

**Quality Measures Workgroup**  
**Draft Transcript**  
**May 5, 2011**

**Presentation**

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good afternoon, everybody and welcome to the Quality Measures Workgroup call. This is a Federal Advisory Call, so there will be opportunity at the end of the call for the public to comment.

Let me do quick roll call. David Lansky.

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

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Paul Tang?

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Neil Calman?

**Neil Calman – Institute for Family Health – President & Cofounder**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Eva Powell?

**Eva Powell – National Partnership for Women & Families – Director IT**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Marc Overhage? Carol Diamond? Peter Basch? I don't think Bob Kocher could make it. Jacob Reider?

**Jacob Reider – Allscripts – Chief Medical Informatics Officer**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Karen Kmetik?

**Karen Kmetik – AMA – Director Clinical Performance Evaluation**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jesse Singer? Timothy Ferris? Laura Petersen? Jim Walker? Cary Sennett?

**Cary Sennett – MedAssurant – Chief Medical Officer**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Paul Wallace? Kalahn Taylor-Clark? Helen Burstin? David Kendrick? Patrick Gordon? Sarah Scholle?

**Sarah Scholle – NCQA – Assistant Vice President, Research**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Russ Branzell? Tripp Brad?

**Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Charles Kennedy? Norma Lang?

**Norma Lang – University of Wisconsin and American Nurses Association**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jon White?

**Jon White – AHRQ/HHS – Director IT**

Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Patrice Holtz?

**Patrice Holtz**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Tom Tsang is on. I know there are a lot of other people, but did I leave anybody off?

**Richard Bankowitz – Premier Healthcare Informatics – VP & Medical Director**

Richard Bankowitz at Premier.

**Kate Goodrich – ASPE – CMO**

Kate Goodrich, ASPE.

**Peter Basch – MedStar Health – Medical Director**

Peter Basch, MedStar Health.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Thank you. I'll turn it over to David Lansky.

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

Thank you, Judy. Good morning everybody. Thanks for making the time to join us again. We'll continue plowing through some of our guidance we're trying to put together for the benefit of ONC and CMS and the Policy Committee. I apologize that I'm in an airport this morning, so I'll try to keep myself on mute, and of course, I'll ask everyone to think about staying on mute when they're not actually speaking. Lanre and Tom did a great job giving us some preparation for today's meeting as—hopefully you all received the e-mail and the attachments just recently. There were really three topics we wanted to talk about today, and probably the first one is the bulk of our time, which is seeing if we can review where we're at with the stage one approach that we took to core and menu measures. Then from there asking ourselves if that approach seems like it's the right way to go for stage two, and would we recommend continuing that model, or would we consider some changes to it.

You have a page of shorthand suggestions of several options we might consider as ways of rethinking the structure of the measurement submission process for quality measures. So hopefully you have a grid that's labeled "QMWG Stage 2 Core/Menu Options," with three options on it, plus the current stage one approach. So that's our main topic today, to see if we can make progress on thinking through that question. To do that, there's some supportive materials that came along with the e-mail, some of which were used with the Meaningful Use Committee that Paul convened a couple of days ago. Paul, I think you're going to come back to those topics on the next call, which is from the Meaningful Use Committee's point of view, looking at the alignment of measures across several programs and the National Quality Strategy.

At this point, we don't have that particular task, but we thought it would be useful background and context for everyone in thinking about this core menu question to also look at the structures that are being used to organize measures for other purposes. I think we all feel that to the extent that we can get a common structure or alignment or bucketing of measures with other major programs. That's probably helpful to the provider community, and even the Policy Committee, to see that we're focused on a consistent set of themes and measures and trying to reduce burden in both cognitive and technical burden in putting these programs together.

So that's what the three layers of background materials are. You see one that's a PowerPoint. That illustrates the National Quality Strategy priorities and how that maps to meaningful use and ACO categories. There's another one called "Crosswalk of National Quality Strategy with Future MU Stages," which covers some similar material but groups it with a little more granularity than the first Power Point did. Then the third one is actually some specific enumeration of measures within the meaningful use buckets including the detailed ACO quality measures that are proposed currently from CNF.

So it's a lot of material, and it's one of those things that isn't totally harmonized yet, so I apologize that people feel a little categorical confusion from looking at all of these things, but at least it's fodder for you to reference as you ponder about the question at hand, which is this core versus menu structure. After we see if we can come to some clarity about that, we'll talk a little bit about the May 19<sup>th</sup> hearing coming up that's being conducted jointly with the Standards Committee on quality measures. Then we'll have a brief update on the methodology issues for e-quality measures.

So that's all by way of setup. Let me see if there are any questions about our charge today and the materials we received.

**Peter Basch – MedStar Health – Medical Director**

David, were these sent out before today—the materials?

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

I think Lanre sent out a set yesterday afternoon about three o' clock my time, I think.

**Peter Basch – MedStar Health – Medical Director**

I'm just struggling with looking at these for the first time and it's—I understand we're putting things together, we're building the plane as we're flying but just curious as to that. Another question on the overview is one of the options—I see options about all of them keeping the core or enlarging the core. We don't have an option about eliminating a core.

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

Okay. We can put that on the table.

**Peter Basch – MedStar Health – Medical Director**

I'm not sure that we should; I just don't see that there. So I guess the idea is already in most people's minds that keeping a core set is a good thing. We feel pretty comfortable—even though there's probably only a handful of people that have submitted yet—that the concept behind having core measures actually ended up being a correct one for people in multiple specialties and settings and actually was advancing the general vision of all of us working toward priorities and improving health care quality.

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

You stated that very nicely, Peter. I don't know if that's the consensus, and I think that it's one of the first questions we should ask this morning is to review where we are with the stage one approach and see how everyone on the call feels about that, given the framing you just offered. Myself, I don't think that we should assume that the core is an absolute given. I think there are probably some views that think it's an important piece of the structure, but I think that's open to discussions today. Yes, go ahead.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**

May I add a little bit to your introduction?

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

Please.

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**

Just to add to your excellent introduction, I wanted to add, as far as the alignment with other agency strategy initiatives like the National Quality Stagey and the ACO/PRM. A couple of things in the National Quality Strategy that are not necessarily functions of the EHR but may very well suit the quality measure, one is on the prevention, which is probably more aptly addressed in the quality measure, and the other is in the initial focus on cardiovascular disease. That may be something you can take into account.

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

Any other contextual questions? Then I think we'll turn to the review of where we are with stage one?

**Ahmed Calvo – DHHS/HRSA – Senior Medical Officer**

I think the initial framing considerations are critical. I've maintained for a long time that we need to plan for a national quality index—a composite index—and that could come from any number of different measures being combined. One can quibble about the waiting and all this, and even as that instrument doesn't really exist, we should at least consider that in this kind of discussion about whether the core would keep or it would be added to or deleted some components. Because I think medicine is constantly changing, and there may be a critical new thing that gets developed that needs to be included in meaningful—understanding of value or meaning. Similarly therefore, I don't believe most practices will want to send hundreds of measures, and therefore a few parsimonious numbers that arrive to the department may ultimately force us to end up on the composite index .... But the point is that for now, at least considering deleting, adding, or keeping, I think, is a much better framework than just simply keeping.

**Peter Basch – MedStar Health – Medical Director**

If I could comment on my own question if that's okay, David, as a primary care doctor, I'm obviously in favor of and I like the choice of core measures, and they make a lot of sense to me. But as an implementer now, selling these to 60-plus specialties in a large health system—it is a sell job. I'm delighted to say that there are a lot of specialties that look at this and say, "Okay, I get it. I see the relevance with this to how I practice medicine." I'd like to say it's a done deal, and I can't, so I would just say that if there is a very strong message and vision about how all of this together helps to advance a national quality agenda that's widely known inside the beltway and probably to people on this call. I'm not so sure that it's widely embraced by the medical community and I would just caution against an assumption of widespread embrace of this concept of we're moving together as a country toward improving blood pressure, smoking, and obesity.

In fact, maybe the learnings as we get further along in stage one will be that it's working and in fact, that it is correct. I just hate to see us talk about enlarging when we're not sure that the initial arrows are correct. And I'm sorry, I didn't catch the name of the speaker who just went before me, but I would second the call to—as we look at expanding measures, which we have to do in the menu set—to expand relevance for people in other specialties. That we need to be careful about diluting focus and succumbing to what I call measure-mania, and have hundreds, if not thousands, of required measures because people will lose focus.

**Eva Powell – National Partnership for Women & Families – Director IT**

Just pursuant to the idea of having on the table adding measures and subtracting measures, I think also it's important as we have those conversations to keep in mind the need to leverage both the quality measures and the functional measures. Because I feel like we're constantly in this dilemma of meeting quality measures based on information we don't have in the EHR, and then trying to justify requiring collecting particular information in the EHR when people don't get why they need to do that, which could be answered in part by the quality measures. So I think it's a delicate balance, but using the quality measures to drive some of the functional capacity that we need will be an important thing to consider as well.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

I'd like to suggest that we differentiate two aspects of core and the other measures. One is whether it's appropriate to think in terms of some aspects of care that represent quality universally or not—and that's one issue. I think that the answer there is yes. I don't think you can take care of a patient—I don't think anyone would want to go on the front page of the newspaper and say, "I can take care of a patient without knowing their problem list, without knowing their allergies, without knowing their medications list.

The second question is, "Do we have the core right? I think that's an open question. That's the question we often are discussing, but it can blur over into, "Should there be a core at all?" It seems to me that to achieve quality, efficiency, safety, anything, there is a core. The question is, "What is it?"

I think the second think I'd like to say is that the structure that we have is really core versus context-specific. You need to know the patient's problem list if you're going to take care of the patient. Others are context-specific. Maybe dermatologists don't really need to be asking the patient if they have a family history of coronary disease in some first-degree relative under the age of 55. The way we have set up core and menu and alternative core blurs the whole point of the categorization between core, or universals or whatever, and then measures that are context-specific. They may have a very wide context. Smoking cessation may be relevant to practically all settings and all types of caregivers, and others may be very, very context-specific. But the point is that they are all context-specific, and we don't expect everybody to use them or record them. So just those two thoughts.

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

Let me ask Tom Tsang if you could do two things. One is indicate if there is any experience from stage one that would shed any light on the use of the core at this point. Secondly, what you're hearing in terms of the Federal Interagency Workgroup on quality and the themes that Peter initiated and others have commented on, of whether it's—and Paul raised this—whether it's appropriate or expected that ONC and CMS through the meaningful use program should be echoing the national priorities on what they ... care or others on health.

**Tom Tsang – ONC – Medical Director**

Yes, thanks everyone for joining the call. I think, just speaking to folks on the field as they're implementing the measures, the comments are to be expected that the primary care doctors, and particularly the family practice, internal medicine, and pediatricians. That the core and the alternative core measures are extremely appropriate and relevant to their practices, at least from the interventional proceduralists that some of the core measures would not be applicable.

With that said, there's a lot of desire for what the ... teams have been recommending, a more parsimonious set of measures that may be selected as part of the core universe. So measures like perhaps documenting care coordination processes, or measures that are documenting patient activation measures—so more measures that are across the board and cross-specialty.

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

Tom, what about in terms of the larger federal strategy that Paul discussed—any expectation that we should be trying to reinforce or signal alignment with particular themes or priorities that are in the other programs?

**Tom Tsang – ONC – Medical Director**

Well, I think it makes a good case in terms of both achieving the triple aims to be aligned with some of the other policies coming down the pike as well as the quality initiatives related in support of the national quality strategy and the ACO and PRM and the patient standard medical home initiatives. I think someone had mentioned cardiovascular diseases being the number one cause of mortality in the United States. I think that's certainly going to be getting the most bang for the buck. Patient safety is going to be another huge push in terms of selecting either structural or process measures that would facilitate decreasing harm.

**Karen Kmetik – AMA – Director Clinical Performance Evaluation**

David, can I add one thought?

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

Go ahead Karen.

**Karen Kmetik – AMA – Director Clinical Performance Evaluation**

This may be a little bit out of left field, but it just occurred to me. Maybe going forward, we think of core a little differently as not necessarily core measures, but core sets of standardized data elements. I'm only saying that because I'm thinking about some of our prior discussions about registries, and I know that's listed on the APO definition. So I think in the future, we want to get to a point where the number of measures, this measure or that measure, is not something that we anguish over because we've got standardized data elements in databases, registries, what have you, and we can mind that. So I'm wondering if we just think about core as being core sets of data elements within each specialty, clinical area, that we want to make sure are being collected using the common standard vocabularies and common places. So when you get to the menu, those are measures. But are we sending enough of a strong signal of the capture of the data elements that are going to be needed for the measures of tomorrow?

**Peter Basch – MedStar Health – Medical Director**

I like that idea, Karen. But one of the things that I like about the thought of a core is that it provides for those that are not necessarily technically focused. An approach to create strategies on and get people to think about IT as more of a, "Why are we doing it," rather than, "How we're doing it." So here's a good news example, at least from within our health system where I've been starting discussions about, "Can we agree on anything that we could focus on trying to do even though we don't have to do it yet for stage one. But this is leveraging an opportunity to—and with that widespread consensus, believe it or not, on obesity.

It was strongly pushed, not by the people who I thought would be doing it, the primary care doctors, but actually the surgeons who felt, "Well, if we need to focus on one thing as a health system, this affects all of us. This affects all of our patients and postop healing and why people need knee replacements and hip replacements and so forth. So if that wasn't there at the core or if we didn't have pressure to start thinking about ... rules that lead to measures that matter, we never would've done that.

**Karen Kmetik – AMA – Director Clinical Performance Evaluation**

That's helpful, and so maybe what I'm suggesting is really just another piece of communication that we could help put out alongside these measures to say, "And here's your list. In order to report on the core or focus on the core, you need to be capturing these 20 data elements in this way.

**Tom Tsang – ONC – Medical Director**

But, Karen, I like your idea also, but I think that's what we're trying to achieve with the other functional requirements is to capture those aspects of the ....

**Karen Kmetik – AMA – Director Clinical Performance Evaluation**

I'm just trying to make a real strong link though, Tom, to say—I mean, I agree. So maybe it's just a matter again of how displayed. So when you are looking at and you are talking with your physicians about

collecting data for the core or the menu, (the measures) right there in the same place you see every specific data element you would need and what the standard vocabulary is that we want you to use to capture that.

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

I think part of the work also is to try and get the measure to both the developer community to think about as they develop the measures. Like for example, I always use this example of when we say moderately decrease ejection fraction, what do we mean by moderately decreased—because we don't have standards for mildly decreased, moderately decreased, or severely decreased ejection fraction.

**Karen Kmetik – AMA – Director Clinical Performance Evaluation**

In the last set of measures we put out for public comment, we put on top the list of data elements and the standard vocabularies. So you're right, we all need to pitch in here. So I just wanted to emphasize it.

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

Yes.

**Jacob Reider – Allscripts – Chief Medical Informatics Officer**

I have two thoughts, Karen and Tom, I agree, I think in the last iteration especially the value sets that NQF put out as a piece of the 113 measures, do represent a good first step in the vocabulary alignment domain. I think if we can continue that, that'll help a lot.

Another thought along this discussion, Karen, is when you say things like, "When you are collecting your data," and I assume that means that after the provider—and I brought this up during our last call, I think it's important for us to think about a patient-centric perspective rather than, or in addition to, a provider-centric perspective. I might ask Tom, or another one of our federal friends, to help us understand what the boundaries are for this because I know we're talking about an incentive rule, which is EP-focused or EH-focused, but still, the patient is one patient. As we measure providers, is it really appropriate to measure Peter's orthopedist against a certain measure—any measure in fact—that's relevant to something that the primary care provider ought to be measured for? I think that we from the vendor community are having trouble helping our customers understand some of the rationale here, as we look at provider-focused things and provider-focused recording, that may be redundant when several providers in an organization are taking care of the same patient, and it gets complicated.

Anyway, any thoughts about that?

**Ahmed Calvo – DHHS/HRSA – Senior Medical Officer**

I'd like to comment on that. I think that the NQF work on the quality data model and really thinking about which elements need to be there so that one can then get the actual measures actually cranked out is a very big and very positive step. The difficulty that I see going forward is addressed by the recent comment here and that is if we think about it at only the doctor or the nurse practitioner or the provider level, we haven't yet been able to get to the measures at the individual level well enough to my taste. But it also really means that the provider level is really a panel of patients, which means that thinking that through, that it actually gets to a population health level, which has some interesting implications for what we mean by population health.

The reason is that you end up with information, not just from the clinical experience, but also from other things that happened to the patient in their life. That's the hard part as we think about the ... and getting to the clinical and the population health and the e-measures that BP is striving to do. You sort of have to back up and ask what the data elements are not just for the individual patient-centric measures, but for the big picture in the public sense also, which opens up another can of worms, I know. But we have to deal with all of that if we're going to get electronic exchange.

**M**

If I could add a can of worms to the can of worms ... the comment you made about a panel is certainly something that many of us who have been trying to do quality work prior to meaningful use in our

vocabulary and thinking. I don't see in any of the quality measures in the denominator definition, the concept of a panel or the dominator is defined by who you see, not necessarily who's on your panel. So you're raising an interesting issue that I think speaks to the overall attribution of who is responsible for reminders and so forth. It gets to a concept that I think that are not being considered, at least not in these measures, which is the attribution models.

**M**

Could the typists put their phones on mute?

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

If you could go back up a little to the structure that we began thinking about and we'd started drilling down into some dimensions, and Karen led us into asking what we think the core is really about, which took us down an interesting path. The highest remaining question is, is there a core, and if so, what characterizes it? We know from the stage one experience we've had a core. Several of us were in meetings about a year ago where we started with a somewhat longer list of core measures and ended up critiquing them one by one and finding them difficult to legitimately apply across the entire eligible professional category. So core became quite small. Whether we would be able to expand the core and still have a feel for legitimate and appropriate provider types was a question.

Then we have in front of us today the options are—I think Peter initiated the question—of whether we want to keep the core at all, so we have to consider that. So does the core change its character from what it is today or its scope? Then, as pertains to the alternate core menu structure that we've had, you've ... option sketched here on the stage. Option 3 is the one that is probably the most different and would lend itself to eliminating the core as a group if one chose to, which is to group—essentially replace the menu with a structure that maps onto the domain that we've been working on. Then as people within their specialty select measures that populate those different domains. That's a different approach to just, "Here are the seven measures. Pick three," that we've seen in the past.

So let me go back to the conversation and ask you all for your ... thoughts on whether to keep the core or whether to look at one of these other structures that are displayed on the page.

**Neil Calman – Institute for Family Health – President & Cofounder**

David, can I throw in a comment?

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

Yes, Neil. Go ahead.

**Neil Calman – Institute for Family Health – President & Cofounder**

Two things—from a national point of view, the measurement of quality is really a step towards seeing quality improved. All of us that have been involved in quality improvement know that there's only so many things you can focus on. I think we're setting ourselves up for disaster if we really look at huge—even expanded—numbers of core measures. I'd love the idea of having people be able to pick measures that are relevant to their practice from different categories because I think what we're really asking people to do is to transform their thinking about quality in a larger way, not just to spit out a bunch of measure things.

My belief is that if we start doing some overall kind of measure and start reporting on this across the country, the country is going to look at us five years later and say, "Oh my. How come we're reporting on all this stuff? It looks so terrible." It's the same thing they're going to see that we see in our own practices. How come we look at all this stuff. It looks terrible, and it's not improving at the rate that we would expect.

So I think teaching providers how to pick things that are relevant to their practices. And focus on improvement is really important. The part that's probably out of our purview, but we have to deal with in one of these kinds of forums, it seems like we've got all these forums now thinking about measurement. But I worked with New York State on the ... improvement stuff, and I don't care how many measures

people looked at with ..., people didn't know how to approach the improvement of their outcome. What do people do?

We don't want everybody struggling over the same set of issues. So I think if we can keep the selection set small and keep it categorized. What will evolve from that is the dialogue that people can have because there'll be some commonality of interest over a small set of issues so that people can learn how you work with colleagues, how associations across the country helped their providers improve their measures around these things. There's more likely to be more dialog and improvement around a smaller set of measures. If we keep it large, people are going to be all over the place, and there won't be any real movement, I think, around getting people to learn how to improve the measures. Ultimately, that's what we're looking for. We're looking for improvement, not just spitting out a report about how people are doing today.

**Peter Basch – MedStar Health – Medical Director**

Neil, it's Peter. I love what you said, and I think the other option that I was going to introduce, after I threw the Molotov cocktail into this meeting about half an hour ago, was one option could be not just to eliminate a core but maybe reducing the core. In other words, I don't necessarily know that we shouldn't consider the conceptual framework of the core as something where we're looking at a couple of national health priorities that if we all focused on, we might be able to actually move the needle. So I like what you said, Neil, about it not being just about producing lots of data. We could do that, but being able to look—I think in relatively short order—that if we focus on something and think not just about the data but how it got there, wasn't necessary in patient engagement, provider workflow change, change care models, and so forth to move the needle. My hope is that in a short period of time, we could actually see a number that we know and trust, and see that number improve.

So for example, if years ago the March of Dimes had decided to work on every disease in America and make it better, it would get nowhere. If we focus—and I'm not necessarily saying that this is the focus—but if we said that core is in line with the First Lady's objective on—I know ... childhood obesity—but let's say was beginning to get her arms around the obesity epidemic in this country. One could make a case for that's a core that most doctors (not all but most) and most patients could say is relevant. Maybe if that was adopted not just as a measure but as a QI strategy, might be able to get somewhere. Or if we can't do that, then I would say I agree with Neil. Let's come up with enough measures—not necessarily more, it could be less—but that are relevant to every doctors practice to at least get people focusing on quality measurement as a piece of the QI cycle.

**Neil Calman – Institute for Family Health – President & Cofounder**

Let me just jump in. I'm not suggesting that the core be something that everybody can engage. I'm suggesting that we have a set so that people can find relevant things in it to their specialty. I don't care what we do, the oncologists in America are not going to start focusing on cardiovascular disease. We have to be able to get the oncologists talking about something and working as an organization about something that's relevant to the improvement of care in their specialty. We're not going to turn elephants into giraffes here.

**Peter Basch – MedStar Health – Medical Director**

Neil, do think that maybe aligning this ....

**Neil Calman – Institute for Family Health – President & Cofounder**

So I think by saying the categories, we're interested in family engagement. We're interested in patient safety, and we need to try to think of a set of measures within that where every specialty can find something in those categories that's relevant to them and begin working on those issues so that we actually find out two years from now that there's improvement in those measures because people are working on them. They're relevant to what they currently do. I don't think we can use IT to transform what people are interested in. I think we have to go with the flow a little bit and get people to do a better job at what they currently see their jobs as doing.

I think the other thing is just going to be a flash in the pan. Maybe you'll get them to focus on it for a year or two, but it's not going to transform what the different specialties think of as in their purview or what they need to focus on. I think we should deal with that.

**Peter Basch – MedStar Health – Medical Director**

How about this, Neil. What if we took ...?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

Peter, I want to respond to that there is a core. If we say there isn't, we'll just get laughed out of town in the first place. Every clinician should document for every treatment decision that it's at all relevant for; if the patient's unconscious, it isn't, that the patient was involved in the decision-making. IT can enable that; it can't cause it to happen. It's not clear to me why anyone should be prepared to reimburse for care when that particular criterion wasn't met in terms of care coordination.

Care should not be reimbursed for if the person providing it doesn't communicate it in a useful form to the patient and whoever else is involved in the care, and someone else is almost always involved. And so there are cores. If we haven't defined them well, we need to do it. But to say that we're just interested in patient involvement in decision-making or we're just interested in care coordination will not get us there. What we're saying is that you're not going to get paid if you don't do certain things that area always part of good care.

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

David and Paul, let me see—I can always come back to you Paul—I just want to get everyone trying to focus on there are two questions on the table. One is if there is a core, how to characterize it—and Jim just offered one approach that's a little different than the one we used in stage one. I'd like for people to speak ... if you want to keep the core given the debate we've just heard from a couple of people. The second on is Neil's suggestion that we look at option 3 of the chart of having the menu be organized the thematic areas, the domains, so that each specialty can find themselves within their domains. So those are two questions. Let's start with the core question again. Then, Paul, do you have a comment?

**Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO**

Yes. I'm going to try to build on the comment that Neil and also Karen—because I think there was a lot of wisdom in what Karen said. One, I probably would speak on behalf of option 3, which is much more like Neil was talking about in the sense of trying to make it as relevant as possible so that the professionals are getting out of the program what they need in order to take care of their patients. But I think Karen had an important addition, which is that quality measures are going to come and go, but the data is valuable to everybody—clearly the patients and multiple specialties—regardless of whether they're using it to measure a specific quality measure.

So speaking for option 3, which is making it relevant—the various practices and various perspectives that including the data that you're actually trying to capture. And someone else made the comment that the evolving NQF quality data model is one way of trying to create one place where you have a common definition to these themes.

Tom made an example of the ejection fraction and we talk about what is moderate dysfunction. Well, we don't even actually have a common definition for ejection fraction. Is it the core angio? Is it the echo that determines it? So having precisely-defined data so that multiple parties and multiple perspectives can make use of it is perhaps one of the common objectives of this overall quality measure because I think that quality measures themselves are .... So I'd like to combine those two and maybe that's part of the ... of is there really a core measure, or are there core data?

**Helen Burstin – NQF – Senior VP, Performance Measures**

David, if I could jump in. I just want to make one comment about the data versus measure issue. I agree completely that using the QDM to standardize the data is a critical first step, but I think that one of the other goals here is really getting towards a parsimonious set of measures used across different purposes. So whether that's the ACO regs or whether that's the various CNF regs and meaningful use. But I also

think it's really important to identify the actual measure for the folks out in the real world to reduce the cacophony of having to have this measure for this or this measure for this. That's why I think the standardized data elements here are critical, but I also think that given the cacophony out there and the multiple federal programs, the importance of getting towards parsimonious actual measures is key as well.

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

Yes. And please, as to whether or not you'd like to keep the core, and if so, in what form?

**Sarah Scholle – NCQA – Assistant Vice President, Research**

I think there should be a core because we need it as a focus of quality improvement, and we need to coalesce around some measures that will be relevant in different programs. I like the idea of trying to expand it along the different domains in option 3 on the document that was shared. I think the idea about the data elements being critical to creating the measure and being able to update the measure—I think that if we just talk about data without talking about how it's being used in a quality measure, it will have less salience to people.

**Peter Basch – MedStar Health – Medical Director**

David, it's Peter. I like option 3 if we're choosing one—or just to change the term 'enlarge core' to 'modify core' because people read things quickly, and when they see enlarge, they think of expanding as opposed to we're making this choice. The other thing in terms of thinking about parsimony was if we think—and I like the optics of focusing on a core that people outside of policy wonks and medical informaticists can say, "I get it." So I also agree that focusing on something that makes sense is useful in terms of incentivizing and making meaningful, improved care.

But we can also think of alignment. For example, one of my favorite measures is probably the one that's intentionally described as a CDS measure—choose one. Choose one that's relevant to what you do. Well, I think it would make sense if you're choosing a CDS rule, even though there is no requirement in stage one that you actually use it—you just choose one. And that may make sense to make that your core measure. We selected for our practice that our highest focus is on 'x', and we're going to measure it, and we're going to start to implement whatever we need to do, whether it's patient safety, safer medication use, patient engagement, and to improve on that measure. So I would encourage some parsimony there.

**Jacob Reider – Allscripts – Chief Medical Informatics Officer**

I think I'm in favor of what Peter just described, or maybe it's a hybrid of what Neil described earlier, which is really no core, but you have to do something, and the menu is expanded. So it's option 3 prime, perhaps.

**Neil Calman – Institute for Family Health – President & Cofounder**

What I was suggesting is that you have to do something in each of the domain areas that we've called out, and I think what we'll see emerging from that with the people by specialty starting to think about what makes sense because ultimately they're going to need improved care. They're only going to be able to do that through some sort of collaborative understanding and work on that quality measure. They're not going to be able to sit in their little office and figure out how to improve this measure in any kind of significant way. That's been our experience across a number of different areas. So I think that we should try to get people to focus in each of the domain areas though.

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

Can I just ask everybody to just be as specific as we can about—in the option 3 that several people have expressed interest in, are you envisioning that option still retaining the current very parsimonious core for everybody. Then using the structured menu for the various specialty, preservation of the different domains, or are you saying there is effectively no core. There are not three or five measures that every single EP provides data on, but instead, there is only the categories within which we pick some number of measures within each category?

**Eva Powell – National Partnership for Women & Families – Director IT**

I would say that I also prefer option 3. And I guess the way I'm thinking about it now is that my thought on core is like Neil said, the core are really the domains, and then from those domains have under each one a fairly parsimonious three to five measures that people can choose from. That way, people can very clearly see themselves in the measurement strategy for this.

The thing that worries me the most about all of what we're doing, whether it be meaningful use or national quality strategy is that the little doc in rural America is not going to know anything about any of this stuff and is going to perceive this as another government to do crazy stuff that has no meaning to them. I think this is a great way to get real world folks to really see themselves in what this national quality strategy is. I think that's the only way we're going to be successful achieving it.

I also think that as we go through this process, and after a few years of having people report on these core domains on a limited set of measures, we'll get enough data such that we can have comparison nationwide. We'll have what we need for a national quality dashboard, but I think what we'll see emerge are various core measures that rise above the fray, that maybe then could be turned into what we were originally envisioning as a core set.

A great example I think, I was talking to a friend the other night, and her dentist routinely takes her blood pressure. Why would a dentist take blood pressure? But hers does every single time, and it's an opportunity for conversation between the two of them about things that really matter to individual patients. So I think this can evolve into an opportunity for patient engagement as well. We can't perceive exactly how any of those things can happen, so I don't think we need to go there out the gate, but the point is that these five dimensions make sense no matter who you're talking to if they're explained simply. And helping people see themselves in that is ...

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

Is there anybody that wants to speak in defense of keeping the core as it is in stage one?

**Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice**

I'm the little doc out in rural America, and I'll tell you that I think there are some certain national strategies that we should stick to—some of what Jim has talked about—with making sure we know what the patient is and what they're taking, etc. Also, priorities like Eva mentioned about blood pressures and things like that. I think if we allow people to choose too many things, this whole process will suffer from diffusion.

**Peter Basch – MedStar Health – Medical Director**

So, Tripp, would you argue in favor of the three core measures that exist right now?

**Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice**

I think as it's presented, it kind of fits. I think we're all looking at the same thing and agreeing on the same thing from different perspectives. I think physicians out there—speaking about private physicians who may not be captured in a large health system like Peter's, really want to improve care, they just don't want to do it so much so that their head hurts at the end of the day. And option 3, as long as it's—we've used the word parsimonious—is helpful. Then allowing specialties to choose different things in the domain, making sure they know what's important among those things. In terms of national healthcare strategy, I think that'll make a big difference, like the blood pressure in the dentist example.

**Sarah Scholle – NCQA – Assistant Vice President, Research**

I think there is value in—I like the idea of option 3, but I think if stage one is saying that these three measures, everybody reports them, I think there's value in continuing those. And hopefully we could say that if three fit in one of these domains that we're interested in and just continue that. But then as we expand and use the domain option

**Floyd "Tripp" Bradd – Skyline Family Practice – Family Practice**

I think everyone would agree that patient safety is important, and that should happen across every practice in America. And engagement of the family and patient is important in care coordination. All

those things are very important. So we have to do those things if we're going to make a difference. And I think, as Neil mentioned, we have to engage the doctors in a parsimonious way—to use the verbiage that's been ballied about.

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

So one hybrid way to think about this would be to go to option three and not actually have a core of three, or whatever number of measures, but to have those current core measures here in every specialties menu. And with an asterisk, or in bold, or however you want to symbolize it, of saying this is in effect the default measure in this category, which is consistent with what was in the core, so that areas like blood pressure control are given visibility across all the specialties that are offer options for everybody. But that's an option. I think I want to keep going around. We've only had one or two people speak in favor of keeping the core as it appeared in stage one. Let me see if anybody else wants to advocate that we came ....

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

David, just for clarity, I wasn't arguing for keeping it as it is in stage one—just keeping a real core.

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

Jim, just to go further with that, if you were going to keep a real core but go in the direction that you had suggested earlier about some of the competencies. I guess that as Eva just pointed out, the boundary between the clinical quality measure structures and the use-functional criteria structures and some of the ones I heard you mention could be put in either category. Some of the expectations of proper care management—think that they're measuring an impact on HB A1c or some other clinical indicator. What would you suggest in your mind now might be the composition of a core that you would keep?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

Well, I think that some would have clinical content—document and take account of the patient's problem list of med list or allergies or significant medical history—those sorts of things. Then the other would be the domains. Take care coordination for example, I think we would do better with a single measure of care coordination like you communicate the information in a form usable by the patient and electronically to other clinicians caring for the patient—something like that for those domains. You can imagine the same thing for shared decision making. I'm having trouble actually—when you think of care coordination, I guess we could have three different measures of care coordination, but I'm not sure what the point would be.

**Peter Basch – MedStar Health – Medical Director**

Unfortunately, I have to run to another meeting now, but I like the way that the conversation is shaping up. David, I like the way you framed option 3 as it's being modified and just thinking about required choices from menus within certain domains. To Jim's point about problem meds and allergies, I don't know if you're suggesting, Jim, that those be moved from the foundational measures into a core quality measure set. Or you're just making a statement, which is obvious to all of us on the call that you can't begin to talk about quality and safety unless you know who the patient is and what problems they have and what meds they're on and ....

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

Yes, that's all. Part of my point is we've got foundational core, alternative core, and menu. It represents and exacerbates the confusion about what's going on... foundation or foundation in the core or whatever.

**Peter Basch – MedStar Health – Medical Director**

No, I think it's a great point, and early on in trying to message meaningful use to our providers. I actually recategorized measures in terms of knowing who the patient is and key clinical indicators, using medication safely and so forth. Then Farzad gave a talk to a meeting I was in last week where he actually used another model, which is let's assume that you were focusing on caring for patients with this process, and then pulling in different pieces of measures that make sense.

So this is why I was arguing—some of this confusion was people look at this long laundry list of how does this make sense in terms of improving care, I would begin to call out—as I think you are doing, Jim—that a lot of these tie together in terms of advancing a quality agenda.

I would include in what might look like a separate measure, adopting a clinical ... rule or use of reminders. We could come up with another way of packaging them around your choice of—it's almost like we chose foundational measures and then, "Oh, by the way, there's also these quality measures you have to report on." If you start with a quality measures are what you're trying to achieve, then a lot of the other measures actually very neatly fall into place. You can ask docs, even in the solo practice out in the sticks there, Tripp, "How could you do this if you weren't doing these other things? I think it makes a more coherent picture. And I apologize I have to run. Thanks everyone.

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

Thanks, Peter. Let me see if we have gone as far as we can get at the moment without another level of specificity that we can't really do by phone. I've heard some agreement around option 3. I've heard a couple of different ways of articulating what the core becomes as a ... structure, or does it also have some specific, generalized content. My hope is that Tom and Lanre got enough got enough out of this to come back to us with two options of ways that Jim would help us populate. One of the options to at least get so that we could take a look at something that actually does have at least a straw man measure of allocation that would help us see if we took option 3 and played it out in a couple of flavors that we discussed, what would that really look like?

**Tom Tsang – ONC – Medical Director**

David, I just want to ask Neil for some clarity. Neil, how would you put the specialty focus measures, like the clinical content measures for example, that we had that was part of the set of 38 from stage one. So things like the seven or eight diabetes measures, or the seven or eight cardiovascular measures, what domain would you put those specialty focus measures, Neil?

**Neil Calman – Institute for Family Health – President & Cofounder**

I'm not sure. I think ....

**Tom Tsang – ONC – Medical Director**

I know what everyone is talking about in terms of the more parsimonious measures on patient safety and patient engagement, and even when we talk about care coordination and closing the referral measure, that's very, very generic, and that's certainly across the board. I think there's a case to be made in looking at some of the clinical content stuff. So I guess I'm hearing what the group is saying, but I also want to see how this can be operationalized and implemented.

**Neil Calman – Institute for Family Health – President & Cofounder**

I guess my point was the people reporting on that should be people who assume some responsibility for improving in those areas. So if you're taking care of diabetics, then it makes sense to be able to select some of those measures. But if you're not, then it doesn't. And just having people ask or check on the diabetics so that they can report on their A1c or check on their blood pressure so they can report on it doesn't get us to where we're trying to be, which is to have the measures stimulate improvement.

**Tom Tsang – ONC – Medical Director**

So you're really talking about a downstream action, which is perhaps linking CDS to a measure?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

I think what Neil is saying, everybody on the call agrees with. It would be stupid to have dermatologists be responsible for managing hemoglobin A1c, but that's because the measure is a very low level measure—three or four levels down—and a measure at that level could almost always be guaranteed not to be foundational core or part of good care wherever you are.

**Jacob Reider – Allscripts – Chief Medical Informatics Officer**

I'm going to beat my same drum again. The measure is core to the patient. If the patient is a diabetic ....

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

Yes, but that's not what we're talking about core, I don't think. Well, maybe we ought to define that.

**Jacob Reider – Allscripts – Chief Medical Informatics Officer**

Yes, thanks. I'm not disagreeing with you. I'm just sort of reminding all of us that someone needs to be watching that patient's A1c, right?

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

Oh, absolutely. There's hundreds of things that we regarded as absolutely our bound and duty to manage and fix, but it's probably worth asking, David, does core mean that it's foundational, that it's a characteristic of almost all good care, or does it mean something else. Does it just mean it's important to the patient, because those are two totally different things.

**Neil Calman – Institute for Family Health – President & Cofounder**

We're not going to get providers to buy into this because every provider would agree that somebody's diabetes should be managed. But when you put the burden on the provider to say, "We want you to report on their diabetic control," that doesn't make any sense if they're ...

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

Yes, but what I'm saying is that I think everybody on this call agrees with you. I think that's a given. That would be just dumb.

**Neil Calman – Institute for Family Health – President & Cofounder**

Then I'm not clear on what your question is.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

The question is does core mean that it's a characteristic of good care almost regardless of the patient or the caregiver.

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

The clinical setting.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

Yes, or is it something that's important to this individual patient, which is a much larger set of things. And many of them, by the nature of the thing, would be very context-specific and sometimes almost unique—two different things. And the question is, "What are we talking about?"

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

I think we shouldn't presume that we're trying to boil the ocean with our particular program. There are many other programs that assess quality from different settings and intentions. We are charged with seeing whether the introduction of health IT is adding to the ability of providers to improve their patient's healthcare, so we can systematically detect improvements in care that are hopefully associated with this new platform.

I think the core is then meant to be an elegant way to permit virtually all providers to address issues of national consequence and show that the adoption of this technology and the expenditure of public funds is leading to measureable improvements in health. That's very operational, and obviously as we get down to reality across a very broad program ... we've seen over the last year and a half.

I think what I'd like to do is take this conversation—I know Tom you've pressed your desire for help in operationalizing it, and I'm sure a number of us will do that. Hopefully we can go to Paul, Neil, and others will help us, Jim, think about how to do it. But I'd like to see us come back for our next meeting with this group with a couple closures to prepare that are pretty granular, and that'll give us a way of seeing if there's a way that we can take off and try to make it viable. That's the ... if there's any dissent that that's our next step.

I would say let's turn our attention, at least for a couple minutes to the two other topics we had today. One was the May 19 hearing. And, Jim, I don't know if you wanted to say a word about what the intention of that event was or you just wanted me to give a quick capsule.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

Sure. I'm sorry. I was hearing airport noise, so I'm not sure I heard you entirely.

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

Sorry.

**Jim Walker – Geisinger Health Systems – Chief Health Information Officer**

So the agenda is to hear from a wide group of stakeholders with a particular emphasis on small organizations, clinics, and hospitals on the practical complexities that people have encountered implementing meaningful use stage one with a view to taking that very early. What will obviously be exploratory, suggestive, and tentative sorts of information, but using that in a timely way because we're just under time pressure to inform the way we finalize the measures for meaningful use too, and partly how we stratify measures between meaningful use stage two and meaningful use stage three.

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

And so if everyone ... May 19<sup>th</sup> in Washington, you're all welcome to come and help grill the—there'll be three panels: one from the care providers, one from the technology and management expertise world, and a third from consumer patient pairs. We do have a set of questions that we intend to ask them to address either in writing or in their short verbal comments. Then, of course, all of us will have the chance to drill down in the panel discussion.

Tom, is there anything else at this stage that you'd like to get form this group in terms of guidance for the May 19<sup>th</sup> meeting?

**Tom Tsang – ONC – Medical Director**

We have a list of draft questions that people have contributed, so we can send that around to this group, and certainly if folks want to have further questions that they want to submit, then we'll be happy to put that in the list and share that with everyone.

**Floyd “Tripp” Bradd – Skyline Family Practice – Family Practice**

Tom, this is Tripp, when will we be getting the written testimonies from all the panelists? I think the 13<sup>th</sup> is the deadline. Would it be May 16 or 17?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

What I typically do is I'll start sending them out as I get them.

**Tom Tsang – ONC – Medical Director**

David, one more thing is that the two quality workgroups from both the Standards Committee and the Policy Committee would be having a joint discussion after the testimony as well.

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

Thank you for reminding me about that. In the morning will be the panels, and in the afternoon we will have a joint meeting of the standards clinical quality committee and our clinical quality committee to make sure we're all synced up. And hopefully some of the results of today's discussion could inform that as well as we think about what the standards associated with reporting a quality measurement enterprise.

So I hope as many of you as possible will be able to come on the 19<sup>th</sup> and be part of both the conversation in the morning and the meeting in the afternoon.

**Tom Tsang – ONC – Medical Director**

And that would be a really great discussion, and I look forward to folks when they brought up some of the methodological challenges of some of the novel measures that we could actually get some cross fertilization of ideas between the two groups.

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

And that's actually our next topic today. But before I do that, let me just confirm that Judy or ..., would you send out the current draft for the May 19<sup>th</sup> questions to this whole group?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Yes, I will. I'll send it to the other ones as well.

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

Alright. Thanks Judy. Okay. So the last item on today's agenda before we take any public comment was an update on the methodology issues that have been bubbling with us for six or eight months. And Tom, do you just want to mention where we're at with that methodology work?

**Tom Tsang – ONC – Medical Director**

Well, we wanted the clinical quality work that Jim Walker is chairing to tackle some of these methodological challenges. I think what we want is actually some of the members from the tiger teams to resurface some of the issues during that joint meeting so that the other group members can actually understand what some of the issues are, specifically related to patient reporting outcome, the longitudinal measure issue/delta issue. Then thirdly, some of the measures that require computational algorithms overlaid on top of EHRs, and I believe the fourth issue is measures that span across settings here.

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

So we had talked about whether it would be helpful to have some short discussion papers—I don't know what you call them—statements of the problem that would begin to get everybody a common vocabulary about what the challenges or major ways of addressing those challenges might be in each of the areas Tom just listed. Rather than having an open ended conversation about each of these topics, begin to organize our thinking about that, and that might be something that we would take on this summer if we could identify some people to help us draft short reviews of those problem areas.

Part of what I think will happen is what you're still intending to get them contract help to address the measure development pipeline that we've all worked on last fall—and I think that process is still in place. Hopefully by the end of 2011, we'll come back with proposed new measures that address the measure concepts that we all worked up in the fall. And those will probably invoke these same methodological questions that Tom just listed. So somewhere between now and the end of the year, I think part of our job is to advance our thinking about those methodology problems and work with the people developing measures in these new areas like longitudinal and care coordination to improve the cross-cutting methodology of solutions.

Anything further on that, Tom, at this point?

**Tom Tsang – ONC – Medical Director**

No. You summed it up pretty well.

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

So let me ask if anyone on the committee, given today's discussion, has any last words or thoughts before we take public comment? Well, we made some very good progress today. Judy, let's see if we can get any questions or comments from the public.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Of course. Operator, can you check and see if anybody wishes to make a comment?

**Operator**

We do not have any comments at this time.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Okay. Thank you, David. Thank you everybody.

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

Thanks everyone.