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

Thanks Brendan. So for – I would – I think we are coming closer to a consensus that there's value in a core set of measures plus innovative measures, even in a future state, but I just wanted to make sure I understand your point about the intention of the Fiscal Cliff Act. I think from the RFI that CMS produced in that area, it wasn't clear that measures that are used through the program for meaningful use should only be those where there's a limited amount of data for risk adjustment.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Sorry, you'd have to repeat that one; I didn't follow that last –

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

Well, your point – as I interpreted your point was that the intention of the Fiscal Cliff Act to allow for physicians to report via registries was for the sake of capturing data that would not be captured otherwise through meaningful use.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Right. So let me just give you a very tactical example of why we think about that. Our CathPCI Registry or our ICD Registry, which is actually mandated by Medicare, for example, has an anywhere from 85-99 percent of all hospitals that do these procedures. So we essentially capture the entire, practically speaking, and the universe there. They've been around for 15 years, hundreds of publications. They're pretty well developed. Almost none of that information can come from an electronic medical record, or at least you could never get a complete set, because of the detail required to report out on metrics like, a sophisticated risk adjustment metrics. And so for that not to be considered a registry for reporting to PQRS, would kind of blow my mind, but I could understand how, because that data's not coming from an electronic medical record, it would not meet the EHR Incentive Program for Meaningful Use, and I would understand that that could not fulfill that criteria. Do you see the – I'm trying to make?

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

Yeah, thanks for the clarity. It wasn't clear if you were saying the information that is not captured in the EHR, whether that information – whether those data should make the measures applicable to meaningful use, you were saying they should be applicable for PQRS.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Yes, yes.

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

Got it.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I'm just glad I'm not the only one that gets tripped up on this stuff. You guys all make me feel a lot better.

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

So in the 1-2 year time frame, I'm – I guess a question, I think somebody tried to raise this before. If you were, let's follow with the example of the ICD registry, for example. They're probably not in the next year going to be reporting 10 standard meaningful use measures plus some other stuff that they're reporting now, just probably not realistic to get there, I'm guessing, as good as those folks are. So, I mean – speak of the changes the data capture processes plus a whole bunch of other implementation stuff, so is there a glide path that we create? If the consensus is in the longer run, it sounded to me like there is a – disagree with me if you didn't hear this, that there is a base level of measures that have gone through some kind of review process and whatever, maybe there's a meaningful use measure where, we can talk specific in a minute. But if that's the trajectory, is there a glide path to that for reporting, or is that something that we say, golly gee, you've got to do that day 1 to really make this worthwhile. I mean my personal bias is it's a little – this is just me thinking but, is that for the reasons that we talked about before where you want some level of basic comparability, that having a modest set of comparable measures seems like a fundamental criteria that you'd like to meet, if this is going to be a substitute, an alternative if you will, whatever gets reported for the Meaningful Use Incentive Program. I'll let folks argue with me on that.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Again this is Brendan from ACC, I would absolutely agree with that for Meaningful Use and the EHR Incentive Program. I think it absolutely makes sense to have a core of meaningful use measures and then you can expand beyond that. The ICD Registry and the CathPCI Registry, for example, will never report likely on those meaningful use measures, it's not what it was intended to do. And partially because we can't get them NQF approved because they're not intended for public performance, they're not widely – they don't meet a lot of NQF criteria, as well established. But I would put them up there as some of the best actually usable performance measures ever created. So again, as long as we're saying yes, for EHR and Meaningful Use, I would absolutely agree that there has to be a core set that in your specialty or in your area, you're willing to submit.

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

Marc, this is Jim again. I think the – if you wanted to have a glide path again, it might be in the sense around if – allowing some substitution. I mean I still like the idea that you've got at least have a few of the measures but the – of a core set of measures, but it might – I'm trying to anticipate where it might shut down somebody that could, over the longer term, be able to provide more meaningful measures. Especially ones that maybe haven't been NQF endorsed aren't on the Meaningful Use list, but still are pretty valuable. But then you'd need a process to actually identify those and approve them. Because I think we – I mean – obviously when you look at that from the other end of the spectrum of the purchaser wanting something meaningful, you don't want to open the door to registries springing up that really don't generate, over time, useful measures.

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

So, you raised a question which we sort of touched on here which is – which we can come back to in a second – is what are the requirements for the measures that, in the sort of innovation space, you may or may not want to have? Are there other thoughts or questions about this notion of – so what I'm kind of hearing, summarizing the conversation so far is, even in the one-two year time frame a base set of measures, presumably drawn from the Meaningful Use set in some way. And that there can be additional measures over time, or initially, but that that's sort of a price of entry criteria, table stakes criteria?

**M**

Uh huh.

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

Anybody like to take a contrary position to that? Wow, talk about consensus. So let's turn for a moment to the notion of, and I think we were just touching on this issue of endorsed measures, if you will, through the NQF process were – the NQF process was created with a particular framing in mind, I think. And one of the tensions that's obviously emerged as that process has rolled out and people have been looking at developing measures and trying to really make a difference in the care we deliver to patients is, those are sometimes a little bit at odds and sometimes there are timing challenges, there are effort challenges, all kinds of things. So what, if any, criteria should apply to the measures that an organization that is a qualified data intermediary were to develop and report? Straw man would be, they should be NQF endorsed, I don't know that that's a good straw man, but –

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

I think that could break NQF personally. We're already seeing it taking years, and I mean, more than two or three or four by the time calls for measures come out and we get them in and they get reviewed and get implemented. I mean, we sort of estimate these as like five-year cycles now. So if you only have a one – maybe, it depends on the kind of grace period you provide, maybe you need a five year grace period to get – as opposed to one year. But I, when I read this, I really struggled with it because on one hand, I don't want kind of cowboys all over the place, on the other hand, I don't know if NQF is capable of tracking against all of these things. And it's starting to get to the point where you need to have gathered tens of thousands of records to be able to have the data to validate the measure in the first place. You know –

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

Yup.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

– Kind of the chicken and the egg solution. One thing that we've internally talked about is maybe you don't have sort of central certification and that sort of thing, but you require, and I haven't even gotten much traction internally with my organization on this. But everything's got to be open, completely transparent like, you need to put out the data elements, the data definitions, the algorithms and – so doctors and other people can rip them down in the marketplace or build them up. And you allow the market to – for the new innovative measures, to decide what they think is going to be meaningful, but you have to be completely transparent on that. Whereas now organizations, mine included, tend to think of those as sort of private, intellectual property and a very actually loathe to share them unless they're going through the NQF process. So that was one option, that if you're going to report them, that's fine, but everything's got to be completely public about how it gets calculated.

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

So that would be one alternative to offer is, rather – maybe some guidelines around process, but then transparency. And at some level I might guess there's acceptability to the payer that you're reporting to.

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

Right, though it's – this is Jim again. I'm – it's interesting, if you have sort of some requirement around you have to produce some measures, why do you need to regulate that – any other measures that you do need to be a certain thing. This is – nobody's forced to participate with these intermediaries, as I understand it, so there's sort of a natural regulation there around. You've got to get people who are willing to share data with you and in order to do that, they're going to expect that there's some reasonable use of those, as far as the kind of measures that you're generating. So I'm just concerned that we set up some kind of requirement that you can only report something that's been NQF endorsed, whether that's truly necessary.

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

I think the bas – so certainly for the participants I agree with you. The other side of the coin though is for the recipients of the measure results, what assurance do they have because at least if this becomes an endorsed, qualified clinical data intermediary and we say that measures reported satisfy the EHR Incentive Program requirements, CMS is going to want some kind of assurance that the measures aren't too schlocky.

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

Yeah, I was just getting to the – you deal with that through saying a minimum set, you have to do these to get – a certain number of them have to be NQF or meaningful use measures, but beyond that, you're free to do other things. Then the purchaser could decide whether they want to use them or not, they're not obligated. But it seems weird to regulate other things that the intermediary might be doing.

**Janice Nicholson – Co-Founder, President & CEO – i2i Systems**

This is Janice –

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

This is Walter Suj – oh, I'm sorry. This is Walter Sujansky jumping in with a quick question about the intent of the "qualified," maybe this is in the legislation and I've just forgotten it, but we're talking about what are the criteria now for being a "qualified" again what I'm calling clinical measure intermediary versus another clinical measure – any old registry or non-qualified clinical measure intermediary? And is the intent for the – to qualify, is there funding associated with that on the part of the government? Is there endorsement of that as an intermediary specifically for Meaningful Use or any other specific government defined measures? What is the significance of the "qualified?"

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

The term qualified was using in the Tax Relief Act and retained in CMS's RFI. How qualification – so one of the questions that CMS included was, how registries or the entities might be qualified or verified to have the characteristics to capture data, maintain the quality of it, perform analytics or calculations on measures, send those data and have them be faithful to clinical activity. So along that stream, there would have to be some levels of verification, which at its lowest might be attestation. I, as this organization, as a society for left toe podiatrists attest that we can capture data from EHRs and our measures are valid and data that we send to CMS is faithful to clinical care that would probably – that might be –

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

So the qualification then is related to whether CMS will or will not accept measures from a particular data intermediary. Because we're talking about payers here more generally and kind of that these intermediaries are between – are the quality measure reporting agents between providers and payers in the general sense, and that they're free to come up with their own measures, to some extent. And to the degree that that's true, why – if they're – if someone is an intermediary between Blue Cross and Palo Alto Medical Foundation for Clinical Quality Measures, why would either Palo Alto Medical Foundation or Blue Cross care whether they were qualified by the federal government?

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

They might – I would anticipate they might be interested in being qualified to offer services to their clinicians where practitioners could report on measures that were part of Blue Cross of California or your local HIE or your professional society, that you were reporting to anyway and now can get credit for Meaningful Use or dot, dot, dot PQRS or dot, dot, dot IQR, etcetera, etcetera.

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

Okay. So the only cont – okay, I'm sorry, go ahead Jesse.

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

(Indiscernible)

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

– the only context then in which the qualified matters is for reporting the government – federally specified quality reporting, whether it's Meaningful Use or PQRS. So, I guess my point is, where I'm going with all this is that, perhaps it really only matters in the context of those specific quality measures that are relevant to the federal government, the notion of being qualified or not.

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

I think that's largely true today, but obviously that's a pretty big importance for a lot of people.

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

Oh absolutely, absolutely. But we're also talking about, well, whatever measures that they come up with need to be NQF endorsed and so forth. Maybe the marketplace is – I guess I'm suggesting perhaps the marketplace is better between the providers and the private payers who care about these things, they can determine whether they want to use that measure or not, whatever's going to come up – whatever – come up with. The only ones they really care about being sanctioned by the federal government are the ones that need to be reported to the federal government.

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

Fair enough.

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

Does that make sense?

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

Does to me.

**Kelly Cronin, MPH – Office of the National Coordinator**

This is Kelly Cronin. I just wanted to make a brief comment about the commercial payers. We've been spending a lot of time trying to figure out how to sort of build infrastructure and how to scale, through intermediaries, the ability to do multi-payer payment reform. And so while we're not going to see multi-payer alignment in every market clearly. And there will always be a certain amount of measurement that will reside on the commercial side for other populations that the federal government's not interested in, we are trying to get alignment across the core set around whether it's supporting comprehensive primary care or if it's – sorry – it's supporting multi-payer ACOs. So I think we want to be mindful of balancing the need for commercial payers to have an infrastructure and this can leverage those.

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

Yeah, I think that's a good point that there's value in the more alignment we get, but also the – contemplating the possibility that different payers might have different criteria or different thresholds for different measures. Well, we certainly haven't brought this discussion to closure, I might suggest, because we've certainly captured a lot, that we spend a few minutes on the ensuring data quality and public reporting? Or are there other burning things that folks would like to get in before we move to those? Not that this discussion has ended, and as I said before, certainly welcome either offline discussions or email comments or whatever. So are there other things folks would like to raise before we move on and touch on the others? Okay, well let's move on and then, like I said, I want a couple of minutes on data quality, a couple of minutes on public reporting and then a little bit of open mike time towards the end, to talk about any other issues, such as the sustainability of scale issue or anything else that folks would like to bring up.

So on ensuring the quality of the data transferred and stored, you can read through the draft that we'd sort of thrown together here, but, in some ways this seems like data management 101. I think the tricky thing is, how do you assure this or measure this, and I know some of the folks, Micky for example, you've been doing this for real for a couple of years and probably have some scars and things to share about that, as do some others.

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

**Collaborative**

Yeah, this is Micky. I'm sorry; I missed the first part of what you had asked Marc?

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

Just as we think about how does a data intermediary – what do we need to require or demand of a data intermediary in terms of how they ensure the quality of the data that they receive and that they – and that there are processes for managing it in a way that's believable, if you will. So when they compute the quality measure, it means something.

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

Right. I mean I guess there are two ends of that. One is, what type of sort of certification process do you need to have – what kind of validation process, I guess. If we're thinking specifically about who the consumers of the data are and if it's for something official, like Meaningful Use or PQRS, then there are the current processes that are used to certify. And I know I heard someone else on the phone talking about their data warehouse going through certification as well as ours have. There are still gaps in that and I think as we – we've certainly encountered gaps and to the extent that the – sort of the tightness of those requirements starts to affect the way people get paid, for example, that's where we might get more attention paid to how such validation would happen right now.

People more or less don't really care that much about it, as long as their numbers are good enough that they're still going to get paid, or in the Meaningful Use case, no one's really looking at what the number is, just that you're submitting the number. But, once we go forward, we obviously are going to have a lot more diligence around some of this stuff and care a lot more about it. So, I think until we can get to a place where that's electronic, and then we're going to have this quandary. Now, with meaningful use there are electronic platforms with Cypress now that we'll be able to leverage, and perhaps that's a model that we could think about in a set of recommendations that's on the validation side of whoever the consumer of the information is for the data intermediary.

I think there's the other validation process going back into the value chain here, about the provider validation of what is being done with their data and whether it accurately reflects what has come out of their source systems, which has sort of been – is sort of a more difficult challenge in some ways. Because it's hard for them to validate against sort of what is the source of truth when the data intermediary may say something very different than what their source system says. So, there may be a whole set of issues there that we need to consider as well.

**Richard Cramer – Chief Healthcare Strategist – Informatica Corporation**

This is Richard as well. And I do think if you look at the state of the art in terms of data lineage and transparency, what we want to avoid is the black box where you have data that's submitted to the intermediary and results that come out with no necessary transparency between those two. And so I do think that the concept of not only validating the data that you get, not only having valid results that are generated, but providing a mechanism, as an intermediary, that provides visibility and transparency from source to target. So, whatever results were reported, that you can tie those back to the source data.

**Richard Cramer – Chief Healthcare Strategist – Informatica Corporation**

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Okay. I sort of struggle with what validation means in this situation because, I mean, we call this a zero or one hundred rule. When a practice has a zero performance rate, we know something's wrong and when they have 100 percent performance rate, we know something's wrong. And anything in between we've seen as actual reasonable reflection of performance rates and/or combinations of documentation. What we've also found is that the practitioners themselves, in the vast majority of situations, not being terribly technically savvy, increasingly not having direct control over the EMRs because they are being outsourced of their AST model or their servers are hosted centrally with Cerner, have actually very little ability to dig into that data.

And so the biggest black box I think for the physicians, and in some ways for us, is what happens between that user interface where they're clicking on the screen entering patient information, and what that looks like when we're seeing it on the tables in the back-end, and the degree of customization that is there. And so, I don't have a solution for this other than to offer that this is one of those kind of perplexing existential questions for us, just because of the kind of volume that we're seeing, where we'll see 35,000 records in a day. How do you audit that? You can audit the systems, I think, the technology to make sure that that's working right, but actually knowing whether the right thing is getting entered into the EMR that reflects what is happening with the patient in that encounter, I think is a much more tricky –

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

So on the one hand, one of the beauties, if you want to call it that, of the ONC certification program is that there's a level of confidence, I didn't say a high-level notice, that the data captured and so on – there's a test of that integrity. As soon as we open up the intermediaries where we say not all of that data comes from an EHR, we lose even that level of confidence. And I agree it's hard, but we certainly probably can't throw up our hands and say, there's nothing we can do. So the simple thing – I mean, there's the ONC fallback of course is, okay, we'll have them attest that they do a good job. So let's say an A-level of confidence we might gain, is there a higher level of confidence we might strive for.

For example, one of the ways in research that we try to validate millions and hundreds of millions of records is, we look at distributions of variables that we have some notion how they ought to be distributed and if they're distributed funny, it raises red flags. So, genders in the general population ought to be roughly 52 percent and 48 percent, or the utilization of drug "X" in the general population would generally be around 3.2 percent so when you see 12 percent it's a red flag. I mean, that's just a notion of something that you could do more than saying go out and audit every record by hand, but maybe a little more than, yeah, I promise you it's good.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

So that's precisely what we're trying to do at the ACC –

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

It must be right then, must be right.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

No, I'd almost say run away based on our experiences, but that's what we're trying to do, we're trying to use the like system engineering techniques to look for those outliers that would suggest systematic errors, coding errors, transfer load errors, that type of thing or blatant systematic misuse. But we're seeing legitimate practice variation amongst cardiologists that can be 20 percent or 30 percent on either side of a media. And – if you think about anticoagulation care, like there are practices that are intimately anti-coagulating, and this is one I focus on a lot, in atrial fibrillation, 20 percent of their patients, and there are practices that are doing 80 percent of those patients. In there you could have a whole lot of legitimate practice variation or you could have a whole lot of data error, and what we've found as we've tried to do this is that you can do it on simple things like gender and that sort of works well. But that's usually not the things that are being screwed up, in our experience. The things that are being screwed up are things like ejection fraction, New York Heart Association Class are much more complex variables and then there is no known benchmark that we've at least been able to find, so we internally benchmark –

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

Right.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

– then we're not sure that the internal benchmark it tells us what is happening in theory, but it doesn't actually tell us what is supposed to be happening. And so, this is the kind of discussion I could go on for a long time, and I'll stop myself, I would simply say if others are out there working on this and are looking to have offline conversations, we would love to do it. Last point is that when we're looking at the cost of doing that, this runs in, as we start to project this out every year, into the millions of dollars to do this properly at a scale. And that's just barely doable for us. I think it would put a lot of new registries, and particularly specialty society, completely over –

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

But, this is Micky. Should that be what we think of sort of the function of what a data intermediary would do? And I only ask that because I think that what you're doing at the ACC is – there's a whole bunch of things you're doing that may be beyond the scope of what we would think of as a pure data intermediary function. I mean, it seems to me that a reasonable line would be to say that a data intermediary can't be responsible for what is documented, but they definitely ought to be held responsible for the calculations that are done on what is documented. And if they want to offer as a value-added service, kind of like you're doing, that they have various algorithms and various ways of pointing out documentation types of issues that may be problematic for – with respect to how something's being documented, well than fair enough, that's a value they can offer back to the market.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

So I worry that we have purchasers using this on the other side more going, especially in the future state, where there's real money tied to this. And just everyone passing through and saying, well, what I got was valid, without ever checking it, seems like that will eventually come back and be a problem, especially where it relates to federal programs. I think in the near state even, it's reasonable to ask intermediaries to do something more than just attest that their data is okay; there should be some validation plan that you have to submit, to identify systemic errors, as you mentioned, at a minimum. But I think eventually, when you get to the future state, there needs to be some primary auditing of this if it's used for payment. And Micky, you may be right, somebody else could do that, but it needs to be done – that has to occur. We do it, it's not that onerous, it's part of your own quality improvement process to occasionally check back and make sure that what you're reporting is factual.

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

Yeah, this is Walter Sujansky. I would totally agree with that in terms of the audits. For the California Joint Replacement Registry that we've been working with the last 3 years or so, we do a chart audit – a limited chart audit, not a statistically significant, but more of a debugging exercise with every site we bring on board, and we've done over a dozen now. And we have yet to see one where we didn't identify some kind of systematic error in the data being provided, unintentionally erroneous data in every single case. So, the errors are definitely there, more often than not, and so – and the degree to which they are there and so forth varies a lot, but if you really want to verify quality of data, accuracy of data, to some extent that's needed, at least on a spot check basis.

The second thing I would say on this point is that – this is obviously, as we're all saying, this is a really vexing problem and at scale, it's very, very difficult to solve. And I wonder if there's room either through this intermediary mechanism or through the Meaningful Use EHR Certification Program, to push this issue down on the EHR vendors. Because that's why there's more in the EHR systems, there's more control over what data are collected, how they're collected, what's structured and not structured, what can be discerned in a structured way needed to support the computation of the measures and so forth. The EHRs and the design of the EHRs, as well as the use of the EHRs, that's where the control is over the data quality. The recipient of the data, in terms of a data intermediary, actually has very little control over that.

**Janice Nicholson – Co-Founder, President & CEO – i2i Systems**

I will ditto that, this is Janice Nicholson. I mean we currently interface with 35 different electronic health records, all of the leading electronic health records and I think this is a very, very important issue. But this is not going to be an easy one to tackle, because essentially the way that the EHRs have dealt with collecting non-codified or non-standard data is to let each and every individual organization customize templates –

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Yup.

**Janice Nicholson – Co-Founder, President & CEO – i2i Systems**

So what you have is, you have – it's a mess, it is a total mess and I think there does need to be auditing, but there is no transparency to the data. That's the other problem is, every day they're using these systems and hundreds of providers are entering data, but there's no transparency to what they're entering into the system. So, the data's not just behind in a sense an iron curtain, it's very difficult to report on and it's being captured in so many different ways. And I do believe that we have to find a way to audit the data, but I agree with Walter, the scalability of how we're going to do that, because of the way the EHRs were built, it's going to be a big one to tackle.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Well guys, you've now made this the best call of my week because you've confirmed that I'm not the only one that screws up the EHR and PQRS, I'm not the only one who's kids occasionally join these conference calls and now I'm not the only one who struggles with how to validate an audit at scale So, than you, you've made my week.

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

I agree. This is really good. I'm going to again encourage folks to continue this discussion through email or phone calls offline. And I'd like to spend just two minutes sort of – well, maybe a few more than that, five minutes, on reporting to the public, which I expect to be an equally interesting discussion and then that'll leave a couple of minutes at the end for any public comment that we might have. And I apologize for nudging us along, but, trying to keep; to our allotted time here.

So in terms of reporting to the public, again, if you think about registries as an example of a potential intermediary, most registries – I think this is a true statement, but maybe I'll learn not, don't report to the public, it's just not part of their mission and purpose in life. But you could also argue on the flip side that if you're going to be doing reporting for purposes of Meaningful Use incentives, those results ought to get reported and posted. And maybe that's a responsibility of CMS as the recipient of these data to do that public reporting. But then when you think about these innovation measures and so on, do those also go into – fall under that category or not.

**Janice Nicholson – Co-Founder, President & CEO – i2i Systems**

This is Janice. I feel like public reporting is our future, I feel like it's a place we absolutely need to go. I think it's an important aspect and I think it should be a big part of all data. And I think – the bottom line of what I experience is data changes things. When people get face-to-face with data, it changes things and I think that more organizations will even be more engaged with data validation if their data is public because you're going to want to be in control of the story that the data is telling about you. And you're going to want to know that it's the right story. I feel like public reporting will change so much and is super, super important. I say – I vote yes.

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

**Collaborative**

So is the question – this is Micky. Is public reporting of the meaningful use CQMs a requirement of the – from the legislation?

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

So is your question Micky, is already, forget all this data intermediary stuff or does CMS report the meaningful use quality measures publically?

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

**Collaborative** Are they supposed to eventually?

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

There – from my understanding, there has been a commitment not to report the CQM data from meaningful use in the current stages of the program. I cannot speak to future stages, but as for Stage 1, Stage 2 and on the Policy Committee's discussions of Stage 3, the discussion has been not to report CQM data to the public, for meaningful use.

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

Okay. I was just going to parse out – this is really a question of whether we're recommending that CMS should do that, and if – then the data intermediaries or their contractors, they just impose out on their contractor that you are doing that on our behalf. Or is this something separate that we're saying, regardless of what CMS is required to do, we think that a data intermediary in order to be a qualified data intermediary, whatever that means, needs to do public reporting and then that would beg the question of public reporting of what.

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

Let me clarify. So, in some of the comments to the RFI that CMS sent out earlier this year, some comments suggested that for the – some of the societies, the registries in particular, but suggested that for the innovative measures that are not the measures that are currently a part of meaningful use, that some of those innovative measures could be reported publically. Some other entities suggested that the measures should not be reported publically, there were questions in the RFI about whether – if there was public reporting, should clinicians have an opportunity to check their numbers before they were reported to the public. I think there is a point of view from the patient engagement or patient advocacy stakeholder groups that giving credit for participation in meaningful use through measures that was not part of meaningful use might be “paid for” by giving the public more data on measures that there have been minimal transparencies on. And those measures being the proprietary measures of some of the clinical registries.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

So I'd like to philosophically agree with the value of public reporting and I think the College does too, as a representative of one of the specialty societies. If you move too fast, I think you will create a howl, and I think based on the kinds of data problems that we're talking about, that howl is actually appropriate, in some cases. I also think you're going to create some incentive – you're going to create some positive incentives, you're going to create some negative incentives. So I'll tell you what would happen – what I would recommend to our members, for example, if we had to publically report. I would say, you know what, we have a choice of ten or fifteen cardiovascular measures, and we're going to pick your top three. And so every cardiologist probably has a couple of measures where they're up in the 90's on, things like blood pressure checking, you know, and I would have to be obligated to advise them, in that situation, to game the system. Where now I'm in a situation where I advise them, submit everything because it's the best transparency for you, you're going to learn the most, CMS is going to learn the most, that's important, and I can encourage them to do that, take that risk. If it goes to full on public reporting, we completely change our attitudes towards it, even over the long term I think we agree as an organization that it's the way to go. As long as it's done right, because we've seen it done wrong and poorly and it doesn't actually advance the cause, at all.

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

This is Jim. I had one suggestion. Right now in the chart here you have in the short term no reporting and in long term, all reporting. I wonder if there couldn't be some sort of minimal reporting requirements in the near term, that wouldn't have to be provider specific even, it would be nice to see if you're an intermediary you should at least be sharing some total data. Or market specific or something to give people an understanding of what's the range of results, what kind of information you can get from this. I haven't really thought about what that might be, but it seems like maybe we could come up with something more than just leaping to full disclosure in the long term but not expecting anything in the short term. Thanks.

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

It seems like to a degree we're getting at transparency with a lot of this discussion, how you establish a level of transparency, whether it's different levels of reporting or whatever, and that we're trying to get to.

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

Marc, I think we have to open to public comment.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Thank you, this is an incredible discussion.

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

It has been a great discussion and I strongly encourage folks, while the things are fresh in your mind, it's 4:30, you probably don't have anything scheduled until 5, so before you head to your cars, jot down any other thoughts or ideas that you might have, so that we don't lose them. So, thank you very much for your active participation and operator, if we could open the phones for public comment or question?

**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.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

Marc, while we're waiting, just a compliment on structuring this, I know that wasn't easy, but it's one of the better conversations that I've ever been in around that and I think it's because you guys did a great job of structuring this and actually laying out issues that we could tangle with at a tactical level. So, just wanted to put that out there.

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

We've got a lot of engaged, energized people, which makes it all work. So –

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

We have no public comment at this time.

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

I just can't believe it, after that discussion, nobody had anything to add.

**J. Brendan Mullen – Senior Director, PINNACLE Programs – American College of Cardiology**

– there are thousands of people listening –

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

I am sure there are.

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

**Collaborative**

We answered all their questions.

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

Well thanks everybody and we will take the notes from this discussion, circle back. I don't believe we have any additional calls scheduled at this point. But what I think –

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

We do have a call later this month –

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

Oh, I'm sorry, that's right, that's right. Thank you. Thank you. But what I think we'd like to try to do is take the elements from this discussion and any other feedback that we get along the way. And I'm kind of shooting for the next call to have a document that reflects an evolved version of this framework that you all will have had a chance to look at and review. And what I'd like to do is get kind of a final sign-off, if you will, at that call of we've covered the important issues and we don't have any too glaring misdirection's or overreaching in there, so that we can get to the point where we have something to report back. Does that seem like a reasonable objective for our next call or –

**Janice Nicholson – Co-Founder, President & CEO – i2i Systems**

Sounds reasonable.

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

If anybody does, yell at me offline and we'll try to do it. So thanks everybody for your time today and thanks, as usual, to our expert facilitators and folks from ONC and CMS providing clear and crisp answers to not always clear and crisp questions. So thanks very much everybody.

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

Thanks everyone.

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

Thanks all.