

Quality Measures Workgroup
Final Transcript
March 2, 2012

Presentation

Mary Jo Deering – ONC – Senior Policy Advisor

Good morning. This is Mary Jo Deering in the Office of the National Coordinator for Health IT, and this is a meeting of the Health IT Policy Committee's Quality Measures Workgroup. I'll begin by taking the roll.

David Lansky?

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

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Peter Basch? Christine Bechtel? Tripp Bradd?

Tripp Bradd – Skyline Family Practice, VA

Here.

Mary Jo Deering - ONC – Senior Policy Advisor

Russ Branzell?

Russ Branzell – Poudre Valley Health System – CIO

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Helen Burstin? Neil Calman? Carol Diamond? Tim Ferris? Patrick Gordon? David Kendrick? Charles Kennedy? Karen Kmetik? Rob Kocher? Norma Lang? Marc Overhage? Laura Petersen?

Laura Petersen – Baylor College Medicine/VA – Chief, Health Services Research

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Jacob—oh, Jacob. That's right. Jacob's— Sarah Scholle?

Sarah Scholle – NCQA – Assistant Vice President, Research

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Cary Sennett? Jesse Singer? Paul Tang? Joachim Roski?

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Yes.

Mary Jo Deering – ONC – Senior Policy Advisor

Jim Walker? Paul Wallace?

Paul Wallace – Kaiser Permanente – Medical Director

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Excellent. And I have missed any work group members?

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Marc Overhage just

Mary Jo Deering – ONC – Senior Policy Advisor

Oh, good. Thanks, Marc.

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

Eva Powell.

Mark Weiner

Mark Weiner as well.

Mary Jo Deering – ONC – Senior Policy Advisor

Okay. Back to you, David.

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

Thanks, Mary Jo. Thank you all for joining today. We didn't get our materials very early for this call, I'm sorry to say, but I hope everyone has been spending their leisure time this week working through the NPRM and in some subliminal way getting ready for this conversation.

I think the general notion is we have the next month or so to digest the proposed Stage 2 quality measures and decide whether we have some comments we would like to relay, as a group, to the Health IT Policy Committee, which as I understand it, Mary Jo or Josh can correct me, at the early April meeting, April 2nd, April 4th—something like that—would be looking to get some input from the various work groups about any issues concerning the ... wanting to be rendered for the NPRM.

Josh Seidman – ONC

Yes. That's right. Basically want to get a first set of draft recommendations for discussion by the Policy Committee.

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

So that means we've got essentially a month from today to work through any directions we want to take as a group. Obviously, individually our organizations may have other comments they make, but this would be our channel to relay them through the Policy Committee, which would then, in turn, make a comment letter—supply a comment letter to CMS and ONC.

So our charge today, I think, is just to start by taking our own pulse, see how we're feeling, see which categories of concerns or issues we may want to spend more time drilling into, and then think about a work plan over the next three to four weeks to come to any more formal consensus we're able to come to. So that's the rough intention. We also, today, want to take a minute and catch up on the adverse drug event measure that we've talked about at a couple of previous calls and Lauren will catch us up on that, and we will have an opportunity for public comment.

But before we go further, I think Josh would like to catch us up on the staffing support we're now getting from ONC, and I just want to, first, thank Josh and all the staff for having done such a huge amount of work to bring the quality measures portfolio as far along as it's come in the last couple years. I think the NPRM reveals that our work has had some impact and certainly the staff has done a tremendous job getting it to this point, so thank you, Josh, and everyone—and let me turn it over to you.

Josh Seidman – ONC

Thanks, David. Well, the thanks really goes to you, David, and the whole work group who really has helped to drive this agenda forward through this great public process, so I really appreciate that. I just want to let people know that we have a number of new staff that have joined over the last few months, but I kind of want to just make sure people knew who was here. So I was just going to ask each of them just

to give 30 seconds on who they are, what they're doing, and where they come from. So first, Kevin Larson is our new Medical Director of Meaningful Use. Kevin? Kevin, are you there?

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Sorry. We had mute on. I was just finding the un-mute button. I'm Kevin Larson; I'm a physician—a general internist by training, and I've most recently come from Hennepin County Medical Center in Minneapolis where I was the Chief Medical Information Officer and Associate Medical Director at the hospital. I have a background in health services research, have worked in quality improvement—both on the inpatient side as well as in ACOs and in patient-centered medical homes, and have led an informatics team at Hennepin County for quite awhile.

Josh Seidman – ONC

Great. Thanks, Kevin. Next I'll ask Jesse James, who is a Senior Medical Officer in the Meaningful Use Team.

Jesse James

Thanks, Josh. My name is Jesse James. My background is I'm an internist and preventionist. I previously worked at MedAssurant as the Director of Product Innovation and Associate Medical Director, where my work was primarily on a predictive analytic product for quality improvement. Previous to that I worked at the hospital in patient-centered medical home level on quality improvement at the University of North Carolina, Chapel Hill. Thanks.

Josh Seidman – ONC

Then Lauren Richie, who most of you have been introduced to before but just quickly—Loren, go ahead.

Lauren Richie

Hi, everyone; Lauren Richie here. I am the lead on the Clinical Quality Measure Development for measures intended for Meaningful Use Stage 2 and 3.

Josh Seidman – ONC

Then Anca Tabakova who is a Health Policy Fellow; Anca, are you there?

M

I don't think that Anca is on the call.

Josh Seidman – ONC

She may have had a conflict. She is a Health Policy fellow. She is also a physician who is working with us for this year.

So with that, thanks very much and David, turn it back to you.

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

Thank you, Josh, and welcome all of the staff, folks, to our team, and thank you for the work you've done and I'm sure the work you will be doing. So with that, I think what we'll dig into now is the NPRM itself. Josh and I compared some notes and put together this very quick outline that we sent off yesterday, which is not anything more than our own, I think, fairly reactive way of capturing some of the issues that have surfaces for our initial reading. This may not even scratch the surface of other things on your mind, so this is, by no means, meant to be exclusive or inclusive.

But, nonetheless, we flushed out a few categories of topics. I thought we might want to start with just some high level reflections, reactions, kind of taking our own level set on where we want to see the Stage 2 portfolio of quality measures come out at a strategic and philosophical and policy level, so we understand what we're trying to achieve with this particular strategy, and what our voice is going to be with regard to that.

And then digging a little bit into the EP proposed CQMs under number two of our outline, talk some about the optionality proposals that have been made, something about the size and structure of the approach and the reporting options that have been brought forward. Similar conversation—a little bit less complex but a similar set of topics for the hospital proposal. And then we can discuss whether we want to, as a group, weigh in on the individual measure proposals, how they're categorized, what's in the list. CMS asked for some input on the prioritization, saying they don't necessarily want to have this full roster of measures in the final rule so we may just want to talk, without doing it in detail today—do we want, as a group, to respond to the actual roster of measures or not during the comment period.

So those are the major topics that have surfaced in our preliminary review, and of course, please add to this list if you think we're missing some important topics. I'm sure there's more in the rule that we could be talking about.

But before we do that, let's just go around the table and in fact on my first, number one section here—overall policy expectations, I'm just going to make a couple comments and then just turn it out, open for everyone to react. I have not done this systematically, but it would be worthwhile since all of us put a lot of effort into the Tiger Team work in late 2010, and then leading up to ultimately the Policy Committee recommendation letter last summer, it would be worth at some point, maybe this next couple weeks, to go back to those Tiger Team recommendation letters, both their prefaces which describe some of the expectations those teams had in the various areas such as care coordination, patient engagement, and so on, and then test whether the proposal for Stage 2 is sufficiently advancing the directions or if there are some aspects or improvements that we might want to suggest to maximize the ability to achieve the goals we talked about a year ago.

You will see that CMS published some criteria that they were considering in finalizing this rule—I see here, pages 169 to 173 of the published NPRM. So we may want to look at our own suggestions as to important values or expectations and how they compare to what CMS has published and consider some high-level thoughts on that score.

Similarly, under B here I think we go back and forth as a group on what we think the purpose of the quality measures is. I think this will bear upon where we come out on the 1a versus 1b discussion, that is—do we want to have meaningful users absolutely drawing from measures within each of the six clusters of measures and specific to their practice area, or do we want to support the advancement of a core set of measures that is applicable to the vast majority of providers, and what do we the role of this program is in driving the quality measurement agenda forward, knowing that other programs also will be calling for their own quality measures built off of this platform as well.

The third issue, C, here at the high level—just noting that we've talked about a number of broad, strategic concerns in the evolution of the program, and we may want to talk about whether the proposal, as we see it now from CMS, does or doesn't sufficiently advance these strategic directions that have been important to us. And those include the issue of having a flexible reporting platform versus hard wiring measures into the EHR product, the ability to capture data from multiple sources including claims, multiple providers, from patients and families and mobile devices and so on. And then we've consistently talked about shifting the measurement strategy toward more outcome-based measures, and we fell like this roster of measures does that in a way we like.

So those are some of the things that I think surfaced as I read through this. Let me pause there, and I think now is a good time just to go around the table before we get into some of the nuts and bolts of the proposal to get people to react. In general, do you think this rule is doing what we hoped it would? Or are there areas you'd like to see us make some broad comments? Or philosophically, how do you think it's playing out? Let me just pause there and ask for people to reflect a little bit.

This is like homework. Maybe I should ask if anybody read the book, assignment.

Russ Branzell – Poudre Valley Health System – CIO

I'll comment because I've been on two or three national calls this week with individuals as we've tried to go through and specifically talk about the measure side of this as well. I think we're going to get a lot of feedback, period, just because of—just the nature of the difficulty of the measures areas.

Overall I think some of the feedback has been positive. It's headed in the right direction. I think there's still going to be, once again, a flood of feedback that we will receive relative to the overall NPRM. And part of it's just going to be everyone being at different places at different times. My personal belief is I think we hit the sweet spot in the middle, but with hitting anything in the middle, with everything that was being done—whether it was feedback from the Tiger Teams or anything, that means there's still going to be some standard deviations of people's expectations on either side of that middle, and so I think we just need to be prepared to look at that from an overall perspective of the measures.

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

Yes. So do you sense from those other discussions that the users who are moving relatively rapidly are feeling more comfortable with this proposal and those who are still wrestling with Stage 1 feel like it's daunting?

Russ Branzell – Poudre Valley Health System – CIO

I think there's two factors with that. One, I think we've now—just the natural momentum of working on these, working on measures environment will actually work well. The other part of this is there seems to be a sense, and in my personal belief, again, it's very accurate that there's a much greater willingness and openness to work through a discussion process of what these measures mean, how they're interpreted, what the exclusions are than in previous cases, especially in Meaningful Use Stage 1 where we were in a new period of discovery of how this would all work. And so with Dr. Mostashari and the entire ONC's overt efforts at HIMs last week of saying, "I really want your input in this process" – I think are less defensive than they've been in the past.

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

Oh, good. Good. Other general reactions to the proposal? Particularly whether it fulfills things that this workgroup has been looking for?

Tripp Bradd – Skyline Family Practice, VA

It's kind of representing the doc out in the woods perspective. Part of the challenge is, I think, with a lot of small practices have been, you know they're still wrestling with Meaningful Use 1 and this NPRM is just way over the top for them. And the first brush responses from a lot of people out there on LISTSERVs that I've been on, I've been ducking effectively but I think as long as we keep the smaller folks who don't have large IT staff and infrastructures to help meet these requirements—if we keep that in mind I think we'll move forward in a positive way for the smaller practices.

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

Well, I'm just now kind of thinking through this but given that what we heard at some of the hearings back in October was that this is absolutely the—so far, the kind of downfall of meaningful use, that this is really a tough spot where things aren't working like we want them to from the technology itself. It may be beneficial to focus on a smaller set of measures from the vendor perspective that we need the technology to be able to enable and make sure we get that right, and ... of doing—begin getting the data coming in, and then start to expand. I just worry if we put out lots of measures with the intent of having something for everyone absolutely then that's going to create even more of an issue on the vendor end. Such that we're going to just have the same problems at Stage 2 that we've had in Stage 1.

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

Have any of you talked with vendors about implementation of views they have of the proposed rule in terms of the numbers of measures or the types of measures being more or less challenging?

Marc Overhage – Siemens – CMIO, Health Services Business Unit

I can comment a little bit from that perspective in that I think that many vendors have—and this is part of the previous discussion—many vendors have hard-coated, if you will, the phase 1 quality measures and

so ... that these two quality measures is again going to be challenging unless they make the switch to a model that is more about quality measure engine, which I think several of them are looking at but I don't think anybody has done yet today.

One of the related things is when you look at the certification criteria there are some questions—and I know a number of the vendors will be commenting on this—about how the certification process would work in a world where you could essentially just load a quality measure definition into an engine and have it run. There seems to be a little bit of—conflict may be too strong a word, but not clear that the certification approach and the notion of a configurable quality measurement engine are completely aligned in the two documents.

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

Interesting. Josh, do you have any reactions to that feedback? Are you hearing the same question raised between the alignments, between the certification criteria and the meaningful use?

Josh Seidman – ONC

Well it's obviously something that we're still trying to balance. We actually have been working hard to try to improve the coordination between those two things, and I think we are making progress but it remains something that requires vigilance.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

And don't get me wrong—every person I have ever talked to since the documents have come out have said, "These are wonderful." These are some of the best proposed rules they've ever seen. I hope the team—ONC recognizes and CMS recognizes that people do appreciate the overall clarity and focus of these documents. You know, these are complicated things and why these questions are sort of missed but the purpose, I think, of the proposed rule making process.

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

Yes. I mean—absolutely, just to build on that. This is a proposed rule and that's exactly the kind of feedback that we need. And the more specific the feedback can be along those lines, the more helpful it is.

Russ Branzell – Poudre Valley Health System – CIO

I was on a call yesterday with a bunch of the CIO—kind of national CIOs from around the country, and that was actually one of the primary points of—I don't want to say concern but at least points of discussion was the perception, without a lot of specifics, that the certification criteria and the NPRM are not matching up as well as they could.

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

Okay. Anyone else with an overall reaction or anything you're hearing from your colleagues that you want to relay as we begin to dig into some of the detail here about the overall approach to quality measures that's reflected?

Marc Overhage – Siemens – CMIO, Health Services Business Unit

I'd be interested to hear folk's perceptions or comments about—it feels like we have made—we, ONC, CMS, have made progress in alignment of measures across many programs. But just recognizing that where it seems to me, reading through this, that we're sort of 50% of the way there or something. So it's moved in the right direction but we're not done yet. I don't think ... measures across the many programs.

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

Marc, I have a personal lack of comfort or clarity about that issue. I definitely understand from the burden from the user point of view why it's important. But what puzzles me about it is almost by definition the Meaningful Use Program was meant to break away from the pack of existing available measures based on non-EHR sources, and to push toward a new capability in the health system which would address the new policy requirements, including payment model, delivery redesign, so on. So it seems to me that what we would want to achieve with Meaningful Use was to lay out the new capabilities that are built on EHR

as ... technology. And to the extent that they fully align with programs already announced, which almost by definition had to rely upon traditional reporting systems, it wouldn't be doing the job that the stimulus bill was meant to—

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Fair point. What I think many of us hope will happen is that we ... exactly what you said, the burden on the provider of doing both. We've got to reduce the period of time where that burden exists. There just isn't enough bandwidth and providers to do both well. So I think we've got to rapidly get to the—okay, I'm in the alternate world. I've done the work. I can now be reporting in the sort of new world EHR measures. I don't have to keep doing the old one. We can't ask for both.

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

Right. That makes sense. And what I felt in the rule that I would, if I could, if I had a magic wand I would inverse—invert is if you can meet the Meaningful Use criteria then we should give you a pass on other things, like PQRS and—

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Absolutely.

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

Rather than go the other way and say, well you can submit PQRS measures and then you get a pass on Meaningful Use. I'd rather go Other broad comments? And then we'll dig into some of the specific measurement issues.

Russ Branzell – Poudre Valley Health System – CIO

I will throw one out and I think part of this is perceptual and part of it is just a lack of understanding—that with the shifting of Stage 1 and Stage 2 compliance requirements, and the adjustment thereof of the payment adjustment that's in there, and the reporting periods, there is significant confusion about the time periods for reporting of clinical measures and when those windows really start. A perception that we're actually creating a faster timeline of requirements to report, based on a misunderstanding of government fiscal years—and I think there is a lot of people that misunderstand that. Having been at HIMs last week when Dr. Mostashari was explaining this, I think I have a vague understanding of it, and being this close in and still not completely understanding the new requirements, or at least the new expectations of time reporting, I think it will be beneficial for all if that gets more clarified during the process, because it's directly related to the quality measure reporting periods.

Tripp Bradd – Skyline Family Practice, VA

Dave, one other thing, I wanted to reinforce the comment I made earlier about aligning reporting to meld programs together as much as—as you say with the sensitivity of using EHR as the focal point so that—that was a common thread I got from a lot of docs out there, so if we can keep that alignment going it will only make them happy.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

Tripp, I would echo that. I've heard that a lot, that real appreciation for Meaningful Use trying to align with other programs in whatever direction that might go, based on David's comment. One thing that may be helpful is to actually be very explicit about that and maybe offer tables and clarification of what measures meet which specific other programs at the same time, to really reinforce the notion that you can get a twofer, maybe a threefer, if you will, that if you meet Meaningful Use requirements you can get incentives in other ways as well.

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

Josh, is there a crosswalk of that kind that is a reference document that might help us review that issue?

Josh Seidman – ONC

We have been working on various kinds of crosswalk documents, and I think the—probably not exactly what Joachim's suggesting and something that we can certainly work on. Obviously, do something that

would kind of jive within the proposed rule with what our existing regulations that are final, but you've got to be a little careful about how we put that out there, to make sure that we're not creating additional confusion. But certainly the concept is a good one and something that we can work on.

I would also just comment about the comments that were made about the need to work on alignment as well as with the sort of tradeoff of that with trying to break new ground. And I think that's something that we are constantly wrestling with here, and with our colleagues at CMS. We're working together, trying to figure out how to balance those tradeoffs. Certainly, we want there to be as much harmonization and alignment as possible, but absolutely the mandate from both the statute and certainly from you all and the broader Health IT Policy Committee was to make sure that we developed measures that really leveraged a robust electronic information infrastructure, measures that certainly help us to understand whether a true meaningful use of EHRs is going on, and measures that really are e-feasible measures that really can be done efficiently and feasibly with electronic tools.

And so we're really always trying to balance those two things. So, I think the comments are well understood and certainly the tension is something that we're trying to balance.

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

Josh, just a small question about the timeframe issue that someone raised—I know in the introduction to the quality measures section it refers to calendar year—and even on the EPs, calendar year '14-'15. But then obviously in the timing of payments, Stage 2 “is a framework for some users payment for many years to come.” Is an expectation that the content at Stage 2 measures as they come out in the final rule in the next few months, while they would clearly apply to calendar year '14-'15, if I got that right, do they also continue to be the measures that a meaningful user entering Stage 2 in a later year would be reporting, or would those measures themselves be updated periodically?

Josh Seidman – ONC

So it is certainly our intention, and CMS's intention to issue rules—again, two years from now or two years from when the final rules comes out. So, certainly, that's something that can be updated. As you all well know, because you've guided us with some recommendations for measures to work on in Stage 2 and Stage 3, we certainly do intend that there will be new measures that we are just getting started on, that are not going to be ready for Stage 2 that are come of the high-priority measures you've identified that we do hope will be ready for Stage 3. So, it is a measurement set that will continue to evolve over the stages of Meaningful Use.

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

Okay. Thank you. Alright. So let's turn our attention to the next, more specific topic, talking about the eligible professionals clinical quality measure reporting. And on this part of our agenda here, we listed three or four issues that deserve some discussion, and the first one that obviously is important is the optionality. There are two elements under Option 1 and then there's Option 2, and I think the options proposed under Option 1, 1a and 1b, deserve some initial reaction and attention from us and, again, I think the outcome would be, do we want to end up recommending one or the other of these in our formal comments to the policy committee in a couple weeks?

So with that, why don't we just see if people have—I don't mean to ... started by beginning to point down a particular direction, but see if people have thoughts as they've done the review of Option 1a or 1b.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

David, are you pointing to a particular document or slide?

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

No. The document is the attachment, the discussion guide attachment that we sent out yesterday. And I'm on item 2a, where we mention those two approaches.

Floyd Tripp Bradd – Skyline Family Practice, VA

I think the document did explain the pluses and minuses of either one. It seems like the flexibility would be with Option 1a for any provider, and 1b might exclude certain people—for instance, with the pediatric stuff that’s in the Table 6 that you have to abide by if you’re not a pediatrician or a family physician, you know that’s almost an opt-out. That was just the comment I had is that 1a seems to be flexible with the problems associated with lots of other little data points that have to be measured with lots of different doctors, but this is going to be tough either way, I think.

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

So you’re thinking, Tripp, that for Option 1b, the actual list of core measures in Table 6 are—because some of them are population-oriented, whether for children or for elderly—whatever, it ends up really reducing the capability of providers to meaningfully hit 11 measures off that table?

Tripp Bradd – Skyline Family Practice, VA

Yes. Thinking of all the different providers that might be trying to do this, it would be somewhat—it would exclude some of them, and 1a would give them flexibility. I think you mentioned that a lot of other different organizations are going to want to have their own measures considered; 1a would allow that to happen a lot easier than 1b, which would be the specific—you have to have the core measure kind of things.

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

So noting that CMS said they would like to have only one of these options in the final rule, we have the opportunity to put our thumb on the scale to some degree. Any people on the phone feel 1b is a preferable option they would like to see a recommendation end up with 1b? I don’t know if either that was where you were headed with your suggestion of a smaller roster of measures.

Tripp Bradd – Skyline Family Practice, VA

You’re talking to me—I would opt with 1a just to be inclusive of providers, recognizing that 1b would be more parsimonious.

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

Right. Any other reactions on this? Or ways of thinking about it that—Eva and Marc have previously made comments that shed some light on this, both in terms of vendor and implementation issues and focus of the industry and field on success, on successful execution of a smaller number of measures. Does that weigh into this, versus this potentially much larger list that would be on 1a?

Marc Overhage – Siemens – CMIO, Health Services Business Unit

And again, I’m new to the vendor world so still learning, but I think many vendors—you know, when you see that from the vendor perspective, they probably have to implement every potential quality measure that anybody might opt into, so a larger list might seem more daunting. It might also nudge vendors to build more flexible systems for incorporating and testing those, all of the cycle stacked to this whole issue of data capture and testing and implementation that the ... other parts of the rule regarding usability and safety testing. So it’s sort of a mixed bag, I think, from my vendor perspective.

I would say from a provider perspective, I continue to be enthusiastic about trying to help providers have measures that they can actually think are high enough quality and are useful to improving care, instead of just something they’re doing to report. So I think the more focused we can be and be comfortable with, the more likely we are to see them actually use the information and create value for their patients. That’s just an opinion.

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

Well I missed in the opinion—does that take you—I didn’t know where it took you though. Does it take it down the longer list of 125 measures gives people a better chance of finding themselves in the list and finding relevant measures for their own program? Or having a shorter, clearer consensus list of national measures drives everyone’s attention in the same direction?

Marc Overhage – Siemens – CMIO, Health Services Business Unit

I'm leaning a little bit—and again, this is just personal perspective in the latter direction of a narrower list that we can all focus around and learn about. Recognizing though, as I say that, given the diversity of practice that we have across the country and the diversity of patient populations that maybe, as you suggest, that some people aren't going to find themselves in the list as well. And that's a tough tension I know everybody's wrestling with.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

One thing to maybe also consider is the crosswalking issue we discussed earlier, i.e., if you have a longer list, it may not be on other incentive programs lists, so one way to think about is make sure you have on the list those measures that may also be in other programs so you have a way to bundle energy, if you will. And then if somebody decides that they want to do something different, that's when a longer list would come in, if you will.

Russ Branzell – Poudre Valley Health System – CIO

I don't think there's any intention of eliminating either Table 6 or Table 8 but rather the Option 1a and Option 1b is from where you have to do most of the pull, so the previous comment about the effect on the vendor community is true. They're going to have to meet all requirements anyway, and having experienced this through Stage 1, there is a consequence back to both the supporting facilities as well as the eligible providers, in the sense that changes happen to the system, data fields change regardless of whether they're going to use the measure or not. If there's any way to hit the appropriate number and shorten the number, regardless of what we say the requirement is, the better off we are because there is a cascading effect to all involved.

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

Any other either thoughts about or specific votes for 1a versus 1b? Or other ways we should be thinking about it?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim Walker; I'm not sure if it's a vote yet but there's a tendency on vendors' parts, which the Policy Committee is trying to address, to just sort of create inclusions instead of changing their architecture to support this kind of activity. And there is a tendency on the part of providers that is similar, and it seems to me that if 125 were evidence-based, represented significant chunks of the patient population, and had some significant overlap with other measuring regimes, that the 125 would have a useful measuring effect to get everybody to change their systems at a more fundamental level. And I guess the other thing, it would be kind of a built-in roadmap.

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

That's really well said, Jim. It's a good way of summarizing that argument. So let's think a little bit about how, as a committee, if we want to be able to come to some degree of either consensus or strong majority view in the next two, three weeks, how 1a versus 1b—I suspect that both the Policy Committee and CMS would welcome a recommendation from us if we're able to come to one. And we've heard today pretty good arguments on both sides. Go ahead.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

I'm sorry. Finish—I didn't mean to step on your—

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

Well I'm just going to conclude. I think if there could be value in our coming to a recommendation, we have a range of views already on both approaches. We need some process—maybe it's a small group of two or three people to think more hard about whether one or the other, or some hybrid of these, would be the best solution for us to recommend. Go ahead, Marc.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

My sense of the discussion is that all of us agree with both positions and that maybe, as you sort of suggested, maybe the useful thing is to think of—is there some alternative recommendation we could make that would try to acknowledge the strength of both. Maybe that's not possible.

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

Thanks. Marc, were you going to make a comment?

Marc Overhage – Siemens – CMIO, Health Services Business Unit

I was just going to add, of course, I would never disagree with Jim because he's always right, but the other piece of this, I think, as we talk about the implementation and I'm not sure how this is going to evolve, but for many of the previous Stage 1 measures, either the specifications that are evolving that are more structured and computable are obviously helpful in terms of being able to create a platform, as Jim described, or change the architecture to make these things not hard coated, but just a run based on data.

There's another tier though, I think, that if our previous experience over the last years with measures and the inpatient study and others is any guide, there's going to be another tier of knowledge or data that's required around those that specify in more detail than we currently are able to in, say the e-measures format, details of sort of qualifications around the data and so on, that seems to be added to the measures in terms of these or implementation guides and so on, that CMS releases. So I think we are probably going to see another evolution of how these measures are specified, that's going to be necessary in order to achieve the same level of competence that CMS has in current ... to measurements that have enough detail about the data. You know it's not just the drug was mentioned, as the drug was ... or whatever it is. There's another layer of detail I think to come yet.

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

So it's interesting. It suggests that even the engine approach that we talked about should only really be supported when the field is mature enough to know how to build that engine. As you say, there may be some components that are still being understood.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Or it's an evolution. Another way to think about it is, build that engine knowing that there's going to be more, so don't lock it down but learn as we go along.

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

Alright. So let's move on from the Option 1a, 1b discussion unless people have any last words or thoughts or suggestions on how to proceed. I think we'll have to come back to this if we want to find either choosing one or developing an alternative, in the next—that will be a task coming out of this call, I think, to wrestle more with that since there's no clear path as of yet.

So let's talk about the next item on our list here, with just a sheer number of measures. Now we noticed CMS said - here's a list of 125 or so in Table 8, but we would like to reduce that number in the final rule. I don't know—Josh, do you have any sense of what the magnitude of the destination is? How much—is it to be cut by half or just cut by 10% or what they're thinking?

Josh Seidman – ONC

I think it's still an open question.

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

Is there anything more you'd say about what the criteria are that you think we should be bringing to the conversation as we think about size of the list or the types of measures to reconsider?

Josh Seidman – ONC

I actually think—I mean, the approach that you have taken in the past I think is certainly a reasonable approach. I mean, obviously, there's a balancing act between—certainly in Stage 1 there was a concern, a valid concern, that there wasn't broad enough coverage of specialties. I think it's also important to consider in the context of other things in the proposed rule—so for example, the proposed rule where it talks about CDS, consumer decision support, it talks about five CDS rules that are linked to clinical quality measures and so that should—those pieces of the rule should be considered in the discussion of what happens with the actual number of measures.

Tripp Bradd – Skyline Family Practice, VA

Josh, is there thought given to sort of—as I look through, for instance, depression or falls in the elderly, some of those could be, conceivably, although they have separate NQF numbers and measure points, could they be sort of melded together so that we would all of a sudden create a smaller—you know, compress it a little bit? Is that an option that is a consideration?

Josh Seidman – ONC

It might be difficult to reformulate measures at this point.

Tripp Bradd – Skyline Family Practice, VA

Alright. Just a thought. I guess I'm a lumper, so—

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

So if the people on the call have any particular thoughts about either the process by which we might help CMS reduce the length of the list in Table 8 or the criteria we would bring to that task, or whether we should even take it on or just be silent on it and let others speak to it.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Well, as always I think the criterion ought to be quality adjusted life years in the population. It doesn't seem to me that anything else makes nearly as much sense from the patients' or the populations' point of view.

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

Well I don't feel competent to do this, but it seems like another framework is—which of these measures best demonstrate or stress the EHR computational capability or, if you like, or quality improvement feedback capability. So there may be something in the criterion you suggested, Jim, is a high gain on quality gain, but we also want to show that the EHR can measure functional outcomes for knee replacement or whatever it is as a capability.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

And it's a testable hypothesis—I think, that most of the things that would achieve the highest number of quality adjusted life years in the population are things like ACE inhibitors and heart failure—things that have excellent evidence, that are prone to be computable, but that's testable.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

And David, ... disagree a bit with your assertion or maybe I'm not hearing it the way that you're saying it, and that is that I don't give a darn whether the EHR is useful or not. I mean that's a side effect.

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

So we can change meaningful users to something else.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Well no, no. I mean the goal of Meaningful Use is to have a meaningful impact on care. And, you know, I said all along, you know—if it's so nice and ... and people can achieve those benefits, so I'm real reluctant to have us put a criteria, but a good measure is one that is somehow enhanced or better within EHR—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think the measure is that it's feasible in EHR so there's some measures that are vitally important, but would be in any existing or over the horizon EHR be incredibly difficult to do that.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Exactly.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

There's more feasibility then.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Exactly. Don't get me wrong here because I do firmly believe you can't do high quality, efficient, effective care without an EHR, so that's why, I guess, I'm comfortable with the notion that if you focus on the outcomes you want, the EHR will come along.

M

Well I agree. I think it ought to be quality adjusted life years in the population first, and then among those—the first ones should be done—probably makes sense if they're ones that are feasible.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Sure.

Tripp Bradd – Skyline Family Practice, VA

David, one of the ones that stuck out as a HIT-sensitive one would be the measurement using the PHQ-9 for depression. I mean that's just numbers; it's very sensitive. Things like that, which goes to a very feasible measure, as an example, perhaps.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

That's actually a great example because the other dimension that we didn't ... about feasibility in the EHR, I think you have to consider feasibility in the end that we place on the provider. Because that example you used, the PHQ-9 I think is a killer, because as a primary care physician, you know 35% of my patients are depressed, if not more. And if I have to administer an instrument to potentially every patient that walks in the door, or my staff has to, my practice is bankrupt. I can't afford to do that.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think that goes back to evidence. The evidence there—I don't believe there's evidence to screening all your patients would accomplish anything useful. But there probably is evidence that in certain populations post-MI, post-partum, or in patients that you have some reason to suspect that it's important—so I, there I agree I think it's a matter of evidence there.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

There are other feasibility aspects; it's not just feasible in the EHR but feasible in a practice from a—

M

Absolutely.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

And then in EHS, of course, they actually have a ... committee structure that essentially if you say collect a new piece of data which is essentially what we do when we place these quality measures into regulation or into rule, we're essentially requiring that people do that and there's sort of a cumulative burden that needs to be thought about.

Tripp Bradd – Skyline Family Practice, VA

Just to clarify, the particular measure was to that in depressed patients and not your whole population.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Like I said, it's 35%.

Tripp Bradd – Skyline Family Practice, VA

Right. But, the thing is they were looking for a delta change which is even better and so that's—you've got to be specific with what you screen with and for. So it's like what Jim and you have said, it just makes sense to be pointed, but I think it's a good example, actually.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

I like this spread though of coming up with some framing for—and I'm sure CMS and ONC have some version of this as they were thinking about measures and whatnot, that can be used since so many of us have spent so much time thinking about this. It seems like that may be a useful contribution, and maybe all those dimensions are already considered in choosing this list. But the framing seems like the most useful thing we might be able to contribute.

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

So Marc, let me go back to what I was trying to communicate—I may have taken it down the wrong path. Let me test if I can try it again and see if it does or doesn't work. Where I was going was, we know there are a number of other entities who are going to be turning to the EHR as a source of data for measurement, including for payment episode, ACOs, etc. So one of our jobs, I think, at a policy level is to make sure to the extent we can that the certified EHR technology which passes the meaningful use test and gets the incentive money is capable of reporting, to the best extent we can predict it, the types of measures other payment and recognition systems will be looking for.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

David, that's actually a good point. And one question that has arisen for me that has come up around the Meaningful Use Stage 1 measures is that I guess there's a perception that they're rather—if the data that's coming is rather unreliable and wouldn't be robust enough to be used either for public reporting or for, you know, let's say private sector payment incentive programs and so forth. And so, if that was the case, is there any lesson to be learned for Stage 2 about either how to specify the measure or how to provide direction to make the measures as reliable as possible, as quickly as possible? Understanding that it always takes a little while to sort of work the bugs out of the system.

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

That was one of the main points to my earlier comment about focusing on the smaller set, and it sounds like that may not necessarily be a useful way to get at these issues. And I'm not sure the reason for all of that lack of accuracy in the calculation, but it's probably part certification, part—maybe e-measure specification and many things that go beyond the work of the committee, but to the degree that we can address those things in some way—I think that's really important.

Joachim Roski – Engelberg Center for Health Care Reform – Research Director

And the spirit in which I offer that comment is to allow physicians and hospitals and the eligible providers to get twofers as quickly as possible because I think ultimately that will reinforce as well meaningful use.

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

I think that's incredibly important because otherwise what we're doing is asking them to do something that has no value and that is, as we heard in the ... costing them a great deal of time and money. And so I think the value of this whole program really rests on resolving that issue at Stage 2.

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

So we talked a little bit about trying to work toward some agreement on the framework, I think Marc called it, for how the measure should be retained in the final rule. And we talked about two or three criteria that might play into that framework. Any other thoughts about the number of measures or the way we might go about—can I ask people to mute if they're not speaking. We have some background noise. Other thoughts about how we might get to a framework in the next few weeks, building on this conversation, or how we might get to a magic number of measures, how to reduce the total size of this roster in Table 8?

Tripp Bradd – Skyline Family Practice, VA

One of the things I was looking at is there were some that have not been approved by NQF, you know the TBDs out there. Would that be a good way of honing down on things that can be ready for Meaningful Use Stage 2?

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

Josh, do you want to comment on the ones that are not NQF-approved on this list? Or how you guys are looking at them?

Josh Seidman – ONC

Primarily in response to recommendations from this group, there were a series of de novo measures that are being worked on. So we certainly are trying to both forward the development of these electronic measures, and then at the same time we're going to be working on how to get them NQF endorsed. It's something that clearly, by the time they are in use, we would certainly want them to be NQF endorsed. But since they are new measures, they haven't gone through that process yet.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

If I can add to that. It's going to be an interesting timing challenge, you know as NQF is trying very hard to ... to make sure that measures that are endorsed by that body have been tested, which is sort of a cycling back—a little bit of the chicken and the egg problem, cycling back to the issue we were just talking about of feasibility and so on within an EHR framework, that that's actually going to lengthen, I think, the time for NQF endorsement of these measures. So if you sort of march forward to 2014, in terms of timeline, and I'm sure this is part of the reason for the timing ... rule, how much testing and how long will that take as part of this process—because it's probably a year, even in some of the fast- tracked approaches to NQF endorsement, it's actually going to measure tested as endorsed. And still leave time for people to implement.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I haven't—

Marc Overhage – Siemens – CMIO, Health Services Business Unit

Oh, good.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

...so can I make a comment on that? And ... may not agree with my comment but I'll give it to you. My concern is taking endorsed measures that have been tested in other environments may not lead to a measure that provides reliable and valid data. So endorsement may not be a good thing, and while I want these measures endorsed, as Marc said, it will take time to test them against EHRs that actually have the capability presented in the certification rule for 2014. And if that capability is not there you won't be able to test reliability and validity, and if you just take a retooled measure that was tested in another setting, it actually may have less validity than if you took a new measure. So, just something to think about.

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

That's a great point, Floyd. Thanks.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

You said it much better, Floyd. Thank you.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Now I realize we're very interested in the endorsement process, of course, but if you really want a successful measure, it may be more advantageous to look at something really brand new that looks at the EHR environment.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

So maybe the model starts to look more like, hey I'm just turning this out—much like with the SAT they're sort of—there are developmental questions inserted into the SAT or the national boards in order to get these psychometric properties of the answers figured out. Maybe there's a similar model here where there are measures that are sort of tested and validated, and then there's measures during the process that are included, so we know they're not going to be fully validated by the time our reporting of those measures becomes relevant, and then it's just question of how are we using information that's reported.

Tripp Bradd – Skyline Family Practice, VA

So Marc, are you suggesting that you'd throw them out there and see which stand and which fall?

Marc Overhage – Siemens – CMIO, Health Services Business Unit

To a degree. I mean, you'd have to be judicious about how you apportioned those. You know, you couldn't have 80% of them be sort of developmental. But ... would still be how are you going to actually test these things well until you have a platform in which you can test them? So we're a little bit out of sync in the sense that we're in sync by saying, here's the new EHR criteria, and by the way there's a whole set of measures and functionality that go along with that, and that all happens at once. You could make an argument that you need the functionality, you need the further validation of the measures and then the requirement for reporting of those measures.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I would also say there are some good measures that are endorsed that may be on that list but to make the measures valid, need data you may not find in the EHR. That doesn't make the measure non-useful, it just makes it not a meaningful use measure, so that needs to be considered.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

That idea could be made just if we said some of these are rock solid and we may be wrong but we're confident we know how they're going to function in the setting. There are others that we think are developmental. We think the content is right. We think the form is right, but we haven't had time to test them. And we're not going to audit responses on those. And maybe next year or whatever, when we are sure they're rock solid from our test, then they're auditable. So you could make changes in terms of what I think you could probably make changes in terms of what providers are responsible for, and can be held accountable to based on how rock solid the measure is.

Tripp Bradd – Skyline Family Practice, VA

Jim, are you talking from an HIT perspective or just a quality perspective?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I mean for one thing I think we'd say if a measure's developmental then your responses to it, your reporting of it, wouldn't be audited, for an example. Or it would only be audited to test the measure, not to test you and you could not be prosecuted or accused of fraud or refused payment because of your responses on that one. And we might publicize—or we might not—all I'm saying is that there are ways when you're using items whose performance characteristics are not as certain, there are ways to make it fair to the user.

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

Well let's move on to other topics. It sounds like we've got a number of teams we'll have to capture as we go forward and whatever recommendation we make, I appreciate Floyd's clarification about the validation process of the measures to date and going forward.

The next item on the list here today was the distribution in categories and obviously we have, particularly for 1a, the recommendation that users have to pick at least one from each category, and CMS and ONC have tagged every measure for one of the categories—the domains they're called on the table. I did a rough count at some point and there were at least 10 to 15 in every category, and we would probably do some quibbling over whether they're appropriately grouped or labeled, but that's quibbling. Something to think about is another criterion if we do a measures reduction exercise is whether we maintain enough numbers of measures available in each of those six categories so that users have a reasonable choice that is relevant for their practice, but that's just another category.

Josh Seidman – ONC

David, just one note about that. Obviously, there are certainly measures that cover multiple categories. Also, just to keep in mind there obviously are a predominance of measures in the clinical process category, and so in general we try to think about, well how do we ensure coverage of the other categories and so sometimes measures that certainly could be in both were put into the other category. And then I think there is also a question about measures that really are pertinent to multiple categories and therefore ... might help as we think about parsimonious sets of measures.

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

Good. So let me just open up for discussion about this issue of categories and distribution and whether you all feel like the rule is about right in having enough measures in each category and having this choose one approach is the right approach or if you don't. Any thoughts about the categorization model?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It's a question—would there be a problem with saying this measure could be used for either one of these categories?

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

So effectively label it for multiple domains in the table, ultimately?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes. I mean if we really believe they could legitimately be tagged to both, that would give users more reasonable and appropriate flexibility.

Tripp Bradd – Skyline Family Practice, VA

And you'd be able to cut down on the numbers too by doing that, perhaps.

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

Josh, any opinion officially about that idea? Have you already talked about that?

Josh Seidman – ONC

I'm sorry. Say that again?

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

Whether some measures that are relevant to more than one category could be labeled that way and then used to satisfy either bucket, or even maybe reduce the number of reported measures because you're getting a twofer.

Josh Seidman – ONC

We haven't explicitly talked about it, but that was sort of what I was suggesting as something that could be certainly considered.

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

Any other reactions to how the categorization seems to look to you as you go through the table?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I guess my concern, when looking at any of these, until you see how they're retooled and all the detailed attributes that they might require, it's hard to tell what's feasible. I understand each program and all specialties need their own special thing, but I think it might make more sense to be more generic to things that are in any EHR if we can do it. It's just once you get into more specialization, you end up with attributes that may just not be achievable. That's a warning.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I'd just add to that because we're trying to be parsimonious, it seems to me that we would do a better job of creating a set of measures that would really stress all the needed capabilities in any EHR, regardless of specialization, if we stayed more generic and leave the specialization to the—the specialist customers will drive that from their vendors, and their vendors will probably know more about that, and their customers will, than we do. So I think there are a number of reasons that staying with general is a good way to start.

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

So when you say stress the system, Jim, you mean that the capabilities that permit one to produce a certain type of measure or the range of types of measures, we want to have at least an exemplar of that but not necessarily substantiate that capability for every specialty of every population type?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right. Exactly. I think it might be simpler and easier to be sure that we've stressed all of the—can you check an allergy, can you—all the different things we want to make sure that you can do to really enable users to improve patient care.

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

Got it. Okay. Alright. The next topic on here, we're at reporting options, and we mentioned both the PQRS approach and the group reporting option, and that's why I, at least, on the outline here it says page 184 introduces the PQRS Option as Option 2, after we've already discussed 1a and 1b, and so this is an alternative option for Medicare EPs who are both in PQRS and this EHR incentive program as an alternative to what we just discussed. If you submit and report the PQRS measures under the EHR reporting option, you're satisfying meaningful use, as I understand the proposal here. Do people here have support or not support that Option 2, and I assume, Josh, that this is unlike 1a and 1b where they want to end up with only one. The expectation is that this would continue into the final rule as an option for PQRS participants. Is that right?

Josh Seidman – ONC

Right. That's why they were separated out that way.

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

Any people feel any desire to have us comment on this proposal, for Option 2 or propose any changes or—?

Tripp Bradd – Skyline Family Practice, VA

I think it goes back to the alignment kind of thing that a lot of providers would love to see, so—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

If I understand it, it sounds right.

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

Josh, can you update us? When I tried to go back and look at this PQRS EHR reporting option, what I found was a little—wasn't 2014 language, it was sort of 2010 language. Is there a way to characterize what that program will look like in calendar 2014 and '15, so we would know whether we're gaining or not gaining for the meaningful use purposes? You see what I'm getting at? If PQRS was locked in 2010, then this makes a pretty easy pass for somebody to get their meaningful use dollars. It doesn't move the ball very far. ... PQRS itself will be evolving, then maybe this does still achieve the same objectives.

Josh Seidman – ONC

I'd like to check to see if any of my CMS colleagues are on the phone. I don't want to speak for them on this one. I don't know if Patrice or anyone else is on who would like to comment on this. Maybe not.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

David, would it be reasonable to recommend that this would be an appropriate way to go, granted that the PQRS measures at some appropriate pace are retooled so that they have the same operating characteristics as Meaningful Use measures?

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

Yes, I like that idea myself. Other comments about this whole question of—I think we all ... alignment. I'm just raising this issue of whether we're aligning with sort of the past or the future. PQRS has not been a hugely popular program. I don't know what this means in terms of segmenting the meaningful user community and the expectations of the market; I just don't know.

Tripp Bradd – Skyline Family Practice, VA

Could the PQRS thing be melded into the Option 1a thing so that it's just a conceptual way of looking at it, perhaps?

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

That's interesting. Any other strong feelings about Option 2 people want to voice at this point? Or we'll have to do a little bit more exploring of some of these questions. Alright, hearing nothing further, on the group reporting option, anybody have comments on that?

Tripp Bradd – Skyline Family Practice, VA

It's interesting as end-users as I've talked to and heard from that a lot of them have had one person do—effectively a group reporting method in the Meaningful Use one anyway. To formalize it would be, I think, an interesting concept and it's a great one, frankly.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It seems to me that as we're trying to encourage system ...care coordination and patient centeredness, it would be great—certainly there, I'm sure, there are many organization who regarded as a group task to get this done, so that—in our organization we no longer regard it as appropriate for a surgeon to say, "I don't do flu vaccines." Wherever a patient hits the system, there are a set of quality interventions that need to be done, and if this supported that, I think it would be all to the good.

Sarah Scholle – NCQA – Assistant Vice President, Research h

I agree.

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

I'm assuming that since this will be recorded by ... that at whatever point there's physician level recording, then that would be possible even if it's done as a group. Is that correct?

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

That's not how I read it. The language in the first option under the group reporting, I'm on page 214, says the clinical quality measures would represent all EPs within the group, but they must still individually satisfy the objectives and measures for Meaningful Use. So Josh, maybe can clarify if I have this wrong. But the measures, the quality measures that we've been talking about would be at the group level, but the individual capabilities of the EHR under the criteria, the functional criteria, would be by individual users. Is that—?

Josh Seidman – ONC

So this has actually addressed in a different section of the regulations ... reporting of the Meaningful Use measures; there are a few different options that are discussed related to that. The one that is proposed in section—I think it's ... , what's proposed is a batch file reporting where a group would be able to report once but would still need to have individual numerators and denominators for every EP. There are comments sought on other approaches, including a sort of a complete group option that would allow one numerator and one denominator for each measure in the functionality measures. And there's a series of questions, actually, that go along with that. We're seeking comment specifically around that. And if people want more information on that I can forward you the section.

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

Yes, let's do that. Okay, so in light of our time too let's move on to hospitals and see if people—now we're onto Table 9, and you will note that there was an expectation of hospitals—now we have this table with 49 or so measures, and the expectation is that hospitals will report at least 24. And we would, again, have this expectation of reporting from the different categories in the table. Let me just ask if a high level of people had any broad reactions to the structure of this reporting approach, or the specific kinds of measures that are now being put on the inventory? Are people generally endorsing and happy with the hospital measurement reporting approach?

Tripp Bradd – Skyline Family Practice, VA

I don't sit on a quality committee specifically in our system, but I would say that if it's specialty it always has the other quality measure programs that use the same measure, which is column three, I'm sure it'd make a lot of folks happy in the hospital systems to have that kind of twofer approach.

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

Good point. So the alignments goals on the hospital side seems to these farther along—

Russ Branzell – Poudre Valley Health System – CIO

I think there's a general acceptance. I think what we're going to see is the same thing we saw the first time, which is a greater concern or a focused concern on the areas relating to numerator and denominators, whether the EHR will actually support that and where the data gathering is coming from. I think we're going to, again, be less concerned about number of measures, but rather the difficulty or ability to easily extract that information.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I agree.

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

Marc, are you hearing anything from your customers on this—in this regard, with regard to this?

Marc Overhage – Siemens – CMIO, Health Services Business Unit

I have not yet heard anything that's been discussed ... dialogue if I haven't heard any summarized feedback from across the customer base; I don't have anything to add at this point.

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

Okay. So apart from the continued operational challenges that people have mentioned, not yet hearing anybody with strong feelings, questioning, or critical of the approach that's in the proposed rule. All right. That was easy.

So we've covered most of the big yellow flags across the big topics. There's another 50 individual questions—we're missing the group reporting. We've got the Medicaid. We have critical access hospitals. We have timing issues that, I think, were mentioned very early on. But let me ask, let's just pause there and are there other things that you have heard or on your minds having read through the rule that you think this group should be discussing and, perhaps, commenting on to the Policy Committee, with regard to the quality measures?

Russ Branzell – Poudre Valley Health System – CIO

I think this is a very basic comment about all of what we've talked about today. I think there's an overall industry perception that most comments that are being solicited from either us providing comments back or in the industry as a whole is relative to the detail within a measure, but rather not whether the measure's actually one we should be measuring or not. So a call yesterday I was on for over an hour and never once did we ever talk about the number of measures and whether we should be cutting that down. We immediately jumped into the detail of how are we going to measure this—and never should we be measuring this. So I think that is actually something for ONC, CMS, and for overall feedback that the industry as a whole needs to also just question number of measures and whether there's a different number that's appropriate than what we have, whether that be for eligible professionals or hospitals.

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

That's a great point. It goes back to the lively discussion we had 20 minutes ago. I wonder whether we might want to make that a particular focus of this group, since part of our job is to advise the Policy Committee, that we spent a little more effort on that topic, than some of the others and see if we can produce some kind of a consensus set of criteria or guidance that both people in the industry and people on the policy side would feel supportive of, that reflects that earlier discussion we had.

Mark Weiner

This came up last month also when we were talking about a fall risk assessment, and there was some discussion around the actionability of a measure, not only to report on something meaningful but is there something that you can actually do to improve it.

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

This is the kind of topic that if we had a mechanism, would-be log, something where we can actually put forward a few ideas and definitions and criteria and then go back and forth with each other, we might be able to develop something that would be a little more formal than the conversation we had a half hour ago. But it seems very valuable to do that. I might suggest that we start, at least by email, some kind of a circulation of a draft comment that would address these questions and see if we iterate our way towards something we all can support.

Other broad thoughts about what we might have missed? Other things in the rule that jumped out at you that we haven't discussed today? Well I'm sure we're all be on more calls and get more ideas over the next couple weeks. The last big topic here, number four, was really a question of do—that's the last point I think Russ made—do we want to talk about specific measures as a committee? So we would discuss having some criteria for how to reduce the Table 8 list and that may be a good piece of work for us to come up with. We haven't said we want to get into the ... of looking at individual measures and voting them up or down or relabeling them or whatever more technical work we may want to undertake. How do people feel about this committee doing any of that work? Or should we stay at the criteria directional level?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Let me just take it a little tangential—I think we want a minimum necessary set, but I'm not sure that 125 is too many, particularly in view of the comment just a few minutes ago that that isn't what people are reacting—people don't seem to be reacting to that negatively. I can't imagine a vendor that imagines that they will have anywhere near as few as 125 measures that they will need to have custom—built and ready for organizations to use for their own internal quality management. Certainly, I can't imagine any health care organization, and I'm in a five doctor practice—I guess specialists would be the exception, but certainly for any generalist practice, 125 will be far less than the number of measures that they need to manage in their own internal quality measurement. So I think it's at last worth questioning the assumption that 125 is not somewhere pretty close to meeting minimum necessary.

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

Josh, can you explain the rationale in the rule—why CMS said they would like to have a smaller number in the final rule?

Josh Seidman – ONC

Again, it really is just this balancing act of trying to figure out how to ... of specialties addressed with the desire to create a reasonable set, and I think it's something that we are continuing to debate and really something that we really would like comment on, but it's hard to—it's important that comments be specific because I think when you say 125, you know almost ... they say oh we want fewer, but then it actually becomes very difficult sometimes exactly what we should take out—this measure or that measure, so I think it's important that whatever comments here are specific.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Just by the way calling two measures one doesn't accomplish anything except maybe PR I think. I think from an IT standpoint, you've still got to manage both. From the user standpoint you've still got to have processes that enable you to capture them both so at some point, and that point may already be ... or may not be, I think people will regard anything except absolutely transparent good faith reduction in numbers as just gaming anyway.

Tripp Bradd – Skyline Family Practice, VA

Josh, in the research network that I participate in, and I'm a board member of, I would say that we've been doing this from EMRs or EHRs since 1995 and I'd be happy to connect your office with the folks who actually do the extraction to show how it can be—I'm sure you know how it could be done but as far

as operationalizing this whole process. And I'm sure there are other networks—not to say that we're exclusive—that are out there, maybe ... health service and others that might be able to help us, by virtue of the fact it's already being done in some other realm, make it easier.

Josh Seidman – ONC

Always looking for all that input from the real world is very helpful.

Tripp Bradd – Skyline Family Practice, VA

Off discussion I'll send that to you.

Josh Seidman – ONC

Thanks.

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

Alright, so let me see if I can wrap up where I think we got to in today's discussion, and again we're looking forward to the next few weeks needing to produce something. We talked early on about the alignment with the certification criteria and the Meaningful Use rules and this issue that Marc teed up about the migration ... and engine of some of the quality measurement engines versus the hard wiring ... back to that. We talked about the alignment across programs, and the need for considering a crosswalk and using that as one of the criteria that we may use in making any further recommendations on the roster of measures.

We talked quite a bit about the criteria to use in revisiting the 125 measure list and see if we can come up with some broadly acceptable language that would provide guidance for at least how that list might be reevaluated. We haven't really said that we feel up to the job of picking and choosing the winners, but Josh has kept asking us to be specific where we can, so we'll have to discuss whether we want to stay at the criteria level or get our hands dirty with individual measures.

Josh Seidman – ONC

David, can I just add in—Patrice Holtz from CMS has been listening in but she hasn't been on the live line so I just want to convey two quick comments that she made in reference to things that came up. One was in response to the question about the number of measures—she said that they expect public comment may find some measures not acceptable, but also that we want to look at measure-readiness and so those were some of the primary areas where they were looking at whether the number of measures would be reduced. And then the issue that came up earlier around PQRS, certainly they are hoping to align those specifications.

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

Good. Thanks. So PQRS discussion—that may be enough of a clarification but we may want to come back and revisit that. I think those are the notes I particularly focused on, especially I think three or four times we came back to this issue of the criteria for the measures that emerge from the program, and whether we can come to agreement about that.

So sounds like that is our principle task, to try to have that conversation and then, of course, on the Option 1a, 1b, and whether there's a hybrid that we think we can come up with; we'd want to come back to that topic as well. So I think what we'll do is maybe I'll talk some offline and see what process we might use with the committee either to develop answers to those couple of issues that we can reconsider on another call. I'm guessing that we would need another call late in March, maybe in two weeks or three, to do some interim work offline by email or on some ... platform to try to come up with some recommendations on those two or three key areas. And then try to get back on the phone later in the month to discuss however far we've been able to get in the offline exchange. Does that sound alright to people?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Sounds good.

M

That sounds great.

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

Now, again I remind you that the expectation is we'll bring something to the early April Policy Committee meeting. So that's our target, to see if we can get to agreement by then. So with that I think the next item on the agenda was coming back to Lauren to have us get caught up on the ADE Measure Development work unless there's any last words on the NPRM; I'm hearing none. Lauren, are you still there?

Josh Seidman – ONC

I think it actually may be Jesse who will be providing some ... I think Lauren may have had a conflict.

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

Thanks, Jesse.

Jesse James

Right. Lauren had a conflict. So I'd like to give you an idea of what the goals for the adverse drug event measure was and where it's been moved to in the interim since your last update. So overall, the goal for the measure is to find a measure that can broadly, over time, improve safety around adverse drug events. We contracted Booz Allen who has, to date, performed an environmental scan, a gap analysis, and also convened an expert panel.

The outcomes from the environmental scan and the recommendations afterwards were primarily to consider an adverse drug event measure based on anecdote utilization, that being either vitamin K, naloxone, atropine, etc. A second recommendation was drug monitoring for labs based on the type of drug that a person is on, and a third one being adverse drug event monitoring based on physician reporting. That was followed up by an expert panel, and the expert panel considered a large number of drug classes, and was focused on some recent research and some less recent research that pointed in the direction of antihyperglycemics such as insulin and the oral antihyperglycemics, antibiotics, contrasts and dyes, and anticoagulant medications such as Warfarin.

The panel pretty much focused on Warfarin, as did the recent study in the New England Journal of Medicine November of last year, that reported approximately a third of adverse drug events that led to ED visits where Warfarin was implicated in a third of those; the next three medication categories were responsible together for another third. And as the panel thought more about Warfarin, it seemed like that was the medication we were aimed at. One, because it's broadly and widely used - more than 30 million prescriptions per year. It also has such disappointingly narrow, but realistically narrow therapeutic window, but also because it can be easily monitored with fairly cheap and routinely done laboratory tests that's also capturable in EHRs. It seems like an e-feasible measure, and at that point also appeared and appears to be a meaningful measure.

So our thoughts going forward after the recommendations for the panel is to one, focus on Warfarin and two, to think about how this could be done in an outcomes-based but also in a process-based way and considering the resources of the time, the time between now and the release of the final rule, our goal was to create a process measure for Step 2 and to continue to develop an outcomes measure going forward.

As we did a scan of process measures which were already in place, the ones that concern Warfarin are not safety focused but there is NQF-endorsed measure on Warfarin monitoring using an INR, and that's where we've begun to focus our attention. I would like to get input from the work group and any contributors on if a Warfarin-based process measure in the short term seems like this is still within the scope of our thoughts on what the adverse drug event measure should be. Is Warfarin the right drug? I would, and our staff here, would agree that it's an important medication; one that can be impacted and one that's broadly used, but would also like to get input on your opinions on that.

I would also like to get input on process versus outcome. Are we comfortable with this approach of having process measure planned for the final of Stage 2 and committing ourselves to an outcomes measure going forward? And now that we've captured a measure that appears to be close to what we're looking for, is it also reasonable and acceptable to retool this measure as opposed to building a new measure from scratch, considering the time that we have between now and the release of a final rule?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think the analysis is correct and compelling. A couple of ... , one that is important; one that's less important. The first one is that there are at least a couple of recent randomized trials that demonstrate that patients can manage their own anticoagulation better than any coagulation clinics, and that of the people on Warfarin, 75% of them, in at least the one study, were eligible for self management. So in the future and you know, it's probably sort of mid-term not short-term, but certainly we wouldn't want to create a situation in which organizations couldn't put patients on self management because then there wouldn't be any official INR until we get to where patients can enter them.

The second one is probably obvious to the people who did the analysis, but we would need to regard this as probably an appropriate first measure, but one that will have a definable shelf life because depending on how insurers assess the cost benefits, Warfarin's probably going to be replaced as the best drug for many or most of the indications that now it's probably arguably the best drug for. So just a couple of—sort of future—but especially the first one. We wouldn't want to create a situation where we were militating against self management of anticoagulation.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

Both of those issues came up in our discussion and we—it's very early in the measure development here, but thinking about how we would appropriately look at home monitoring and the dabigatran, the Factor Xa inhibitors, will be a key to getting this measure to have validity.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Don't get me wrong. I think it would be perfectly reasonable to say we believe this measure has huge impact now and will continue to for five or seven years. I think that's perfectly reasonable.

Jesse James

Right, and that's the point that I would make in particular, is that we do see long term. Patient self management would be more important, and absolutely that's an opportunity for us to further develop our capacity to capture from patients facing electronic health records, but also the use of dabigatran over the next five to ten years will increase, but still it's cost prohibitive to most patients. And as that changes over the next decade, then issues with this measure will change and evolve over time, but in the current short term, the next five to ten years, Warfarin is expected to remain a dangerous drug that's commonly used, but that can also be acted upon.

Kevin Larson – Hennepin Co. Medical Center – Associate Medical Director, Informatics & CMIO

And as we look at the NQF measure the dabigatran issue probably won't be playing into this so much because it looks for a claim against Warfarin, so you have to have Warfarin prescribed, and then it's a certainly frequency of monitoring that it's looking for. So if you're having indication for anticoagulation but you're not Warfarin this wouldn't apply.

Marc Overhage – Siemens – CMIO, Health Services Business Unit

This is Marc. One thing I like about this measure is that it tackles or begins to nudge a problem that I think is inherent in almost every EHR implementation which is capture within the physician's practice of in-office testing, whether it's a blood pressure or an INR that's often done on a desktop machine now which I think has a lot of overall value, so that's another thing I really like about this.

Mark Weiner

Is the goal of this simply to report on the prevalence of elevated INRs in the setting of Coumadin use, or is the goal of this to be able to illustrate some associations with that elevated INR use or where the measure would have to capture concurrent drug use that may have been started recently or patient

conditions that might have contributed, or dare I say the genetics that can be associated with elevated INRs in some people?

Jesse James

The goal of the—and you're speaking now more as an outcomes type measure than the process one?

Mark Weiner

Yes.

Jesse James

So we've discussed whether the measures should be blind to medications being added, changes in a patient's diet, and we've been leaning in the direction of keeping it blind but not having a single INR greater than four which is a measure that's used internationally, or a single INR greater than six being the signal that sets off the measure—but more likely multiple INR checks that appear out of range. And the outcomes measure we haven't got quite concrete on because it's ... but would love to get your input. Do you think—it would, of course, make the measure complicated once we have to consider which other medications, ... should we have an exclusion for physicians to say this patient changed their diet recently? My instinct would be to keep the measure as simple as possible, but would enjoy to get your input.

M

I suppose it depends on why we're pursuing this. Full disclosure on part of the FDA Mini Sentinel so my notion of the purpose of this is to help the FDA derive new, previously unrecognized adverse drug events and to help understand the contributors to non-adverse drug events, so that we don't have to give out black box warnings that this drug is bad for everybody but very specifically in these people we've noticed increased signal or something like that. And so in a way the Coumadin one is a weird one in this regard because its interactions are actually very well known so in one way it's a good starter set because sometimes it can be helpful to demonstrate things we already know because that increases our trust in it.

But on another level I think we do need to be more broad in terms of thinking about the information we're collecting for an adverse drug event Meaningful Use goal.

Tripp Bradd – Skyline Family Practice, VA

Jesse, another problem, if I may throw in, is attribution of who actually—this is what we talk in the Safety Committee about is who's going to be—who's really doing the test versus putting an end to their lab section of their chart, let's say, and claiming responsibility for monitoring it and that goes back to collaboration of care, coordination of care, and all these other issues that—it's going to be very hard to track who it's really attributed to. Is it attributed to the hematologist or the primary care doc or the Coumadin clinic that actually did it. That's what I wanted to say.

Jesse James

No, it's a very, very good point. Again, we've been discussing that. The NQF rule attributes it to the prescribing provider—

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Let me drive that a little farther. In systems that work, this goes back to that is it a group reporting or an individual provider reporting. You might argue that in an ideal system you would have an anticoagulation clinic, you would have business process management software that would do some parts of this automatically, you might have ... pharmacists—well they'd be anticoagulate clinic—so that you might regard getting this right and keeping it right as a group level function. Certainly, that's part of the point of all of the process redesign is that if it's just based on the physician being heroically brilliant and ... and never going to sleep, we already know what we get when that's what we set up. So I think this is one of the places where group reporting makes really good sense.

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

The only other thing I'd add is if you go back to the original Tiger Team patient safety—I think Russ and Tripp were both on, the focus there was really on supporting the FDA ADE-reporting platform and creating a link between the EHR ... and these national reporting mechanisms, and secondly clinical decision support in support of reducing ADEs. So I think it's worth, at some point, Jesse, going back to that and testing whether the evolution of the discussion with a consultant is consistent with the original purpose that the Tiger Team had identified, and if not if there's any way to make sure that continuing work on this one gets as close as possible to addressing what the goals had been originally. I think there's a risk that because of the various factors at play and the realities and so on, we'll end up making a series of adjustments to what we proposed that takes us a little far of field, and that maybe still has merit but it may not satisfy the original goal.

Tripp Bradd – Skyline Family Practice, VA

David, I think we were trying to do the old Staples, this is Easy button kind of thing in the EMR or EHR to record—it wouldn't matter who pushed the button, so to speak, it goes back to the signal comment which is an excellent way of looking at it. It would help the FDA to identify perhaps trends in a particular drug, whether it's worthwhile is another story but it was a great idea. Neil Calman actually came up with the "this is easy button" kind of concept and I think it's a great idea and you can track it. That's a yes/no kind of thing that would be reportable.

M

On the other hand, it's been studied and found not to have a sustained effect on reporting, in the two studies that have been done so it doesn't sound like something I'd want to—

Tripp Bradd – Skyline Family Practice, VA

Well, like I said we've never had this opportunity before in this way, so—across different—

Josh Seidman – ONC

Just to go back to Jim's first comment, the issue of self management and the incorporation of patient recorded data, that broader issue of incorporation of patient generated data, patient reported data, there is—we are planning to have a quality measures work group hearing in the spring to discuss that issue, both as it relates to patient recorded clinical quality measures and to the incorporation of patient recorded data for the meaningful use purposes. This is interesting; that's sort of a—almost a third area or a cross between the two, how incorporation of patient generated data could be incorporated for this kind of quality measurement.

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

Well this issue of self management on Warfarin might be an interesting test case, Josh, for that hearing to look at the distribution of current utilization or the migration toward self management and self testing and see if there's—if it tells us anything about how we want this particular piece to evolve.

Josh Seidman – ONC

Yes. That's definitely what I was thinking.

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

Okay, well I think we're running down to the end of our time and we want to leave—anything further, Jesse, you want to get from this group at this time?

M

David, can I just very quickly—we never really quite answered the question about process measure. I think it's really critical to distinguish between process measures, like checking hemoglobin and A1c, that aren't linked to outcomes and process measures like this one where we have all kinds of evidence of keeping the INR between two and three consistently decreases risk of stroke by two-thirds if you've got A-fib or whatever it is. So you know, I think process measures that are tightly linked by high-quality evidence to patient outcomes are spectacular and should really be distinguished from what we sometimes sort of look down our nose at rightly, which is the other kind of process measures that really aren't connected, but—

M

But just to be clear, the process measure we're talking about here is frequency of testing rather than any results of in-range, and so the process measure would be, for example, monthly testing and anyone on Warfarin—the outcome measure in this case would be INR in range or out of range.

Josh Seidman – ONC

So it's not exactly an outcome; it's more of an intermediate outcome measure or—

M

Correct.

M

Whatever we call it, okay. Well I'm still comfortable checking every four weeks—well, another way to put it would be if you don't check INR every four weeks and something happens to your patient, you're in court. So it's still strongly linked to patient outcomes.

M

Yes. That's right. A final comment I would make in reference to the earlier comment about this being linked to FDA surveillance, the outcomes measure—and we considered also outcome measure based on hemorrhage as opposed to the INR so the outcome measure of a diagnosis might be more meaningful to the FDA than just the INR being outside the safe range.

M

I was just going to say—I mean, I think the process measure seems very appropriate in the spectrum of the various quality measures we're talking about, but if we're specifically talking about ADE I think the criteria should be a little greater than that.

M

Yes, that's my concern.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

We need to remember that the FDA is concerned with populations of tens or fifties of millions whereas if we're going to ... providers or even care delivery groups, their population sites may make hemorrhage such a rare event that it's useful to differentiate quality. So we've got to keep in mind what's the appropriate population for—how many people does it take to make this measure meaningful.

M

Good point.

M

And for the detection of those truly rare events, it's really going to take a cumulation of a lot of individual—in very small practices to develop and really to find a rare but important event.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right. But what I'm saying is as a clinician and eligible provider might have a panel of 3,000 patient ... that's probably too small a population to distinguish between somebody who really did a careful job of anticoagulation management and someone who was not on the

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

Another good criterion for our list. Well, thanks for the update, Jesse, and sounds like we want to stay informed on this one as we all have some opinions about it as it's evolving.

Jesse James

Well thank you so much for the commentary. It's very helpful.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great work, Jesse.

Jesse James

Thanks.

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

I think our last act here as a group is public comment if there is any. Mary Jo, could you help us find out?

Mary Jo Deering – ONC – Senior Policy Advisor

Operator, would you please open the lines for public comment?

Operator

You do not have any comments at this time.

Mary Jo Deering – ONC – Senior Policy Advisor

Thank you.

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

Thank you. Alright everybody, thank you very much for your lengthy commentary and discussion today. We got a lot of work done. We'll get back to you by email about a next call time and some intermediate discussion format for some of the issues that we surfaced today.

Mary Jo Deering – ONC – Senior Policy Advisor

David, you do have a call scheduled for Friday, the 6th of April.

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

That'll be a little too late, I think.

M

I think, David, you need to have something before the Policy Committee meeting.

Mary Jo Deering – ONC – Senior Policy Advisor

Okay. Good, so we'll work with you on that.

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

Okay, great. Thanks, Mary Jo, and thank you all for your time again today.

Public Comment Received During the Meeting

1. I would like to add comment re: vendors. I represent Meditech and have concerns about the number of measures we will need to certify on. Based upon my current understanding is that as a vendor that supports both EPs and Hospitals we will be responsible to coding all reports 49 for Hospitals and 125 for practices. This will be a difficult task to get programmed, implemented and deployed at our customer base.
2. I agree with recent comment on removing measures that are not currently NQF endorsed and do not have e-measure specifications. As a vendor we need to start programming reports before the final rule is released in order to have the large volume of reports certified and ready for customer deployment. It is very important that validated e-measure specifications are available as soon as possible so that programming and deployment to our customer base can begin as soon as possible. Thank you
3. Another comment: Many of the PQRS reporting vendors are not EHR's, CMS needs to be clear on the requirement of certification of PQRS reports for Meaningful Use and also "certifying" as a submitter for PQRS. Will this require two different certifications for the vendors? My understanding is many of the PQRS measures are "abstracted" measures and not e-measures so it is important to have clear e-specifications for all measures being proposed.
4. Another comment: I believe that CMS is moving in the right direction to align measures for MU with other CMS programs. The big concern is that many of the measures hospitals are currently submitted are "abstracted" measures. Workflows and tools sets are completely different between e-measures and abstracted measures. It is key to move to e-measures as quickly as possible, It will be a large challenge for hospitals to have to support both models(abstracted and e-measures). Thank you