

**HIT Policy Committee
Quality Measures Workgroup
Data Intermediaries Tiger Team
Transcript
June 17, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you, good afternoon 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 and there is time for public comment on the agenda and the call is also being recorded so please make sure you identify yourself when speaking. I'll now take the roll call. Marc Overhage?

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

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Marc. Eva Powell?

Eva Powell, MSW – Senior Director – Evolent Health

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Eva. Micky Tripathi?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Micky. Francis Campion? Jim Chase?

Jim Chase, MHA – President – Minnesota Measurement Community

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Jim. Mylia Christensen?

Mylia Christensen, RN – Executive Director – Oregon Health Care Quality Corporation (Ocorp)

I'm here but only for about 30 minutes.

MacKenzie Robertson – Office of the National Coordinator

Okay, thanks Mylia. Richard Cramer? Peter DeVault? Prashila Dullabh? Jonathan Keller? Brendan Mullen?

J. Brendan Mullen – Senior Director – PINNACLE Programs

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Brendan. Janice Nicholson? Steve Ornstein? Chris Queram?

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

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Chris. Alan Silver?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Alan. Walter Sujansky? Daniel Green? Molly MacHarris?

Molly MacHarris – Policy Analyst – PQRS Qualified Registry Representative – Centers for Medicare & Medicaid Services – Health and Human Services

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Molly. And any ONC staff members on the line if you could identify yourself?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Jesse James from ONC.

MacKenzie Robertson – Office of the National Coordinator

Thank you, Jesse, okay.

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

Kelly Cronin.

MacKenzie Robertson – Office of the National Coordinator

Great, thanks, Kelly.

Maria Michaels, MBA, CCRP, PMP – Program Manager/Policy Analyst - Centers for Medicare & Medicaid Services

And Maria Michaels from CMS.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Maria. And I will turn the agenda back over to you Marc.

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

Great, thank you very much and thanks everybody for taking time out of your day to help us work through these recommendations. I think we've made some very good progress in terms of crystallizing things that we can feel good about recommending to the Quality Measures Workgroup who will then make their recommendations onto the Policy Committee who will make their recommendations onto the CMS and ONC. So, but it all starts with some specifics and the kind of work that this group is doing is critically important for getting those specifics on the table for the others to work through and put into the broader context.

I also want to take a minute just to thank Jesse James for his – he has just done a tremendous amount of the leg work, it seems like magic almost for the progress that we're making in no small part thanks to his putting in a lot of work in between the calls and beating people over the head occasionally to keep us moving along.

Woman

Thank you.

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

So, we appreciate that very much Jesse. So, what we thought we would try to do with our time today is based on the discussions that we had last time we made some additions, modifications, deletions, changes to the material that we presented then and Jesse was kind enough to pull those together into a little simpler to review format with the goal of in this call either coming to agreement on the things that we think we can take forward to the Quality Measure Workgroup or areas that we have so much controversy and concern that we want to either dramatically reshape or remove them from the recommendations. So, we'd like to get to sort of a comma on these set of recommendations today in terms of what we'd like to say to the Quality Measures Workgroup going forward.

The other framing thing that I wanted to add and I'm sure for many of you, as it has been for me, there has been some, this larger issue of deeming of registries as intermediaries for various purposes has been a little confusing and just to make sure that we are crystal clear focused, since we are providing recommendations here and there are other groups discussing and reviewing this and making recommendations to various agencies and organizations so we want to keep our discussions today primarily focused in the scope of Meaningful Use, which puts certain boundaries on this.

There are other folks who are looking broadly and asking the question about PQRS and the physician value program and things of that nature. We want to make sure we have our lenses on of Meaningful Use qualification here and make sure we've covered that territory well in particular. Jesse is there anything you want to add to that or anybody from CMS or ONC that would like to clarify or add to that?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Oh, no, I think that's a great summary and clear that the Data Intermediary Tiger Team took it's charge last year at the end of the year to think in the short-term and long-term how the intermediaries can be more active in this space and with the EHR incentive program and that one of the tasks in the charge was to look at exemplars or to propose a straw-man for how data intermediaries can work inside of Meaningful Use 2 and how they could work long-term for Meaningful Use 3 and whatever lies beyond that.

And that has been the inspiration for the work and it's also been propelled by the description of a qualified clinical data registry in the American Taxpayer Relief Act of last year, but we continue this year with – there were a few things that even from our Request for Comments last year that we wanted to focus on in Meaningful Use going forward and that would be involving more clinicians and subspecialists using intermediaries to capture, clean, calculate and report data, and increasing the number of innovative measures or types of innovative measures in the program. And I think what we described as attributes earlier in the year continues to exist in the recommendations that the group feels is important.

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

This is Kelly, I would also say...

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

But it's really up to the group; it's less my points but more up to the group.

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

Yeah, Jesse, I just would add onto, this is Kelly, that I think when we talk about Meaningful Use it's not just, you know, as a part of the EHR incentive program but really we're talking about Health IT enabled or eClinical Quality Measures more broadly since CMS has been very clear that they are moving, you know, there are various programs in patient quality reporting, physician quality reporting systems to a greater proportion of those being eMeasures over time.

And there are some newer programs like the comprehensive primary care initiative that are using exclusively a core set of eMeasures as their clinical quality strategy. So, I think we're starting to see this in some other programs too. So, while maybe the immediate context is Meaningful Use because we have, you know, the set of Stage 1 and Stage 2 eSpecified measures in that program, but I think it's much more broadly relevant because as we go forward under, you know, Medicare, Medicaid and potentially other commercial payers that we're looking at a larger universe of measurement being eSpecified.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Yeah, this is Kevin Larsen from ONC; I'll throw my hat into the refinement analysis as well. I would say we're really focused on how we use the certification program and certified EHR technologies for quality measurement and quality reporting. So, Meaningful Use is the first frame by which that has happened, but as Kelly said, as other groups use eMeasures many of them want to use certified technology for that measurement. So, our task is to focus on how the certification of electronic health records is best utilized to support this quality recording for measurement and for other kinds of quality.

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

And I think that raises another important framing point which is when we, as the Tiger Team, are looking at this that the vehicles that are available to help qualify these registries or processes that the certification is one of those key tools that ONC has available in particular to help ensure that the processes and systems that are put in place actually achieve the intended aims and so I think it's a very important aspect of the framing as well.

Other thoughts or comments from the Workgroup or questions from the Workgroup before we launch into what we thought we would do is take the spreadsheet, which was sent out to you earlier and walk through each of the topical areas one by one, many of them I would guess people would say, yeah, that's motherhood and apple pie let's move on, but see if there are any questions or discussion that folks would like to have about each of those areas and through that process hopefully identify any that we need to spend more time on or modify in some way.

But before we launch into that any questions or things that the Workgroup members would like to bring out or the Tiger Team, excuse me, members would like to bring out or ask ONC or CMS colleagues about for clarification?

Okay, if we can go ahead and MacKenzie I think we have the spreadsheet we can put up on the webcast so that everybody can follow along, is that possible? And I know this may be somewhat difficult to read at a distance, if you will, but hopefully we can walk through that.

So, the preamble really was an attempt to describe the scope and what we were trying to cover and I will let folks provide any specific words to things or suggestions they have about that through e-mail unless somebody has a topical issue or burning comment they'd like to make and after that I'd like to move onto the specific recommendations? If you think of one later come back to it.

Let's move onto the next workbook page if we could. And let's start marching down, what I thought we'd do is just hit the – we're getting there here, yes, keep going, there we go. Okay, so if we start with the exploited topic of accept EHR data for clinical quality measure calculation you can read the sort of two sub-bullets there, short-term and long-term and this is obviously one that has high relevance for certification of HIT technology and for these intermediaries.

And I think the basic theme here was to say if you're going to do quality measurement you ought to conform to the same standards and quality measurement across all certified Health IT, my shorthand for our recommendations here. And what I'll do is just pause on each of these and if folks have things they want to bring up let's have at it on the topic of accepting data for clinical quality measure calculation.

J. Brendan Mullen – Senior Director – PINNACLE Programs

This is Brendan, quick question on the interpretation of that, when it says function as is that the same as certified as an EHR module under Meaningful Use or does it simply mean you can do all of the things that you would be expected to do under certification?

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

That's a good question.

J. Brendan Mullen – Senior Director – PINNACLE Programs

For the short-term function as is the equivalent of being certified for, so perhaps we should make that clearer in the language.

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

Yes.

J. Brendan Mullen – Senior Director – PINNACLE Programs

For Meaningful Use 2 intermediaries that move data from EHRs to the Fed and get credit for their providers for those quality measures that those intermediaries will have to be certified as certified EHR technology.

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

This is Alan, just a point of clarification, do you want us to react to questions about the language and not whether we support the language or not that the latter comes later or is the latter done by the spreadsheet we sent around?

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

I think it would be helpful if you brought up issues or concerns about the recommendations themselves not just the language.

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

Yes, thank you.

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

So, did you have one on this or was that just sort of a...

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

No, no, no, I support it I just...

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

You're getting ready for the next one.

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

Yeah.

J. Brendan Mullen – Senior Director – PINNACLE Programs

Alan is keeping his powder dry.

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

That's right he's a wise man, he's a wise man. Good. And we can always come back if you think of something later but let's move on because I suspect some of these will have some time required. So, ensure quality of data transferred and stored; in the short-term four recommendations, in the long-term a broad one. Is everybody saving up for the good ones in a minute? The role primarily here is attestation that we're doing good things and testing to make sure things are interoperable.

So, moving onto three, ensure privacy and security of data transferred and stored, clearly motherhood and apple pie and intermediaries attest to audible plans and practices, which is I think consistent with how we do things across other programs primarily.

Okay and the fourth patient provider attribution, just basically to say that those approaches need to be visible to both the folks they're reporting to and those folks they're reporting on behalf of, and when I think about this too I'm assuming that a primary attribution method in many situations is going to be whatever the provider has told us to attribute is going to be the method in many cases.

Okay, now we get to more fun things, the fifth one, design innovative eClinical Quality Measures that providers use for Meaningful Use credit. So, this gets back to one of the longer term goals here is to generate new and innovative measures that with our sort of near-term Meaningful Use lens on, the assumption is I think here that...and I thought we might walk through each of these one by one just because there are so many issues around them.

That because the Meaningful Use 2 dice has relatively cast that in the short-term you would have to be conformant with that and in the long-term there should be a minimal set of standardized quality measures that approximate the core measures for the EHR incentive program, in other words, some level of consistency...

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

Marc, this is Walter?

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

Yes?

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

Can you hear me? This is Walter Sujansky. Hi, just a quick comment on the heading of this one, I'm thinking of this...I think the heading is a little bit inconsistent with the items here, especially the short-term item and maybe something more general would be more appropriate along the lines of, you know, calculate appropriate quality measures from provided data and possibly even putting that as the second item or the third item rather than the fifth item. It seems to go kind of hand in...I think it's a more important criterion than some of the...or more primary, if you will, then maybe the other ones.

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

Yes.

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

That, you know, on the one hand, yes, they have to accept data from the providers, on the other hand what are they required to do with this data and that's what this item, the heading I believe should reflect. They're not required to design innovative eQuality measures in the short run.

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

And you raise another good point which is as we put these together right now, in my poor little brain anyway, these are structured relatively in sort of a process flow sort of matching up with the...that ONC talks about for quality measures, but you raise a really good point, at some point here we'll want to prioritize or place emphasis on different of these in different levels and that this just doesn't do that in many ways. Are there other comments or thoughts about this one?

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

This is Eva and I kind of pursuant to the point before, maybe it would be clearer if we said instead of design innovative would be support innovative eClinical Quality Measures, I don't know that's a little bit splitting hairs.

But, my bigger comment, since this is kind of my soapbox, this particular one, is...and what I'm unclear on is exactly what the role given that this is being...that these criteria are being planned in the context of EHR, but maybe Kelly and Jesse, and Kevin can comment on this given what they said early on.

What I'm worried about is that if we fully...if we confine the criteria only to EHR and then in the future providers are qualifying for Meaningful Use through submission...through these certified intermediaries then I'm worried that we are going to, in the future, be giving credit for not being innovative.

In other words, if the rest of the environment progresses to the point, which is what we have to do in order to get to some of the gaps that exist in quality metrics we have to start accepting data from multiple data sources, multiple data types which would include patient provided data, it would also include cost data from claims and other sources and all of those have to somehow, at some point in the future come together to enable future quality metrics.

What I'm both concerned about, but unsure how to handle given that this is in the context of an EHR, which I don't know that we're wanting to say that an EHR would combine the data relative to cost, but we have to somehow ensure that people in the future, when we get to those new quality metrics are not being rewarded for using a method that's keeping them behind the times. Does that make sense at all?

And I think especially...this is especially relevant for specialties and if a lot of the registries are coming out of the specialty societies the role that specialties play in cost is huge and we need to understand that and understand the different components of that and so it seems to me like this is an opportunity to address that issue through quality metrics.

I'm just uncertain exactly what role data intermediaries will play, but it seems to me like they could potentially play an important role. I don't want to combine that role to just data that might someday come out of an EHR. So, I'll leave it there and hopefully others will have some clarity on that that I don't have.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

So, Eva, this is Kevin and it's a really terrific point and the tension is between innovation and the ability to clearly know that things are comparable one place to another.

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

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

And so one of the challenges with innovative data sources and innovative data types is there is less history and ability to know that is it being done the same at Site A as Site B. So, I think you've articulated that tension nicely and that's part of the same tension that we all are trying to find our way through, how do we really give people tools to do quality improvement but at the same time we're being asked to have a performance-based decision making with comparable performance from one site to another.

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

Kevin this is FX Campion from Boston, it may be worth mentioning the other sources you're thinking about in this document. I think we're referring to the potential to use claims data or patient reported outcomes data in conjunction with what we're thinking of as EHR data, but obviously those two streams of information are very potentially powerful when integrated with EHR data and particularly when we think about the effect on the patient for real outcomes as well as for resource utilization for claims data. So, that's where I'm thinking some of the innovation would occur. Some of those things don't exist today in the current EHR measures or MU measures.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

FX, this is Kevin, I think another couple of data types that we've heard talk about, and I'd be interested in the group's thoughts, one is data from home monitoring or patient monitoring of many types and the other is registry data that is typically collected through some kind of alternate way not from EHR. So that could be phone calls to patients, that could be chart abstraction, that registry information for many of the specialty registries comes in not primary through an EHR.

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

So, one of the things...and we...in distilling this down that became less visible but in some ways we're going back and we're talking about topic number one where we said...

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

Right.

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

Accept EHR data, so perhaps too restrictive, you know, because clearly you do want to have the option for folks to add broader other kinds of data. So, one suggestion might be to say we modify number one to make it evident that it could be broader EHR and other or broader sets of data but where we still perhaps want to, for reasons of interoperability and consistency, to push towards how that data is brought in being somewhat standardized.

And then the question about can you incorporate these other kinds of data into measures becomes guided just by what kind of measurement constraints we want to place on folks, would that be a way to kind of get at this just to remove our very narrow number one, which are EHR data to be able to accept EHR or maybe to say accept data for clinical quality measures with the other process forms maybe even have a note there that says...broad types of data?

Then if we did that would that give us enough latitude with the recommendations we have here around the measures? Would people still be able to create the interesting measures that we hope they will?

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

Yeah, this is Walter, yeah, this is Walter, I agree with that, I guess I get the impression that the headings here like number one, number five and so forth those correspond to what we're referring to as the roles which are more general. So, in the general sense, in the short and long-term the role of the intermediary is to accept relevant data for clinical quality measurement calculation. The recommendation that in the short run that...

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

Yes.

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

Relevant data has to include at least quality reporting document architecture category one. They can accept other data already but they don't need to in order to be qualified.

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

Right.

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

In the long-term they may also be required to accept other kinds of data in order to be qualified, but so that captures similarly for item number five, I guess I would recommend making that more general as well. I don't think the requirement is to design innovative eQuality measures in order to be qualified. I think the requirement is something more general along the lines of generate or provide appropriate, or meaningful eQuality measures that providers use for Meaningful Use credit.

In the short-term then the recommendation is that that include at least the measures that are part of the EHR incentive program if you want to be qualified. In the longer term then so forth, but at no point...it seems like at no point is it saying among any of these recommendations that a qualified registry will be required to design innovative eQuality measures. So, perhaps the heading should be more general and if there is in fact a desire for them to be required to design innovative then that should be one of the recommendations in the medium or long-term I would say.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

That's a good point, thanks. From the...I think...I expect there will be consensus from the group that there should not be a requirement that intermediaries create innovative measures, but it would be good to hear from other folks on the group if we want to clarify that, that intermediaries aren't expected or required to create new measures, that the very least they should do they should be able to use the measures that are part of Meaningful Use.

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

Right, I agree they should not be required.

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

This is Alan, I agree with Walter's statement.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Thanks, so I'll clarify that in the role, number five.

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

Yes, this is FX, I was thinking that what would be great is if they were...if you were using them and they were being used for your Meaningful Use process that you would actually have to have them at least publically available. So, let's say there was a registry in a certain part of the country that was making good progress and finding some innovative measures that were helpful it would be nice to be able to disseminate that and have those measures available in other places. I don't know whether there is a concept of sharing the measure definitions in a more public way.

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

Yeah and this is Eva, I would agree with of that and I think part of my concern isn't...it may be taken care of by the short-term requirement as long as that...what I'm concerned about is if the quality measures do progress outside of data intermediaries and providers are getting credit for Meaningful Use for submission of quality metrics through a data intermediary if they are not able to keep up with the new quality metrics that have been developed and tested and have gone through the rigor and then become part of the Meaningful Use Program, hopefully I'm being clear, that I guess I'm not so concerned about the short-term, I'm more concerned about the long-term and making sure that data intermediaries keep up with how things progress relative to the quality measure development process.

And one other thing that we may do is, in reading 5.4, the long-term requires some review of proprietary innovative measures that's less extensive, clearly there's a need to maintain standardization and to promote that going forward while the tension that Kevin mentioned, while still allowing for innovation, but I'm not sure it's necessarily an issue of how extensive the requirements for endorsement it is, it's more the speed with which endorsement can be achieved and of course that's somewhat of a function of the extensive requirements.

But maybe rewording that a little bit might help to provide a level of comfort relative to the standardization that there is step here to ensure that there is a level of standardization even in the midst of innovation, but that the process itself is no so rigorous that it takes as long as it does now to develop a quality metric and that the length of time is part of the barrier to innovation.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

That's a good point, thanks for making it Eva, as you all I'm sure recall on previous calls we discussed whether national endorsement from an organization like NQF should be required for these measures, the measures that the intermediaries make that are innovative that aren't part of Meaningful Use yet and there was pretty broad agreement that the amount of work and time involved in endorsement from a national level might be a barrier not only to innovation but it would be a barrier to participation.

And I did put in that point 5.4 without going into details of what steps might be necessary but I think in previous calls we discussed, and to your point about publically posting measures, that we should probably publically report the measure components too so at the very least a measure would have to pass some type of federal muster for its logic value-set, rationale, evidence-basis and that might be a lower bar than full "endorsement" but also would involve some type of review from someone to say this measure makes sense and transparency. But is that consistent with what the group thinks?

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

So, this is Micky, I mean that would be...it seems to me that that would be, you know, the parsing here that I think we need to sort of make explicit, which is what's a recommendation to CMS about what they want in measurement and how they come up with measure requirements and then the second set...and then secondarily or not secondarily but in parallel there are the recommendations regarding data intermediaries.

So, what you just described, Kevin, seems to me about in the first category, which may be a set of recommendations that we have to CMS about how they come up with measures and then secondarily, I mean, they can require anything they want of the data intermediaries in order for a data intermediary to be certified, but that isn't about the data intermediary itself, they are going to do that following, you know, CMS requirement.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Well, to the extent, if the intermediary is making its own measure then they might make a measure that's different than what a federal agency might have in mind.

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

So, but so let just stop you on that point, so what? I mean, if I'm a private, you know, I'm a private entity I'm certified by CMS to do certain measures and submit those I can only submit those for CMS qualified programs in the way that CMS defines it, otherwise I'm, you know, not going to be compliant and I won't be certified. If I have other measures that I create in partnership with my providers and those providers are okay with my publically reporting those, you know, why does anyone care? Why does CMS care?

Maria Michaels, MBA, CCRP, PMP – Program Manager/Policy Analyst - Centers for Medicare & Medicaid Services

This is Maria Michaels from CMS I just, I guess to kind of clarify that point a little bit, I guess one of the things that CMS would be interested in is if you did create some of those measures that you just mentioned and you maybe wanted them to be included for credit in a program such as Meaningful Use what kinds of requirements on that measure would CMS need to have and then sort of in parallel how would CMS, sorry ONC certify those particular measures so they could be reported if they weren't already included in some sort of pre-set of measures that is required for the program?

J. Brendan Mullen – Senior Director – PINNACLE Programs

This is Brendan, I was going to...

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

...

J. Brendan Mullen – Senior Director – PINNACLE Programs

Go ahead.

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

No you go.

J. Brendan Mullen – Senior Director – PINNACLE Programs

Okay, I was going to say, you know, I think when we think about certification of measures one way that you could sort of compromise here is that if CMS established criteria they would be positive or imperial criteria as opposed to normative criteria, right? And that would mean that if you can show that there is an evidence-based, if you can show that this is calculable and how the calculations work, etcetera, basically in a technical assessment of the measure to make sure it isn't out of Yahoo-land, than that should, you know, get the benefit of the doubt.

Where I kind of get concerned, even in the NQF space, is how many normative judgments are going on, meaning, you know, certain people on the panel they just think less of other parts of medicine, they care less about it, they don't think it's a relevant, it's not in their area of interest and so you get this horse trading that seems to be based more on "my personal opinion" than whether the measure would work or not in reality.

So, I think if CMS could find a nice compromise where it could say "look this is the definition" the technical definitions of what a measure has to meet and as long as you meet those technical specifications the fact that you're looking at a niche area or an area that isn't common or an area that's pretty creative than that should sort of not be judged, it should just be the technical components of it.

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

Right.

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

Yeah, this is Walter; I agree with that I think it's important to have a set of criteria. I worry that if, you know, that there may be...that the good thing may happen and there may be many, many qualified intermediaries at the end of the day and that they're all coming up with different innovative quality measures that they want to count, if you will, for Meaningful Use, for their providers, and that now there needs to be some adjudication process to determine which ones do and don't count.

And I think we just need to be clear whether that's something that we're recommending, that's an operational model that we're recommending in essence and then what is that adjudication process, who is that adjudication process, you know, that's why earlier it was inviting to say, okay, well we're going to use NQF because that's already something that's in place and someone else can do it and not CMS.

But, if we're not going to use NQF I think we need to think through how that would happen, you know, there is having a floor of the EHR, of the measures for the EHR incentive program I think is very important because that's already, in some sense for better or for worse, been vetted and accepted and that has to be, in my opinion, among the qualifying criteria for the registry.

J. Brendan Mullen – Senior Director – PINNACLE Programs

Yes.

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

So, isn't that...sorry this is Micky again, just...isn't that again...and I think that's a valid, very valid, you know, point both of them but that seems to be a bigger question beyond the data intermediaries, you know, question, because again, that's about how do measures get generated from the bottom up and how does CMS decide what are valid measures or not, that's not focused on data intermediaries.

I mean, EHR vendors are a huge source, they are going to be, you know, arguably the biggest source of the measures that get submitted, they could also develop novel measures on their own or the AAFP who doesn't have a, you know, they don't have a warehouse as far as I know or they're not an intermediary, they on their own may come up with novel ways of doing this and CMS should have a process for considering alternative ways, that's separate from the data intermediaries conversation.

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

Well, I see it as, yeah, Micky I think that's a good point, but I see it as related in the sense that we're talking about the qualifications of a data intermediary and if an intermediary is using a lot of...has designed a lot of eQuality measures of their own and they're not supporting any or very few of the ones that are already part of the EHR incentive program and now they apply for being qualified how do you decide whether they should be qualified or not?

J. Brendan Mullen – Senior Director – PINNACLE Programs

To me it kind of sounds like...to me it kind of sounds like we keep coming back to sort of a reasonable compromise paradigm and at least as I understand it it's one that has essentially been used in the Meaningful Use regulation already as sort of a model and that is there is basically a core and then there is supplemental and you can think of that core and the supplemental both in terms of the measures you report and the data you consume.

So, the core is in order to qualify as a data intermediary you need to be able to take EMR data, you need to be able to take it according to the, you know, the certifications and the levels, and that would qualify you as the core consumption of data and then the core production of quality measures would be those that are required as part of Meaningful Use as these already certified Meaningful Use NQF measures, etcetera.

And then there would be a supplement and that supplement would both be supplemental stuff that you can do and that supplemental would be both the kind of data that you could consume, so EMR data plus claims, plus patient reported, plus economic whatever that is, and then likewise in your reporting you could do sort of innovative non-traditional measures, and then you could imagine the requirement with sort of the, you know, a measure, a set that you have to choose from, meaning, you know, you have to report on at least 5 measures or 10 measures, or whatever and at least 4 of them have to be sort of standardized EMR Meaningful Use measures and then up to 6 of them can be innovative, I don't know what those ratios are.

But that seems to be like the paradigm that we keep coming back to and it seems like a reasonable compromise that both would allow for standardization and some experimentation as you push forward. That's just kind of how I'm seeing the conversation right now.

Jim Chase, MHA – President – Minnesota Measurement Community

This is Jim Chase, I would agree with that I've been hoping that this section was about encouraging some innovation that we know we need in this measure development and we don't need to regulate what people do on their own time, but this idea about able to get some credit, so to speak, for innovating measures. And then I was supportive of this sort of third long-term requirement not requiring it to be endorsed because when you're testing measures you generally can't get it endorsed yet and there needs to be I think an opening for that.

And then these three, you know, sub points under that might be some beginning of what some criteria would be sort of short of endorsement that you would at least have to be working on, you know, an area where there is some gap and identified that is going to meet some other standards that we have, so it isn't just testing anything but would actually be in the direction where we hope measure innovation will go on.

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

So, it sounds to me like we're starting to circle on a specific here and I'm going to suggest just to go on, I want to make sure we touch on the others, that we take all of this conversation and try to re-craft this section to accommodate that and I think there have been some really good discussion that points us in the specific direction that we can work from. Are there other kind of different topics about this that people would like to make sure they get out during the call, let's take a minute to do that and then see if we can move onto the other topics in the few minutes we have left?

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

Sounds good.

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

So, I think this...oh, sorry go ahead?

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

No, I just said, sounds good.

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

That's I think very good focus and discussion and I appreciate everybody's input. Report to the public, short-term no reporting to the public, longer-term public reporting requirements mimics Meaningful Use, report to HHS and it seems like that's one of the major purposes here.

Jim Chase, MHA – President – Minnesota Measurement Community

So, this is Jim Chase again, can I just jump back to the last one on public reporting?

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

Please?

Jim Chase, MHA – President – Minnesota Measurement Community

You know, one other concept that might be important here is hopefully this isn't just about, you know, putting data out on a website of the result, but there is a concept here around that if you are an intermediary that is going to qualify for these programs that somehow there should be some standard around making the information available for other uses not just putting it out there and I know one of the challenges with that that we all face is, you know, sustainability, that this doesn't necessarily imply that it has to be free.

But is there some way for us to incorporate something a little bit broader than just scores available to the public, but some concept around in the long-term we'd like to see if you qualify for this there is some obligation that the information gets used for multiple purposes it isn't just for the registries purpose only.

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

Other thoughts about that?

J. Brendan Mullen – Senior Director – PINNACLE Programs

Well, I think it depends on who has control of those multiple purposes. So, for example, at the ACC we use our registries to do all sorts of stuff the quality improvement programs, education, maintenance and certification, research, federal research, retrospective I mean, the whole litany, however if there was a requirement that somehow we had to put our data out in the public domain that would be extremely difficult both in terms of our contractual relations and HIPAA requirements, and, you know, IRB requirements and so forth as well as, you know, we spend 25 million dollars a year on this to make this thing work we've got to be able to recover that and part of it is by using that data to support some commercial enterprises as well.

So, as long as we could...as long as that multiple uses could be within the domains of the organization I think, you know, we could support that because we already do. If it was somehow we had to disclose it, you know, we'd be willing to disclose our data as soon as all the PhRMA companies have to disclose all their data from the trials and CMS has disclosed all the data they have from claims data that's universally accessible, I mean, that's kind of the way I feel about that, a little less than idealistic, a little more realistic on that front.

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

Yeah, and well this is Eva, I think if there is some requirement relative to the innovation component which I think is already written in here somewhere of being transparent about, where was it, about the methods you use kind of at a high level not necessarily that we can still allow for proprietary, some proprietary components but understanding more about how the measure is collected and that can be put toward the public good relative to the development of new measures, to me that's a great payback that still allows for the things you just mentioned that help you sustain this activity.

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

Jim, this is Walter, just a clarifying question, are you proposing that the registries be required to share the data itself with the public in some sense or are you suggesting that the registries be allowed to use the data themselves for other purposes besides reporting to CMS for these quality measures?

Jim Chase, MHA – President – Minnesota Measurement Community

I think I was trying to get at something beyond just putting the results not the data itself, the underlying data, I get the challenges with that, but that, you know, if you're generating results that it somehow is available for others to use would be an advantage here. I also am very concerned in a similar way around the sustainability and, you know, if you're developing these in a proprietary way that there needs to be some way to get compensated for that, but I was just hoping that there is something beyond saying, you know, well we posted on a website and it's really hard to find and that's all we have to do as an intermediary.

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

So, are you sort of saying...?

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

So, that would be a requirement on EHR vendors too then? Because they're performing the same function and if we're thinking about this through the lens of technology certification then...

Jim Chase, MHA – President – Minnesota Measurement Community

Yeah, I think one thing we need to bear in mind as someone who is involved with the registry and on the inside, if you will, that I think an outcome of this is to encourage registries to participate in this program, if you will, as qualified intermediaries and there is going to be some...in order to do that they'll have to do some extra things that they don't currently do or some of them at least and we want to encourage them to do that and that's going to cost them money and so forth, so I think we want to be judicious about on top of that creating requirements for them to share even the results beyond what's required to support Meaningful Use and clinical quality measures just as...because if I understand it correctly, the registries are not going to be paid by CMS to provide this function. They're going to have to be financed in some other way, is that correct?

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

I think that's a reasonable assumption. I don't think anybody knows how that will work.

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

Jim Chase, MHA – President – Minnesota Measurement Community

Okay. So, I would just say, you know, as a registry person I would want our registry to participate in this program but if...unless the providers are interested in us doing that and will fund it or other sources of funding will fund the extra effort required to do it, it may or may not make sense and the more extra effort that is required I think the fewer organizations you'll have for which it will necessarily make sense. So, that just needs to be considered in the balance, I guess that's an obvious point.

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

No, but it sounds like a topic that's going to need a little more dialog to settle in on. I'm sorry, Micky were you jumping in?

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

No, I was just going to say, maybe we just need a...just a little framing from the folks from ONC and CMS that...I mean, I've been assuming that when we started this off and Jesse gave the framing of this being, you know, sort of focused on Meaningful Use and then I think Kevin described, you know, that we should think of it through the lens of the way certification happens with respect to EHR certification, with respect to HITECH, that a data intermediary would just be a component as defined within the certified EHR technology approach and therefore, you know, what would get specified and a provider would have the choice of either having their EHR system let's say Cerner or Epic if they come in as a complete EHR perform that function or they would go out and hire a registry and then include that as a part of their certified EHR technology and they pay, you know, whatever is extra for that.

But, we're not thinking about a separate certification program for data intermediaries it's all within the context of certification for certified EHR technology.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yeah, that's accurate, we haven't seen this as a separate program, we've seen the certification of data intermediaries as fitting with the current standards and certification criteria for modules.

So, intermediaries...I mean, the group could recommend that there was a separate certification pathway of course if it wanted to, but for this one I think we've been thinking of the certification being consistent with certification for other software packages that imported data from the EHRs and exported those data.

But we also, I think the group thinks and believes that registries and other similar entities have a role to play in data quality, they have credibility with their physician members, they have a role to play in improvement and a role to play in innovation on measurement and a deeper knowledge for some of them in some of the sub-subspecialties that EHRs, that traditional EHRs do not tend to have.

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

Right, right, thanks, so Kevin this is Micky again, sorry, so just following up on that then I think barring a recommendation from us that we have a separate type of certification or validation process by CMS then we just need to remember that everything that we're saying with respect to data intermediaries would in practice apply to an EHR vendor as well. So, we just need to keep that in mind I think.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

Yeah, this is Kevin, that's correct in the current frame. If an EHR vendor would certify to the comprehensive, you know, to be...instead of modules to do the whole C1 and C2, and C3 for quality measures you're correct.

Now, I suppose one recommendation from this group would be a separate certification for a certain type of data intermediary and that is not the thing we talked about but this group can certainly do the recommendations that you see.

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

This is Alan, how is that different than being certified for just that module alone?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

This is Kevin again, so in the current way that Meaningful Use 2 works an EHR vendor can certify a kind of black box and say that something comes in and then in the end it reports out and the steps in the middle are sort of focused on not as hard as they are to focus if we have just one module, if you only collect capture and then you use other modules to calculate and report. Now most vendors are certifying to capture and calculate and report as separate modules.

So, what would happen is if you're a large vendor that certifies to the whole thing you necessarily are encompassing the attributes and the certification of a data intermediary as well. You're saying that as a vendor I do the whole thing and I do not just capture, I also do the work of a data intermediary in calculating and reporting.

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

I'm sorry and then I won't prolong this, but could Entity X ask to be certified only under a module that is just a data intermediary?

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

So, right now there are many, many vendors, EHR vendors or other kinds of IT vendors that certify only to the calculate and report C2 and C3, so they assume that some other part of the system...so if I'm a client, if I'm an eligible provider a doctor in a clinic I can put in an EHR system and then also work with the registry for example FX's registry I think is this part of the ecosystem, I can work with FX's registry who does the calculating and reporting of the quality measures and the only thing my EHR does is capture the data and send it to FX's registry. So, that is correct, you can certify just to calculate and report in the current frame.

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

So, unfortunately we're kind of bumping up against our time here and we need to have a few minutes for public comment if there is any. I would in particular ask folks who have thoughts about the achieved scale and viability suggestions here and I have some to share those with the group by e-mail and as far as next steps what I would think we would do here, and Jesse you may have some other suggestions or thoughts, is take this commentary and I'd like to craft this into and there were several good points about for example the headings here really aren't they're sort of topical headings rather than recommendation headings and things like that, craft this into a first version of something that we might take to the Workgroup, to the Quality Measures Workgroup of output from this group and share that with folks off line for any additional feedback or refinements as they might have. Jesse, does that sound like a good path forward?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

It sounds great.

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

Okay, so given that and the hour, if I could ask the operator to ask if there are any public comments or any questions, well I guess not questions, comments?

Public Comment

Rebecca Armendariz – Project Coordinator – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue. We have no comment at this time.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

This is Jesse Marc, I didn't realize you were opening comment now; we do have another 30 minutes on the call.

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

Oh, I'm sorry, I had...my calendar was...I apologize to folks, okay good. I apologize I was managing to the hour.

J. Brendan Mullen – Senior Director – PINNACLE Programs

Wait, does that mean I can't get lunch now?

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

No, it just means we won't get your valuable input if you do.

J. Brendan Mullen – Senior Director – PINNACLE Programs

That might be a good tradeoff.

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

Thank you, Jesse, for straightening me out. So, we can continue to have this...and I'm sorry to cut that off.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Well, perhaps I should be apologizing I'm not sure if I deserve thanks.

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

So, on the certification...

Male

...

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

It seems there was a question raised about do we want to make a specific recommendation about certification being the same as other certified EHR technologies or potentially different and Micky raised the point in particular that if it's not separate then there are going to be thoughts that all of our recommendations apply to everybody. Folks have thoughts? I mean, it seems worthy of a specific recommendation if we did think it should be separate?

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

Could you just...this is FX, could you comment on the current process for PQRS registries, you know, obviously started a couple of years before the MU process started but it continues today there is still a PQRS registry certification process that goes on directly with CMS as opposed to one or the other entities like CCHIT or Drummond. Do you see this evolving away...will that continue? I'm just trying to understand what the future looks like for those types of registry programs.

Kevin Larsen, MD – Medical Director for Meaningful Use – Office of the National Coordinator for Health Information Technology

So, this is Kevin Larsen from ONC, that's part of I think what CMS is asking this group that, as you know from the policy statements and the NPRM CMS is looking to align its quality programs and so some of these questions come in around the alignment of programs like PQRS to Meaningful Use.

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

Anyone from CMS who would like to add to that?

Maria Michaels, MBA, CCRP, PMP – Program Manager/Policy Analyst - Centers for Medicare & Medicaid Services

Yes, this is Maria Michaels from CMS, I would just say kind of to directly answer the question, there is no definite, I guess path to continue or not continue what is currently included in the, I guess, qualification of registries currently and I guess for this sort of newer option that was attributed to the PQRS program through the American Tax Payer Relief Act it is this alignment aspect that we're looking toward.

So, I guess to give you a summary of that there is no real crystal ball to let us know what we're going to do in the future because we are looking for recommendations so that whatever we do put in place policy-wise does make sense for all of the entities involved and the providers involved.

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

So, this is Marc Overhage, it does seem to me that as we talk to providers, payers who are using measures including CMS that having consistency is highly valued even though that the more fragmented and diverse our programs are the harder it is for people to understand them and participate in them. So, I might lean in the direction, if I were king, you know, I might lean in the direction of having it be consistent across, to the extent possible, across these programs so that folks aren't trying to deal with quite so many.

So, I guess I would say in terms of...you know, my thought would be in terms of certification that...and I think Micky your point about we need to think carefully about what we're saying, but my inclination would be that having a single certification process would be preferable.

It is a little bit different I think for certified EHR technology components as they're certified today because we're really just certifying the software capability and then we're placing requirements on providers who participate in the program for the data intermediaries like a registry it is a little bit different, we're sort of blending together I think those two things, right?

We couldn't possibly for example have an EHR component or certification EHR component that attested to their security policy, because they don't have one it's what the provider does with their software for example. So, it is kind of a blended I think of the provider requirements and the EHR or certified HIT technology requirements. Did I lose everybody?

Maria Michaels, MBA, CCRP, PMP – Program Manager/Policy Analyst - Centers for Medicare & Medicaid Services

This is Maria from CMS I actually kind of had another question to throw out to the group and so one of them is related to one of the current certification criteria which is for data capture and the current requirements are related directly to the clinical quality measures that are finalized I guess in this piece in the Stage 2 rule for the 2014 edition certification criteria.

How would you envision or how would you recommend that that particular requirement change for the cases where we're talking about measures that might be developed by the individual data intermediaries?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

And your question to clarify Maria let me be sure I understand the question you're asking, this is Jesse, you're asking how could certification change or how would certification change to ensure that EHRs captured data elements that were unique to the innovation measures.

Maria Michaels, MBA, CCRP, PMP – Program Manager/Policy Analyst - Centers for Medicare & Medicaid Services

Right. So, that for example if a module is certified to the data capture criterion does that mean that criterion moves forward into the next or the next edition of certification criteria that a provider has some sort of assurance that a certified module will also have data elements required for a measure that might be reported through a data intermediary if that's the path they choose.

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

Or should it even? And I guess part of me says it shouldn't because if somebody is creating this innovative measure that doesn't go through this broader vetting process and doesn't...I mean, how could you possibly make everybody take that on given the side-effect well to Eva's point earlier I think about alternative ways to capture and collect data, you know, I think, it seems to me that you'd want to do something like, if you had the innovative measure that was so powerful and so useful that you wanted it to become a basic measure then yeah it should become part of the certification process through the data capture side of the house, but without that broad vetting it seems like a risky approach.

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

This is Alan, following up on that I'm confused, are you asking about so called capture and collection or are you asking about verifying that a measure that is captured and collected is in fact worthwhile?

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

I guess I was raising a point if a registry produced an innovative measure that needed the, you know, the eye color does that then translate to we should add that to the certification requirements for qualified HIT technology that they be able to capture eye color in a consistent fashion. And, I guess I was not...I was struggling to get there because of the implications of that in terms of breadth and scope that would be imposed on providers and vendors.

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

So, my paraphrase is that would be its worthwhile and should be captured by others and I'm inferring...

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

Yes.

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

You think that we shouldn't go there and if I am correct I agree with you.

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

Better said.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

I think there's a feasibility issue that comes along with...that could get in the way of encouraging innovation if we required the data elements that were part of the innovation measures or the innovative measures to also be captured or to be tested for in certification of EHRs.

I think one of the values in having or expecting innovative measures to use multiple source data or encouraging that is that will first capture perhaps early in the lifecycle of an innovative measure, you may have to capture eye color or percent stenosis of an artery outside of a certified data element, but if the measure is so valuable and the data elements becomes so valuable there might be a pathway to have that data element part of the catalog of criteria or catalog of data elements that EHRs are tested for in the future.

But, I think you need some vetting process for the measure to first see is this measure good enough for us to require every EHR to capture this measure depending on how many innovative measures there are you could drastically expand the amount or the number or the types of data that were required for certification.

Maria Michaels, MBA, CCRP, PMP – Program Manager/Policy Analyst - Centers for Medicare & Medicaid Services

This is Maria again, I just have one more thing to add to what Jesse just said which is that at least from the perspective of how the HITECH statute was written CMS is more or less required to use what is considered certified EHR technology which means it includes all the required certified criteria in order to consider that a provider, an EP or a hospital has successfully reported either it's Meaningful Use functional measures or its clinical quality measures.

So, in one sense it kind of does require a certification criterion that matches what's being reported in order to be able to count as a successful reporting to CMS with the Meaningful Use Program and I guess that's kind of where my question kind of came from. Where could we start with including some kind of certification criterion that would capture all of these either extra data elements or however it is that these potential new measures might look like how can we look at that and certify it?

J. Brendan Mullen – Senior Director – PINNACLE Programs

I think realistically unless I'm misreading the regulation the Meaningful Use Program is going to be over before we evolve, you know, as a sector in a society to get to that point, you know, the money is going to be doled out we're going to be at the end of the 5 years and so maybe it's a bit of a moot point, but the whole idea that you're setting up the cycle actually of innovation that you're describing here I think is a good one as long as you don't try to close the loop too quickly.

So, the cycle would be in order to get qualified you have to meet these basic requirements with the Meaningful Use certification reporting on these core measures, out beyond that you can use other information that's available in an electronic environment to create supplemental measures and to innovate, you know, CMS can choose or not choose to incorporate those measures in future incentive programs back into a PQRS or a Meaningful Use Program at their will, but, you know, that sort of creates a cycle.

But, I agree with everyone else that if you start requiring that all of the new data elements required to create innovative measures get rolled back in your talking about an absolute explosion that I think is premature for where we are in the technology development process.

What I think will eventually happen is that the nomenclature or the definition of the electronic medical record is going to change. So, right now we think about it actually, despite the huge requirements on it, it's a fairly narrow slice of all of the HIT, so it doesn't include for example hemodynamic systems and catheterization labs, they have a lot of things that look like an EMR but they're not actually an EMR and I think eventually we'll get to the point where EMR becomes a generic term for really, you know, health information technology that is managed around a longitudinal view of the patient, but that's very sort of future and I think is a future that is beyond this program.

So, if you set it up to promote the innovation but you don't try to close the loop at this moment I think that's actually an acceptable smart policy decision.

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

Other thoughts or comments about the certification criteria? What I hear us kind of circling in on is create a – sort of suggest that the pathway is to allow innovation measures to sort of count but not count as the whole submission if you will. So, you could have core plus menu, plus some innovation in some mixture and then...but that the data for these innovative measures really would be on the qualified intermediaries plate to figure out how to get and capture, because their participants voluntarily do it, they do it through some of the innovative ways that Eva was describing whatever and that then beyond that it's a normal certification or the normal adoption process of measures would then take care of how much we want to embed into other certified EHR technology. Is that a reasonable summary? I'll take that as a yes.

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

This is Eva, yeah that makes sense to me and I think the other thing that we need to just...what I think that does that is really helpful is that I think that's important for us to keep in mind is that this is...what we need to do is create some method of innovation that offers also some assurance that the measures are going to be valuable down the line for comparative purposes, i.e., embedded or based on some standard features, but providers for whom the core set of measures are not really applicable are going to be driven to this method because they want measures that are useful to them and that's where the innovation, that to me is a big driver of potential innovation is if you provide a path for them to innovate and also get credit for that when the only other option is to collect a bunch of measures that may or may not be useful to your actual improvement process.

And so I feel like what Marc just said is a good balance between offering the kind of standardization that we want to encourage without dampening the opportunity for innovation and to do that in a way that really drives providers into a different option rather than boxing them into just this core set of measures or a core set plus some other measures that you may choose from none of which really are very useful.

Maria Michaels, MBA, CCRP, PMP – Program Manager/Policy Analyst - Centers for Medicare & Medicaid Services

This is Maria again, so I definitely agree with everything you just said because that is one of the main ways or main things that we see about data intermediaries in particular those that are going to incorporate measures that are more meaningful to specialists who don't currently have measures in our program. We see that as a way for them to actually get quality reporting in a meaningful way for them as well as a way for us to receive some information related to aspects of their care that we don't currently capture.

I guess my one concern is that we wouldn't have a way or the providers actually wouldn't have a way to make sure that the different data elements required to capture the information needed for those potential new or innovative clinical quality measures they don't actually have a method to do that electronically and if we're talking about Meaningful Use or electronic clinical quality measures that would be something that I think as a provider I would want to know that my technology is able to capture.

And that sort of goes back to the question that I laid out initially related to the certification criterion data capture, because that is its intent to be sure that the technology actually has the capability to collect the data and capture the data that's needed for the clinical quality measures that a provider intends to report.

J. Brendan Mullen – Senior Director – PINNACLE Programs

I personally think that's ultimately where you have trust the market, you can't prescribe that in detail because this would be all over the place and you have to trust that the intermediaries are aware of what the data that's available for them to create measures and the providers selecting those intermediaries are talking about what is the best solution for them and you allow the market to create, you know, the incentives for both sides to get it right, which means, by definition some percentage of the time, it's not going to go right you're going to have screw ups left and right there, but that's just I think part of the game once you get this far out of the mainstream and out of the mainstream for all the right reasons.

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yeah, I don't think you can both create measures that are innovative and doing the types of innovations we discussed and pre-certify, certify that the vendors will be able to capture every data element, the two are at a tension and it may be at the federal level that we decide how to push the lever or how to move the dial in which direction we want more innovation or if we want more standardization, but I do think it makes sense that part of the role of the data intermediaries because they are the sneeze from a registry stand-point the sneeze in our clinical area and they will grow at sneeze in EHR generated data, I think there should be space for them to figure out, for data elements that are unique, how to pass that data from the EHR to the intermediary and to report it back to the Fed in a way that allows for high quality data.

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

Yeah and I agree and the other thing that I'm thinking based on the comment about trusting the market is that presumably whoever becomes a data intermediary is going to be large enough or have enough clout or at least be wise enough to really reach out to vendors and ensure that whatever they're doing from an electronic capability of capturing information on their end is going to be able to be passed along to an EHR and have that kind of capability and so, you know, I agree that there is a tension there, but I would hate to see us try to lay out all the various components of a measure that might some day in the future be selected.

And there are I think tools in place to help that process along and it just behooves the data intermediary if they're going to be successful to really identify the vendors they need to be working with and some of the tools developed by NQF, the...I forget what it's called now, the measure development tool that those things can be employed as a way to promote those discussions.

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

Jesse, this is FX, I think part of the concept is that we actually want clinicians to use the data to actually demonstrate improvement; in your document I don't see any requirement for that. It's one thing for the registry to produce reports and to have, you know, really great and innovative measures; it's another thing for the sites or the clinicians to use the information.

When we do our certification for internal medicine for example we need to be able to demonstrate that we use the data in some particular aspect of our practice. I didn't know whether, you know, we can move beyond the data collection to the use of the data and whether there would be any requirement and I think the burden of proof here would be on the providers and it's possible that the registries or the...you know, these new entities could keep track or at least log that the users were active members of the collaborative or using the information. I'm just trying to understand whether there is any burden there to demonstrate improvement?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Thanks, FX, this is Jesse, you are dead on where our goal and our vision has to state that we measure for the sake of improvement and otherwise we really shouldn't be measuring but for the sake of improving clinical quality and I guess there's an argument for payment and value, but at the center of what we do should remain the goal of improving clinical quality and Marc and I had a similar conversation last week.

But, I think it might be in...and the group can comment on whether it would be over prescriptive to make requirements on the provider and how they use the data. I think to this point we've been thinking that was a bit out of scope for the roles and requirements, it should remain the goal for the program and for the intermediaries, and for the practitioners that are in the space, their goal should be quality improvement, but I don't...I think there is a risk of being over prescriptive if we make requirements on that.

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

Any other thoughts or comments on that from our CMS colleagues?

Maria Michaels, MBA, CCRP, PMP – Program Manager/Policy Analyst - Centers for Medicare & Medicaid Services

No, I think Jesse said that pretty well.

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

Okay, well this time I think I have my time right, right Jesse?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Right on.

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

So, I'm glad we had the additional 30 minutes because this was a very important topic to spend some more time on. I started to sum up before the action items but I think it's the same of we'll try to turn this and add a recommendation around certification and try to capture some of this discussion into a specific set of recommendations that you all can take another look at. Then sort of starting to form them into something into the shape of what we might take to the Quality Measure Working Group. And do we need to again ask for public comment just to be compliant with the process here or are we okay since we've done that once?

MacKenzie Robertson – Office of the National Coordinator

If you don't mind if there's nothing left we still have two minutes left I'll just go ahead and open it again for public comment since it is the end of the call.

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

Sure enough.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Sure, operator can you just quickly open the lines and see if there are any additional public comments?

Rebecca Armendariz – Project Coordinator – Altarum Institute

If you would like to make a public comment and you are listening via your computer speakers please dial 1-877-705-2976 and press *1 or if you're listening via your telephone you may press *1 at this time to be entered into the queue. We have no comment at this time.

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

All right, well thank you everyone and I will get a new calendaring program so we will...no it was my inability to read my existing calendaring program that threw me off so thank you Jesse for getting us the full time for our discussion and thanks everybody for taking the time out of your day and skipping your lunch in some cases to help us think through this and I would think probably sometime in the next 10 days we would get a document out to you that reflects our best shot at summarizing the discussion and the recommendations, so something like middle of next week. Any other closing thoughts or comments Jesse?

Jesse C. James, MD, MBA – Senior Medical Officer for Clinical Quality Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

None, thanks everyone for your effort and your thoughtfulness.

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

All right, well thanks to the Workgroup to our colleagues at CMS and ONC and enjoy the rest of your day.

Male

Thank you.

Male

Thanks.

Male

Have a good day.

MacKenzie Robertson – Office of the National Coordinator

Thanks everybody.