

Quality Measures Workgroup
Draft Transcript
March 28, 2012

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you very much. Good morning. This is Mary Jo Deering in the Office of the National Coordinator for Health IT and this is a meeting of the HIT Policy Committee's Quality Measures Workgroup. It is a public call and there will be an opportunity for public comment at the end of the call. I'll begin by taking the roll. David Lansky?

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

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Tripp Bradd?

Tripp Bradd – Skyline Family Practice, VA

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Russ Branzell?

Russ Branzell – Poudre Valley Critical Access Hospital, CO

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

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

Norma Lang, RN – University of Wisconsin

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Marc Overhage? Laura Petersen? Sarah Scholle? Cary Sennett? Jesse Singer? Paul Tang? Kalahn Taylor-Clark? Jim Walker?

Jim Walker – Chief Information Officer – Geisinger Health System

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Paul Wallace? Mark Weiner?

Mark G. Weiner – University of Pennsylvania Department of Medicine

Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Have I missed any members?

Eva Powell – National Partnership for Women & Families

This is Eva Powell.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I thought I, I'm sorry Eva I guess I called you but you were down below, I do apologize, I had you on my list. All right, would staff from ONC and other agencies please identify yourselves and your agency?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Kevin Larsen, HHS, ONC.

Josh Seidman – Office of the National Coordinator for Health Information Technology

Josh Seidman, ONC.

Ahmed Calvo - Human Resources and Services Administration – OHITQ – Health and Human Services

Ahmed Calvo, HRSA.

H. Westley Clark – Substance Abuse & Mental Health Services Administration – Health & Human Services

Westley Clark, SAMHSA.

Patricia Santora – Substance Abuse & Mental Health Services Administration

Pat Santora, SAMHSA.

Maria Michaels - Centers for Medicare & Medicaid Services

Maria Michaels, CMS.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, back to you, David.

MacKenzie Robertson – Office of the National Coordinator for Health Information Technology

MacKenzie Robertson, ONC.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Oh, I'm sorry, who was the last one.

MacKenzie Robertson – Office of the National Coordinator for Health Information Technology

MacKenzie Robertson, ONC.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Oh, thank you Mac, all right, back to you David.

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

Okay, thanks, Mary Jo, thank you again for making time for this. We're in the home stretch of phase one I guess. I especially want to thank Jesse James and Kevin Larsen from ONC for doing heroic work over the weekend to try to capture some of our last discussion into some tables and charts that we can talk about a little bit today, highly colorful, which I appreciate. We have made good progress on tackling the NRPM.

I think our immediate target is to present to the Policy Committee next Wednesday of our preliminary directions of how we think our comments to CMS are likely to come out and capture any input from the

Policy Committee next week that we want to bring back to this group again prior to try and finalize our work. We do have a month ahead of us that would leave us some time for digging deeper into any issues that remain in motion as of today, so I don't feel like we need to get to a final decision today on our comments, but this is a good weigh station to make sure we're on the same page.

Again, I really appreciate the staff having done a nice job summarizing the conversations we've had on this call up until today. So, there are a couple of documents, I know you got a flood of documents in the last 24 hours and some of them are long and complicated, but fortunately a couple of them are also very tidy and well organized that will guide our discussion. So, we'll try to focus on those.

The document that says Summary of Quality Measures Workgroup of the Health IT Policy Committee is probably the best version of an agenda for today and it really has three sections in it. Let me first make sure people have found that document and that we're all on the same page. So, let me know, and I don't recall, Mary Jo, what that was called in the e-mail? Hopefully it was called something like what I just said.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I'm not sure either; I was just going to check what I sent last night...

Kevin Larsen – Office of the National Coordinator for Health Information Technology

This is Kevin; I think was it called summary of QMWG?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Yes, there actually is something that is called a Summary of Quality Measures Workgroup.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

All right and that's good.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

I had exactly the name that you said Summary of Quality Measures Workgroup and it was sent last night at about 5:12 last night, it's one of about 4 or 5 documents.

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

Great, okay, so let's look at that, if you all have it. So, the first section has 5 bullet points summarized in some of the agreements we've come to, the next session has issues for follow-up of today's meeting, which of course we'll talk about shortly, and the third section is essentially a parking lot and things we want to come back to and maybe we'll use some of the time in April to address some of those questions if we wish too for purposes of the comment period.

So, I would also point you to the summary chart that I think Betsy did which has a little more detail of some of these bullet points that are summarized on the summary document. And on the far right-hand column under Quality Measure Workgroup on the large spreadsheet, you'll find a little more narrative of our discussion from last time and presumably some of those comments will end up being folded into a comment letter if we end up feeling like this is right way for us to go.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Just for clarity, David, there are two separate spreadsheets. One is really the Quality Measure Workgroup's comments onto the Health IT Policy Committee's comment spreadsheet, and another is a crosswalk spreadsheet between the Tiger Teams. So, I think you're referring to the one that is the Quality Measures Workgroup version of the Health IT Policy Committee working spreadsheet.

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

Yes and that has both the Meaningful Use Workgroup comments and our pending comments?

Kevin Larsen – Office of the National Coordinator

Correct.

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

Thank you. So, I would have you keep that in your hip pocket as a crosswalk for what we're talking about here. So, my suggestion for our agenda today is we will first talk about, first just confirm that the consensus agreement items on the summary page, secondly, let's look at the crosswalk of the Tiger Team recommendations with the NPRM and the draft criteria for clinical quality measures that is a continuing discussion we're having and that will probably take the bulk of our time. Then come back to some of the more technical questions that have been carried forward to us by the Standards Workgroup and Jim I think is on the phone and can help us understand some of the issues they have surfaced there and then we can see where we're at as far as the remaining items on that summary page.

So, going back then to the consensus agreement items listed on the summary page, just to refresh our memories, we supported the 6 measure categories that CMS asked for comments on. We tilted in favor of the 1a reporting option that is picking one or more measures from each of the 6 categories from the long table 8. We tilted toward indicating concern that there is alignment, which we do support, between PQRS and Meaningful Use we should in effect flip the requirement so that if one qualifies for Meaningful Use and the eligible professional qualifies for Meaningful Use that is reasonable to have that deemed as satisfactory for PQRS purposes and then vice versa was not what we felt was appropriate, that is you shouldn't be qualified for Meaningful Use only by reporting 3 measures to PQRS.

Under #4 we had a discussion about the batch reporting options where we didn't come to a definitive recommendation, but we surfaced a concern that while we advocated the opportunity for groups of physicians to report together where they were practicing as an effective group, we were concerned that there may be very diverse business groups of doctors under a common tax ID who are not in fact practicing to a common standard and the matrix would actually be somewhat misleading if they were aggregated. So, there was a suggestion that we may want to come back to it and think some more about tweaking the financial incentives so that they would really reward those groups which practice as a group or as an ACO kind of model and that may be a complex thing for us to think through, but directionally that was where we came out last time.

And then we supported the hospital reporting approach that was in the proposed rule, but I see the Standards Committee Workgroup has another thought about that that hopefully we'll hear about in a few minutes. So, let me pause on those 5 points and see if people had any additional clarifications or comments they want to make sure we capture, and again this would presumably be some of what I would represent to the Policy Committee next week as our attentive thinking, so this is a good time to flag any concerns you have about those points.

Jim Walker – Chief Information Officer – Geisinger Health System

David, this is Jim Walker, I have a concern about 4, it seems to me that if a group wants to pretend that they coordinate care among themselves that this is all to the good and if it isn't the case that they do any or very much currently as the requirements go from 50 to 80 to 90% and so forth, they will have to actually coordinate their work among each other to continue to make the standards. I mean, a great example is, you know, EDs had widely...many organizations had not made any effort to coordinate the ED with the inpatient, just used a completely separate Health IT application and Meaningful Use forced them usefully to actually coordinate the way they take care of patients and document care. So, I'm not sure that it would be a bad thing. I'm not sure what would be bad about having people report together even though they are not very well integrated yet.

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

Okay. I think the concern was that the measures won't mean anything, maybe it will be a mush of, you know, a variety of...and the other question that really arose was how will they pick measures to report given that the measures in the table are fairly specialty or condition oriented. They may have...if you have a group of 10 physicians say who have different practice populations or even multispecialty groups under one tin, they will in effect have, out of the 10 physicians 4 can report some set of measures and 6

can't and are they going to have exclusions or how are they going to represent...do you have to require that all 10 have a satisfactory denominator or etcetera, etcetera? It just seemed to create all kinds of layers and complexity, we couldn't quite interpret.

Jim Walker – Chief Information Officer – Geisinger Health System

Well, I think we just said all of that is your problem, again, then it becomes a pressure to either not do it or to actually integrate. I mean, we're a multispecialty group. I mean that what we used to call ourselves and maybe still do, and, you know, we had done most of this integration beforehand, but I know for a fact that many organizations have integrated things that it was never discussable before because of the pressure of MU and I think we want to be careful before we get rid of that pressure.

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

Yes, so, you know, there is a set of questions on page 242 that CMS surfaced around this issue, which raised quite a bit of complexity and I want to think, Jim, if we were to respond to those questions in the way you suggest in effect I think we would say sort of set a high bar, either you can satisfactorily address some of these complexities or you shouldn't use this option?

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah, you know, if you don't all or 80% of you address smoking cessation or whatever it is, then don't do it, that's easy. But the point is from CMS's standpoint or from ONC's standpoint the complexity is on the group, you know, all we are saying is, if you can do it this way, then fine do it, if you can't then don't. We're not going to give you any help or give you any exceptions, or you know, send you any consultants.

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

Any folks on the call have additional comments about this issue?

Mark G. Weiner – University of Pennsylvania Department of Medicine

I guess only to agree with Jim, this is Mark, I just think he said it pretty well.

Tripp Bradd – Skyline Family Practice, VA

This is Tripp; You know, one of the things with the 1A option, actually I think you alluded to, David, is the permutations of the measures that would come out of that in a group setting would be a whole lot more versus the 1B version which would force them to, you know, deal with probably some priority measures just to comment on that.

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

It would suggest the possibility that we could encourage 1B as the solution for group reporting and 1A for others or at least as an option for all, but 1B might be available to those who want to report as a group and that would help drive the direction I think Jim was suggesting.

Tripp Bradd – Skyline Family Practice, VA

Yeah.

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

Any other questions or comments about the 1-5 points that were listed on the summary memo?

Kevin Larsen – Office of the National Coordinator

This I Kevin Larsen; Just a point of clarification is there a consensus around something different that we should put as a summary?

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

Well, I don't know if we have a consensus but a couple of comments I think we want to capture here include that, I think affirms what's in this note. I heard Jim's comment, Mark's to say yeah, if we want to encourage groups to use group supporting options where they are able to satisfy the criteria, because there are literally 20 questions that CMS asks for guidance on regarding the definition of these groups, I think we have to come back to the question of whether we intend to answer these 20 questions or are we

going to say to CMS, however you choose to answer them they should be applied to any group reporting candidate, but there are a lot of complex questions here and I fear that we haven't tackled them yet.

Russ Branzell – Poudre Valley Critical Access Hospital, CO

Yeah, this is Russ, I think we need to preserve the option for those groups especially that are single specialty or decide to standardize within their group. This could actually be a fairly easy thing for them.

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

Yeah.

Russ Branzell – Poudre Valley Critical Access Hospital, CO

For the vast majority out there this is not going to be applicable.

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

Yeah, so I think that affirms...I think the spirit of Jim's comments affirms the note that we had from last week with the clarification that we really want to encourage groups who can't do so to report as a group, but we may have to come back to this and look at these 20 questions with a little more care and decide how to focus CMS's attention on certain of these issues. In the sense, what I think we're saying is the criteria for how to answer these 20 questions is the idea of coherent clinical groups who are actually managing and trying to report as a group or Jim your point is, given the opportunity to report as a group will encourage people to group up in a meaningful way.

Jim Walker – Chief Information Officer – Geisinger Health System

Right.

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

So, I don't know. Mark, do you have a thought on the driver of group integration through reporting and whether there is a way we can split this difference, that is accommodate the sort of pluralism of the menu options without getting into basically a bunch of noise that doesn't mean anything because of so many exclusions and exceptions that are going to end up being applied to the group?

Jim Walker – Chief Information Officer – Geisinger Health System

David, this is Jim, just quickly, I think one driver is that this reporting is very difficult and an organization that can figure out a single process and then run more physicians through that process is going to be more efficient, that's one driver. I think we estimated it would take a doctor two or three hours to do the initial reporting and we got it down to about 30 minutes for the industrial process without the doctors doing it, we were doing it for them, but that kind of thing...you know, you don't get that kind of economy scale with a 5 person practice.

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

Okay. So, we'll try to capture the spirit of this and again, we will have some time next month to sort out a little bit more of the underlying recommendation if any to CMS.

Marsha Smith - Centers for Medicare & Medicaid Services

Hello?

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

Yes?

Marsha Smith - Centers for Medicare & Medicaid Services

Hello, this is Marsha from CMS, hi we got on the call late, we just wanted to be sure are you talking about group reporting for the purposes of Meaningful Users or are you talking about reporting as a group for reporting CQMs?

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

CQMs.

Marsha Smith - Centers for Medicare & Medicaid Services

For CQMs?

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

Yes.

Marsha Smith - Centers for Medicare & Medicaid Services

No, that was not the intent. This section was not specific to CQM reporting.

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

By this section do you mean section of the rule?

Marsha Smith - Centers for Medicare & Medicaid Services

Right, you're on page 241, starting questions to 242, is that correct?

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

Yes. So in those apply to the broad Meaningful Use...?

Marsha Smith - Centers for Medicare & Medicaid Services

Right.

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

All right.

M

These series of questions aren't necessarily associated with a group reporting options that we have proposed in the CQM section?

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

Right, this applies to the broader question.

M

Right, okay.

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

So there is another...do you have the page reference where the CQM group reporting issue is?

M

Sure, let me just...

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

I'm looking at the crosswalk table to the summary table and I'm not easily finding it.

M

It's on page 213 using apparently the same printed copy that I have.

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

Yeah, right, okay.

M

Its group reporting options.

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

Good, thank you.

M

No problem.

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

We have the 3 group reporting options described there, which was the 2 or more EPs.

M

Correct.

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

And the clinical quality measures reported would represent all the EPs within the group that is where we started stumbling in our analysis earlier.

M

Correct, okay so that is a distinct section that is separate from the reporting, the group reporting of Meaningful Use objectives that you're referring to on page 242?

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

Right, yeah. Thank you for getting us back on the right track.

M

Okay.

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

So, the issue, again of mushing the data, which I think is where we started our digression was implied by having the clinical quality measures under this option, would represent all EPs and so we remain challenged with the question of how to do that, but you're right the 20 questions on page 242 don't apply here.

M

Yeah, I'm not exactly sure if I follow the meaning behind the mushing of the data. It sort of implies that there are multiple electronic health records that you are having to combine in order to run the algorithm of the CQM against it. Is that the issue?

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

I didn't think the issue was around the technology support, it was around the applicability of measures to all of the physicians in the reporting group.

M

I see, in the way that we looked at it with respect to group reporting for CQMs is that the group of physicians are sort of, contributing different levels of course, to the care and outcomes associated with a particular patient population. So the CQMs are applied to the population and the group of physicians that contribute to their overall care are granted or are sort of just given the value that is generated from those measures. I think, if I understand your question correctly or your position correctly, it's more of a problem with group reporting in general that seems to unfairly attribute varying different levels of contribution to a patient's outcome by physicians within the group?

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

I was concerned less about that than the pluralism of the population and the nature of it. So, if a group of physicians are practicing under one tax ID, but are not serving the common population, they just happen to have offices and a bookkeeper they share in common, they actually have lets say 10 physicians, they have 10 separate patient populations for the purposes of reporting they could call them one large population.

M

Right, I understand that, yes.

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

But they are actually very diverse and trying to take a cross-sectional measure across that blended population doesn't really mean anything about anyone's practice performance.

M

Right, I understand now. And you've got a very valid point. I think where we tried to counterbalance that perspective is with the statements that we have throughout that say, you know, we want the CQMs to reflect the patient population that is being treated both as the...I mean, because an individual provider could do something relatively similar by choosing measures that don't necessarily reflect their patient population. So we tried to sort of counterbalance that possibility with the insistence that any measure that is reported sort of does represent the collective, you know, input.

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

Yeah. Well, I think that's in the spirit again of Jim's suggestion. So, if there is a way to in effect enforce that or interpret it that would go toward, I think both what Mark and Jim had emphasized, of helping to drive coherence and the fact that it's around a population as you initially outlined it. Well, good, thank you for getting me off page 242.

M

No problem at all.

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

Any last comments about the points on the summary page? And then we'll come back to the hospital question after Jim takes us to the summary of the work they have been doing in the Standards Committee. So, let's turn to the crosswalk item which is #2 down below on the summary page. The crosswalk of the Tiger Team recommendations in the NPRM. And, I think we have both the actual crosswalk, which was given to us as a spreadsheet. And, in addition, we have, I think a summary. Jesse, did you do the summary of the findings as a result of the crosswalk analysis?

Jesse James – Office of the National Coordinator for Health Information Technology

I did.

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

Do you want to walk through where you came out?

Jesse James – Office of the National Coordinator for Health Information Technology

Yeah, I'd be happy to. Forgive me for being late; I'm also at a conference so I'm splitting my time. If you look at the Word document which is a summary of the findings, then you can look at the larger Excel document. So, in the Word document, well I should start with the limitation, so the crosswalk was from the recommendations made by the Tiger Teams to the Workgroup for measure concepts over the 5 domains. Those 5 domains were clinical appropriateness, population and public health, care coordination, patient safety, and patient and family engagement and of course those 5 domains were eventually split into 6 and its 6 domains that the measures are described by in the NPRM.

So, but just starting with the big picture view of the 5 domains that were high priority for measurement, all 5 domains have at least 1 measure concept that was described in March last year as being high-priority. One measure concept where the NPRM, from my point of view, was faithful to that measure. Now, an important limitation to appreciate is that this is from my point of view, my reading of the measure concept and then comparing that measure concepts to what is in the NPRM, but as I was not present for the Tiger Team deliberations, there are probably some points at which I may be inaccurate on what the Tiger Teams were thinking and what the Workgroup thought and how CMS described their measures in the NPRM. And also it's important to note that CMS, due to quick turnaround, CMS hasn't had time to comment on the faithfulness of them representing the concept towards the measures.

So, that being said, for each of the 5 domains, there appears to be at least 1 measure inside of that domain that is faithful to what the Workgroup was thinking and that was the first point under the 5 domains, all 5 have at least one concept that is faithfully represented and those are represented in green on the grid. And then for all 5 domains there also appears to be 1, at least, green measure concept, but also a yellow measure concept. And the yellow measures are those measures that are not clearly faithful to the concept but appear to be close at least, it's not quite outside of the scope of what the Workgroup was thinking.

Now, the 3 domains that I would say are the best covered would be population public health, care coordination, and public safety. And also, it's important to note, in the defense of the NPRM, that there was a split between the Stage 2 and Stage 3 measures in the recommendations of the Workgroup last year and that there were a few measures that appear in the NPRM that were actually recommended for Stage 3. So, there are some points where CMS has gone farther than was recommended.

If there was a single domain that appears to be at risk, I would say that's care coordination. When you look at the grid it has the most measures that either were red and they were labeled red because there does not appear in the NPRM to be a measure that captures that concept. It was not a measure that was really very close to what the Workgroup was thinking.

So, to go, in particular, to the 23 measure concepts that the Workgroup described for Stage 2, 13 of the measure concepts either have a measure in the NPRM that is yellow, that's where it partially fulfilled the Workgroup's recommendation for was green where it appears to fully fulfill the recommendation of the Workgroup. And, another high-level point is that there seemed to be sort of 2 areas where there are clear gaps, longitudinal measurement, and self reporting, but these gaps, just from our experience over the last two months of working with CMS and our measure developers, that these are largely technical gaps. There are some technical challenges to longitudinal measurement and self reporting via the EHR that we are combating and we're finding solutions to as we move forward. So, it's not that CMS is not aware of them it's just that it's rather challenging to approach them in the EHR.

Now, to move on to the spreadsheet, so the first sheet is just my notes to say, what you see in yellow is partially representative of the Workgroup's recommendation. What you see in green fully represents and what you see in red I feel was not represented well. And the second spreadsheet is a crosswalk. And in that crosswalk it's split between Meaningful Use Stage 2 and Meaningful Use Stage 3. And under Stage 2 you'll see there's each of the 5 domains and I preserved this from the previous document that was a deliverable from the Tiger Teams.

So, for each of the 5 domains I go concept by concept and this then list the individual measures here, NQF numeration, the title of the measure, it's description, and the status of the measure. And the point of adding the status of the measure was to give a little bit more granularity about if this measure was endorsed, has this measure been supported by the MAP, and how close in its testing is it? Because for each measure, depending on whether it's a new measure, de novo measure or a measure being retooled from NQF, over the summer there are measure that will be closer to complete testing and measures that will be farther from it. So, that is to give an idea of the likelihood of this measure really making it into the final rule.

So from that description, I think what would be helpful from the Workgroup would be if there are measure concepts that were very important that the Workgroup would like more focus to be put on and the time that we have between now and the final rule for development and also perhaps some thoughts towards Stage 3 how we might focus our efforts going forward.

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

Okay. Well, first thank you for doing this. This is a great table and very helpful to have a look back to where we started with the Tiger Teams and a look forward to what we're trying to get to with Stage 3. So, it's an awful lot to take in since we just obviously received this not too long ago, but let me just put it out for discussion. My own thought is that may want to make some broad comments in our comment letter that reflect in general no how well we feel the Stage 2 proposed rule fulfills the intent of the Policy

Committee in their letter from last August and how well it puts us on track towards the Stage 3 objectives. And, then as well to the points Jesse just made, if want to get into a little more granularity about either things to accelerate or emphasize at the individual concept or measure level we can certainly do that. So, perhaps...

M

...

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

Go ahead, was that you Jesse?

Jesse James – Office of the National Coordinator

Yes.

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

Why don't we just go through each of the 5 or 6 domains, 5 domains here and just quickly if you have any initial reactions, since we probably haven't had time to think this through in great detail and there is a lot of material here, let me just take a minute with each group and see if people have comments that they thing we should relay to the Policy Committee in each of these broad areas. So, the top one was clinical appropriateness and efficiency and you see here the 5 or 6 proposed measure concepts that came out of the Tiger Teams and the Workgroup, and then how well the current proposal seems to address those concepts. Anybody want to offer any particular thoughts or reactions on the first cluster?

Tripp Bradd – Skyline Family Practice, VA

Jesse, this is a question from Tripp, the Workgroup concept which would be I guess column G, you know, they seem to be discussion items that happened at each of the Tiger Teams but never really came about to anything other than just discussion, is that correct from your creation of the spreadsheet?

Jesse James – Office of the National Coordinator

Yes, but Josh may be able to add more detail on that. What I took was the deliverable that the Tiger Team came up with to describe their thoughts on the measure but it wasn't in detail to say numerator/denominator, it was more an ideal measure in this area should measure x-y-z.

Tripp Bradd - Skyline Family Practice, VA

Yeah, more of aspirational kind of thing?

Jesse James – Office of the National Coordinator for Health Information Technology

Right.

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

And then Josh, maybe you could explain or Kevin the contracting process by which these concepts were meant to be tested and realized.

Josh Seidman – Office of the National Coordinator for Health Information Technology

This is Josh, basically the goal was to try to take the measure concepts that were identified by the Quality Measure Workgroup through the Tiger Teams and also through the request for comment and public process that led to that and do our best to try to identify measures that could be developed and also trying to prioritize based on what measures were kind of in development and had been worked on, what measures could be developed for Stage 2 and what should be on a longer timeframe for Stage 3 development.

In some cases, those measures that were high priorities, you know, there were a series of methodological scientific issues that made it difficult to sort of in a sense live up to the desired measure construct precisely and so there was, you know, additional work that was identified proxy to that or, you know, sort of the next steps thing.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, this is Kevin Larsen, I think that part of this is that some of these concepts, although high-priority are newer in the development of measure lifecycle and so the contractors and the teams had to start at an earlier stage in the measurement lifecycle and many of those are moving ahead. They just weren't at a place that they could be produced in time for the Stage 2 NPRM.

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

Okay, thanks. So, any other suggestions or questions or points you would like us to relay to the Policy Committee regarding the efficiency appropriateness group or any questions or concerns about the representation Jesse has put together? All right, hearing none, let's go down to the population public health section.

M

So, one point to make about the clinical appropriateness and efficiency group that there is absolutely a cluster of clinical appropriateness measures and less efficiency but that's sort of the reality of measurement. The data isn't quite as mature when it comes to measuring efficiency and medical care, but it is good to note that there is at least one measure that is de novo and Non-NQF endorsed measure that is being worked on and it covers exactly what the Workgroup desired for it to cover.

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

Jesse, the fact, back up on the appropriateness, efficiency section, but the Stage 3 section of the grid is not very heavily populated yet, but the Stage 2 section has a number of things that are pending. Does it mean that the things that are penciled in for Stage 3 are in development with the contractors and we should look forward to them getting shaped in the next year or so or that the ones in Stage 2, that are now yellow for example, will be carried over to Stage 3?

Jesse James – Office of the National Coordinator for Health Information Technology

It's not exclusive of either, it's the ones that are in yellow may be carried over. The ones in green may also be carried over. The coloring is more that it's faithful to the recommendation and it appeared in the NPRM. But, if there is a yellow or green in the Stage 3 column, that's saying that it appeared in the NPRM so it is sort of early so to speak, but there is no comment on what's in development for the Stage 3 measures, that's outside of the NPRM. Is that clear?

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

Yeah, I think what I was getting at is, this may not be the place to represent it, but let's take the cardiac imaging appropriateness measures, hypothetically right now that's red, there's no indication on the grid of what the status of that is and it may be a high value set of measures for 2014/15, Stage 3 and we may as a group, say "yeah, we think that's a really high value set of measures to make available by Stage 3" and we want to encourage CMS and ONC to keep that in progress. So, there is not a way yet in this model to indicate that this is priority for us and these calls probably aren't the best way to try to get to that level or granularity.

So, I'm just wondering, you know, how we take a step back and say, one other thought is quality appropriateness measures in particular will expect indications for treatment or testing to be in the medical record in a way that maps to the appropriateness guidelines from the professional societies, and I think it will be a question whether we have recommendations back in the standard and certification process that says, you know, if you're going to be looking at imaging appropriateness measures for example, you have to be capturing New York Functional Class or some other indication in the EHR and do we have to ask whether those data fields are currently available to eventually support the appropriateness criteria that the societies are developing, and that's a long loop of analysis that we, again, can't do as a committee but I think we would want to be encouraging CMS and ONC to have thought that through in parallel to where we're trying to get on the measurement side.

Jesse James – Office of the National Coordinator for Health Information Technology

Right, and I think that's an appropriate high-level use of the grid and that's one of my first questions

that I asked, this grid might be useful to say, look at the measures or the concepts that are red and decide if there are some of the red ones that the Workgroup would like to put more focus on and tell the Policy Committee that these are measure concepts that we would like to see as a high priority and if they have not been addressed in the NPRM and will not be in the final rule, then perhaps they should have strong consideration for Stage 3.

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

Very good, yeah, that's very clear. So, let's go back again, one more pass at this section of appropriateness and efficiency. Anybody on the call have any further thoughts about the question Jesse just raised or how else we want to address the red zones or the other topics on here? And if not, we'll keep going down to the population public health section.

Jim Walker – Chief Information Officer – Geisinger Health System

David, this is Jim, the ones in red, well and yellow, are going to be problematic because of the lack of sort of randomized control trial level data supporting them and also because of the care process complexities that will have to be understood and then represented, I think, to deal with them. So, you know, I think, it's just a caution that to me, those look like hard work, conceptually hard work from a design and build standpoint, and then hard work to...it would be very easy to attack them as being a whole lot of judgment and not all that much evidence by people who are opposed to this whole process I think.

M

I'd agree with that wholeheartedly. The two, the head CT imaging, very specific situation for a non-traumatic brain injury and the cardiac imaging appropriateness that's more broad and there is decent evidence, but since there haven't been as many measures in that space before, it would be controversial to the field and there would also be technical challenges to both. I think the measures that are represented in green and yellow do show the measures where there was previous work in the space and where there is less controversy about the measure. Of course, efficiency and appropriateness has a bit of more subjectivity than what's clinically evidence-based.

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

Jim, so I think we have this separate discussion, we'll come to it in a minute about the criteria for eventual measure inclusion on here, but obviously, you're arguing that one of the criteria that should be highly weighted is the evidence-based through control trials or otherwise.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah, I think particularly for the first measures, the more rock solid they are and the low back pain is an example where we actually do have very high-quality evidence. It would just be hard for someone to get around.

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

Okay, well let's continue to go down the list and we'll come back to the criteria here shortly. People have any specific comments on the population public health section?

M

What's happening to the red sections for Stage 2 that don't appear in Stage 3?

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

So, are you just speaking for example on the cardiac imaging one or we do have the longitudinal blood glucose control?

M

Yeah, and the undiagnosed hypertension.

Jesse James – Office of the National Coordinator for Health Information Technology

So the measures that are under Stage 2, they were there because that's how they appeared in the original recommendation that the Workgroup put out. Their status for Stage 3, that's a decision on CMS's end and I haven't received comment back from CMS about their plans going forward. So, the scope of

this analysis was limited to what the Workgroup recommended for Stage 2 and whether it appeared, but without commenting on its likelihood of it being in Stage3.

M

So, are you looking for a comment on whether or not something like measure, assess the patients with a diagnoses of hypertension should be part of Stage 3 or 3?

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

Well, I think it's pretty clear it won't be part of Stage 2 given the current work underway and what is in the proposed rule. However, I think it's appropriate for this group to say we think it's a high priority for Stage 3, you know, keep the development work underway. I'll see if Kevin and Josh think that's an accurate summary of where we are at.

Josh Seidman – Office of the National Coordinator for Health Information Technology

That sounds correct to me. We do not have measures under development contract. For example, for the undiagnosed hypertension, but we are having discussions with some thought leaders about who has done measures like that already and how those measures might inform us if they are chosen as a priority into the future.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim; by undiagnosed, do we mean people who haven't been screened or people who have hypertension on their record but aren't in care for it?

Jesse James – Office of the National Coordinator for Health Information Technology

So, I think there is more than one way to interpret that. There are some measures that exist that talk about people who have diagnosed hypertension on their record and are not adequately treated, but the discussions we had this last week with work that was done at Geisinger was looking at blood pressures in the record and how many patients have more than one elevated blood pressure in an electronic health record that don't have evidence of hypertension diagnosis or treatment.

Jim Walker – Chief Information Officer – Geisinger Health System

All right. I think the calculated algorithm is probably over specifications and just also quickly, I don't think longitudinal assessment or management of blood glucose control is considered standard of care for diabetes anymore. I think it would be hemoglobin A1c management if you were going have a measure like that.

Jesse James – Office of the National Coordinator for Health Information Technology

Yeah, I assume that was referring to A1c.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah, but I think we ought to say it.

Jesse James – Office of the National Coordinator

As a proxy, fair.

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

So, it's a good clarification and would note that it doesn't show up as being under the Stage 3 in this sketch that we have today, neither of those two, the hypertension or the Hb1c, so we may want to...I mean I think we do have the improvement in blood pressure but not the measurement of undiagnosed blood pressure in the Stage 3 draft. So, again, this group I think needs to say whether you want those two red items to be given attention and focused by the contractors going forward.

Tripp Bradd – Skyline Family Practice, VA

This is Tripp; how would you actually, given the fact that you have an EHR and you have undiagnosed hypertension with the two measurements as you mentioned, how would you actually measured this?

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah, this is Jim, I agree with Tripp, it seems to me hypertension is a huge problem with all kinds of downstream badness, if we just suggested that it follow the arm of the depression measure immediately above it, you know, if you screen for it and you follow it up, if you find it, that would be a lot more straightforward to measure and to execute clinically, even though we're very proud of our ability to find people with evidence of diabetes or hypertension, or other things that aren't in care and get them into it, that's a much more complicated thing to identify, measure and I would think report also probably.

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

Well, I think today we probably can't get into the best approach for each of these measures given the short time that we have and our purpose, but these are all very excellent suggestions that for the moment let's relay them back to ONC and we may need a process Kevin and Jesse to capture the input from people on this committee and elsewhere to refine some of these and also prioritize them for Stage 3 now that we've seen the interim report so to speak, how do we take what we have in front of us today and give guidance of you guys from the FACA point of view of where we think the priorities should be going forward. So, let me keep going down.

Jim Walker – Chief Information Officer – Geisinger Health System

David?

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

Yes, go ahead.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, could I just ask a process question? Are the red ones...is letting sleeping dogs lie an appropriate approach to them or do we need to comment on them?

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

Well, I think we need to say since this was in effect our work product as a Workgroup from a year ago, I think part of the purpose of the exercise is to say, you know, were we right, do we still want to stand behind the importance of some of these concepts and make sure they get addressed by Stage3 or in hindsight they weren't important enough to warrant additional work, it makes sense to back off. So, I think that is the work we have to do, but obviously, I don't think given that we just received this material we can probably do all the thinking to do that on today's call, but we have a few weeks to come back to that if we had some structure on how to do it.

So, let's go through the patient and family engagement section. Let me see the red items, we have some green, indicating that the functional status assessments are underway for a couple of topics and some red indicating, not addressing a couple of the domains, health risk assessment being captured and the experience of care data being captured. I think both of those raise platform integration questions of the data source being fed back into the EHR and so on, which there is some work going on in parallel on. And then you see some notes for Stage 3 carrying forward some of the other concepts that were identified.

M

So, I think the big picture for this is functional status work is well underway and the work in the health risk assessment space is not as developed or is not being pursued as aggressively.

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

Yeah, which is ironic. I know the Dartmouth Project is trying to bring those back together, I was going to say it's ironic because health risk assessment is probably is considered an important part of care planning and capturing it and bringing it back into the record seems highly valuable and certainly from my constituency the employer will...but I hope we'll come back to that. I would certainly encourage CMS to keep working on integrating the data sources together.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim. The first one, the 10 priority conditions sounds very aspirational.

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

Yeah, I think the challenge there is there was a concern, which, you know, we're probably realizing at the moment, for example tackling just total hip and total knee, which is in fact where we are now, you know, it doesn't spread the opportunity very far to capture the patient functional status as part of care planning or assessment. So they wanted to say you have to do more than just one or two token categories, but it's not going to happen probably in Stage 3, we're not going to get to 10 that's for sure.

Kevin Larsen – Office of the National Coordinator

This is Kevin again, another aside, part of the things to think about here just like you mentioned above, is which elements might we suggest as standards or the Workgroup might suggest that would be required for standard certification to make the EHRs capable of these tasks.

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

Exactly. Yeah, I think where we want to end up, back to Jim's point, is the EHR needs to have the capability of accommodating these data sets, so for example the ophthalmologist have a functional status measure they want to use, you know, if the orthopedist or ophthalmologist always want to do that, does the EHR structurally have the capability for capturing and manipulating those fields and we don't want to, you know, suboptimize if it were just one specialty for example, but have it be a general capability. So, any further comments on the patient and family engagement summary of where we are today? Okay, care coordination I think...

Jim Walker – Chief Information Officer – Geisinger Health System

I'm sorry David?

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

Go ahead, Jim.

Jim Walker – Chief Information Officer – Geisinger Health System

Just, Jim, real quick, they don't read...if you didn't know the title of this domain, you might not understand that these measures were measuring patient and family engagement depending on what we mean by that in our shared decision making.

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

Right.

Jim Walker – Chief Information Officer – Geisinger Health System

So, that's sort of the oddity, if I understand, what the domain means.

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

Well, that raises a larger question, I think if you look at the master table, table 8 or at the hospital table in the rule there are many items you might scratch your head a little bit to see if it really fits those titles. So, I don't think we quite have the purity of mapping that, you know, in the perfect world we might want, but...I think part of what's happened is anything that is sort of patient centric has been clumped, so for example, I think in the hospital measures they have pain assessment on admission for a pediatric ICU, that's patient and family engagement. Okay, it's a little different than what most of us mean by patient and family engagement, but it's a good thing.

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah, just at some point, we're going to get...and...for calling what we care about or what physicians care about, or somebody cares about patient engagement instead of what patient's care about.

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

I totally agree and I guess I the optimistic view is it's a work in progress and this is Stage 1 or Stage 0.1 and I think we're going to start migrating more of the measures into these categories that hopefully

patients will support, but I agree with you 100% that part of our job is to give some feedback on whether or not we're hitting the mark and if you think we should make a comment for example on this section that the concepts aren't being adequately addressed or we are missing some important concepts, I would say shared decision-making, which is here, but really pushed off to Stage 3, we can certainly make those comments. Jesse, I should ask you, speaking of shared decision-making it's in white on the Stage 3 section and it's not clear, is there some of those emerging topics on patient and family engagement, is there contractor work underway to develop measures for Stage3?

Jesse James – Office of the National Coordinator

For the entire domain?

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

Well, I was looking specifically at the one called honoring patient preference and shared decision-making. Where you've got the 3 sub-bullets.

Jesse James – Office of the National Coordinator for Health Information Technology

Right, so the one where there is a period of ellipses it's saying that in this area the Workgroup last year did not recommend Stage 2 work but recommended Stage 3 work. For the Stage 3 work, under honoring patient preferences and shared decision making, from what I know, I don't know of any Stage 3 development in these areas, but I would not be the best person to comment. It would be better for CMS to comment on that.

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

Okay.

Kevin Larsen – Office of the National Coordinator

Yeah, this is Kevin, ONC under our contracts do not have any development for those areas, but it's possible that they are under development by someone else.

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

Sure, well there are certainly measures out there. I mean, Josh, obviously knows this area really well.

Marsha Smith - Centers for Medicare & Medicaid Services

Hi, this is Marsha again, I don't know specifically if there is a contract for looking at that, but we've had meetings about patient engagement and collection of patient reported outcomes and so it's in the early stages, something that we're interested in and we're looking into, but I can't specifically speak to a contract on it right now. I know that there was a meeting last week that I missed because I had another meeting to attend.

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

Sure, good, thank you.

Marsha Smith - Centers for Medicare & Medicaid Services

Okay, all right.

Josh Seidman – Office of the National Coordinator for Health Information Technology

This is Josh. I'll just say that the scope of the work to be done for Stage 3, you know, I think is still somewhat in bit flawed and input from the Workgroup could certainly be valuable in helping us.

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

Good.

Marsha Smith - Centers for Medicare & Medicaid Services

Hello, this is Marsha again, I know that NQF is going to convene a forum around this and I know that Academy Health was interested in looking into mining or finding out more about their process as well.

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

Thanks. So, I think we should consider whether we want to make a comment encouraging that we would continue to get attention from those parties, lets consider doing that and get to our comments on all the details. Care coordination, we had quite a few areas that were marked in red and the Stage 3 area is a little thin. Obviously, this is a very important area for many reasons; it's also difficult for many reasons given the nature of the HITECH law and the difficulty of capturing the loop closure of the referral loop in a variety of ways. Do people have any comments about the care and coordination area? Anything you'd like to, essentially what we have for Stage 2 is the med rec measure and this closing of the referral loop which sounds good but difficult.

Mark G. Weiner – University of Pennsylvania Department of Medicine

The med rec one is in green and I'm a little concerned about, this is Mark Weiner by the way, I'm a little concerned about how medication reconciliation is intended to be measured. I'm concerned because what I see now is a checkbox.

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

Yes. Any ONC folks have any detail about that?

Josh Seidman – Office of the National Coordinator for Health Information Technology

I have not heard that there is any change in the measurement on details and the measurement methodology has largely been an attestation that medication reconciliation is completed and I have not seen that there has been any change to that philosophy.

Tripp Bradd – Skyline Family Practice, VA

Mark, this is Tripp, I'd say it would be very hard to, you know, try and get congruency between a care transition and medication reconciliation by matching medicines for instance and unfortunately, the checkbox is probably the only way you're going ever be able to do that and record it, I would think.

Mark G. Weiner – University of Pennsylvania Department of Medicine

Yeah, I mean, I agree, but I don't want to put out a precedent for quality by a checkbox. I even joke with my patients after I do all sorts of cleaning of the list and I say "okay, I'm a good doctor yet" and then I click the medication reviewed box and I say "oh, now I'm a good doctor."

Tripp Bradd – Skyline Family Practice, VA

Agreed.

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

Well, this issue of measuring whether care coordination is happening, we have a couple of concepts here including whether the patient and family evaluate and say that it is happening, whether information is in the hands of the receiving specialist or physician when it needs to be, which is implied by closing the loop, but this is a tough area that I think we all want to see better measures available and it does look from looking at the Stage 3 column and the pending work in Stage 2 that we still have some serious challenges to make this concept come to life.

Russ Branzell – Poudre Valley Critical Access Hospital, CO

This is Russ, on the medication reconciliation one, I'm sure there is absolutely some evidence base of why it's 65 and over as we've applied medication reconciliation everywhere else, it had nothing to do with 65 and over. Is there something I'm missing there? Is that part of an evidence-based standard somewhere?

M

I don't know that it is.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim; I don't think so, no.

Russ Branzell – Poudre Valley Critical Access Hospital, CO

Because most of the stuff, for us nationally over the last probably 5 or 10 years are actually people under 65.

M

I don't think that's an evidence issue. I think that's more of a carryover on the patient population that some measure was originally designed for and to maintain NQF endorsement there is a limited amount of changes you can make to a measure and still keep that endorsement. This isn't a measure that ONC owns, but just from the description of the measure, the fact that it's 65 and older, the fact that it came from a CMS list, I imagine that it's more because it's focused towards an elderly population, but not because there is an evidence-based shift towards that population.

Russ Branzell – Poudre Valley Critical Access Hospital, CO

Yeah, it just doesn't seem like there is good correlation between age and transitions of care.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, I agree, it doesn't seem to me like the retooling would be that hard, but even if it is, this should be addressed. It ought to be all ages, certainly under 2 would be critical.

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

Okay, last section is on patient safety and we have little brighter colors here. The ADE measure is one that is marked here as red.

Tripp Bradd – Skyline Family Practice, VA

David, this is Tripp, can I go back to the referral loop thing.

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

Yes, sure.

Tripp Bradd – Skyline Family Practice, VA

As a comment, hearing from users, when you're doing a referral outside of an organization there are so many variables that are so hard, you know, someone that maybe in Jim Walker's organization internally you can control that quite a bit, but that's going to be a hard measure. I know practices that really try very hard to do that and sometimes it comes down to just how reliable the patient is and whatever we do with that, I hope we set low percentages for that at least initially.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, I agree, first of all it takes high-performance EHR, but it also takes a lot of process agreement and management to get that done, no question.

Tripp Bradd – Skyline Family Practice, VA

Yes.

Jim Walker – Chief Information Officer – Geisinger Health System

And it's the kind of thing we want to be nudging people towards obviously, but like Tripp said probably start with a low bar and increase it.

Tripp Bradd – Skyline Family Practice, VA

Yes, thank you.

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

So, again this isn't criteria where we're setting a threshold of any kind, this is a reporting activity of a measure and the question of whether reports are going to show very low success rates I guess remains to be to be seen. This is an ONC measure. I don't know if people at ONC, is there any empirical evidence of prior rates of achievement on this measure.

Kevin Larsen – Office of the National Coordinator

My only experience is with creating one of these at my last organization and having it live for about 3 years. I would, from that experience; I can say that there was considerable investment in figuring out how to measure it.

Mark G. Weiner – University of Pennsylvania Department of Medicine

Yeah, this is Mark Weiner again, you know, one of the initial steps before you can worry about getting the report back was the appointment actually scheduled, a lot of times orders get written for referral to cardiology and in the checkout area, you know, a call attempt is made or some scheduling attempt is made, but is not successful and then it's not followed up on. So, that may be an intermediate goal.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim; I think that's a really good point. One of the things, to the extent that we could write these measures in a way that they imply step-wise incremental achievement of a complex process, I think that would be a benefit to everybody.

Mark G. Weiner – University of Pennsylvania Department of Medicine

Yes.

Tripp Bradd – Skyline Family Practice, VA

This is Tripp, I absolutely agree.

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

Well, I'll tell you the other, the patient point of view on this and maybe the only way to get this is through that patient component listed in red, is less about evaluating the interim process steps and more about the...when they show up at the specialist office is the appropriate information available and when they come back to the PCP is the specialist report in hand because of, you know, the many, many occurrences of people falling through the cracks and having unnecessary visits without complete information and so on. So, the patient perspective on this care coordination may be as a quality measure, maybe there is a need for functional criteria around those interim steps, but the outcome measure is probably about the adequacy of information to provide care at the end of the day.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

This is Kevin Larsen, another thing that we've been lately identifying is that some organizations will develop an outcome measure but then they'll have a series of other measures that can be used if people want to do process improvement, so they're not required, but it's sort of a library of you want to diagnose your problem try this, you already have all the data elements, here is something you can use for your own internal work. So, we might be able to provide some pointers to organizations that want to be able to do some subanalysis to help them achieve an outcome measure.

Jim Walker – Chief Information Officer – Geisinger Health System

And, David, I think you're right about patient perception, but I do think the other measure, what 5 years from now or something ought to be that every care delivery organization can report 100% that that loop either got closed all the way to the end or that the patient declined the consult, you know, because patients are too forgiving, in addition to the fact that patients are obviously the criterion standard.

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

Right, that makes sense. Okay, we're onto patient safety. Any reactions to the summary provided here on patient safety? So, the warfarin monitoring measure that we've talked about on a couple of calls, is that implied in #1, the first one on here?

Jesse James – Office of the National Coordinator for Health Information Technology

Yes.

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

It doesn't specifically call out warfarin application, but I think that's what it is referring to.

Jesse James – Office of the National Coordinator

Yes. Yes, this is how it was described in the NPRM, which did not go into detail on a medication.

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

Okay.

Jim Walker – Chief Information Officer – Geisinger Health System

I think you're right David. This is Jim, sorry, that we ought to say warfarin so the scope is clear and so it's manageable.

Eva Powell – National Partnership for Women & Families

Well, this is Eva. On the fall screening one, I'm wondering if that measure is in a place where it can be applied across care settings, because I think that's part of what we keep looking at is where do we need to adjust existing measures such that they can be compared across care settings, because typically, as you all know, the measures are specific to a particular provider type. But things such as falls and other care coordination type measures need to be able to be standardized across care settings.

M

That's a very good comment to make and this measure right now is focused on the outpatient, the eligible providers from an outpatient basis, but of course, no matter the setting, you're at risk for fall, you're practically at risk for fall, at a greater risk when you're an inpatient or if you're in a long-term acute care facility, so that's a good point.

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

Is there a parallel measure in the hospital set?

M

There isn't a fall screening, there is a hospital risk assessment screening, but CMS, outside of Meaningful Use, has IQR measures for fall risk assessment and their psych hospital measure set has fall risk assessment.

Norma Lang, RN – University of Wisconsin

There is considerable work done, this is Norma Lang, by the nursing researchers on fall risk in hospitals and in other settings that probably could be referred to here, because most of that work is done by the nurses in the hospital and in long-term care facilities, and actually even in homecare. If one is going to go across venues, but when I asked that question last time, you were pretty clear that you wanted this to only be eligible providers and what might be attributed to them. So, maybe we need some continuous clarity on that.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, just as formal point to Eva's excellent point about the cross venue, you could imagine saying fall risk assessments shall be assessed timely and then saying inpatient, that means based on the nursing evidence, that means within 12 hours of admission, the outpatient setting that means once every 12 months and then so on and so on.

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

So, at this stage our comment though maybe just to try to encourage addressing this domain in the hospital set and as you just suggested, Jim, aligning the structure of the measures so that it's parallel in different settings?

Jim Walker – Chief Information Officer – Geisinger Health System

Sure, exactly, and you know, somebody from ONC is having a meeting May the 3rd on long-term care and how to get them in the game and, you know, I think this might be a topic that would make sense there also.

Tripp Bradd – Skyline Family Practice, VA

This is Tripp, back to the medications; I know that we've about beaten warfarin to death, but how about other medicines or medications? Are we going to be looking at for instance just to use examples of atypical antipsychotics and glucose measurement or potassium and diuretics, you know, are the eligible providers going to have a menu, so to speak, of medications of which that will be reported on?

Kevin Larsen -- Office of the National Coordinator for Health Information Technology

For MU2 though they are not in the pipeline, this is Kevin Larsen.

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

So, yeah, there is a contractor who has been working on trying to take this concept and realize it and they went through several iterations. I think they circulated a report a couple of months ago from their preliminary work and it is problematic. I think most of us would agree that the warfarin proposal that is surfacing is fine but not addressing the broader concept that was originally intended by ADE, both reporting and monitoring. So, I think there is a lot of work to be done there to get it where we want it, but your suggestion of having a longer list of candidates is one of the ones they entertained and I think they ran into a lot of measurement issues that held them back from finalizing that approach.

Tripp Bradd – Skyline Family Practice, VA

Yeah, well the reason why I mention that is it would be relatively easy with, you know, specific data, discrete data elements, particularly lab that might allow it to be measured a little bit more easily.

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

We might want to recirculate that report I know it's been updated, the original, I think Booz report that critiques some of the different approaches to this measure so people could see the work thus far.

Kevin Larsen — Office of the National Coordinator for Health Information Technology

One item I will bring up that has surfaced as we go into the details of warfarin monitoring gets kind of back to this idea of group versus individual reporting of measures. We've had a fair bit of commentary about how we would define who we would measure when we measure medication that's being monitored. Do we measure an individual? And if we measure an individual, does that mean their partners would be less motivated to do refills for them? Do we measure a group? If so, does that group includes specialist that may actually also be part of monitoring these drugs? So, that's just a concern that has been raised on more than one occasion about how to do attribution for the monitoring of critical drugs.

Tripp Bradd – Skyline Family Practice, VA

This is Tripp and using again warfarin again as the scapegoat for all this, I would say that, you know, as long as there is a discrete element to sort of show that that practice or provider is looking at it, for instance the PT INR should be almost adequate enough and it wouldn't matter who is attributed to it as long as it's being measured. It will be hard to attribute it, you know, across organizations sometimes. Don't you agree?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, the concern we've had, at least we've heard raised, is that primary care doctor is doing the INR monitoring but a cardiologist is writing the prescription for warfarin and so then, how does the cardiologist show that they're doing monitoring?

Tripp Bradd – Skyline Family Practice, VA

I think that the timeline would force them, or as they would say, they would have to stretch to sort of make sure that they're getting those PT INRs to their particular lab table we'll say, if they're going to write for it, from a safety perspective, as long as...because people will be slip-shot no matter what you do, but, you know, as long as you're having some discrete element being measured, that's what you're trying to start with at least.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim; it's sort of back to that original thing about groupness.

Tripp Bradd – Skyline Family Practice, VA

Yes.

Jim Walker – Chief Information Officer – Geisinger Health System

You know, it's obvious when this works, even inside of an organization, let alone across the venues of care that the patient needs, it's got to be a group process and I know it's hard, but as quickly as we can, we need to figure out ways to do this because what we all obviously want is a situation where if a patient needs a Pneumovax they get it before discharge in the hospital, they get it from the primary care doctor, they get it at the orthopedic office, you know, if the EHR sees that they haven't gotten it there. So, to the extent that it's possible and it will be hard, we need to at least have that as a goal that more and more we can represent groupness in terms of giving the group the credit for getting the thing done.

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

All right, well in light of our time, let's capture these comments, we'll try to figure out how to distill them into something succinct for purposes of next week's meeting as well as gradually more detailed for the comment letter and let's turn our attention back to the criteria. Now the purpose of this discussion, we because we had a very lengthy and lively on-line discussion and I think today we circulated very interesting integration of comment documents. I really appreciate the staff having put this together, it's titled draft criteria for the Quality Workgroup to evaluate CQM and as several people have pointed out, there are plenty of good criteria out in the world from the MAP and the NQF and other groups that we don't need to reinvent, but the broad question of one of the criteria for a good quality measure, a lot of good thinking about that out there.

We have a specific charge which is what are the right quality measures to bring into the HITECH Meaningful Use Program, which are not necessarily all the quality measures anybody would want for QI or payment or any other purpose, but really just this particular purpose that we are responsible for, we're trying to advise. So, we have this very interesting collection of discussion points and I think our task now is, in my mind fairly focused on the questions CMS posed to the rule, which is they said we would like to have less than 125 measures in the menu table from which providers will choose how to report, please give us some input on how we should go about reducing the size of the list.

So, we started our criteria discussion about one month ago or 3 weeks ago with the hope of coming up with some guidance to CMS on what they should use as criteria for reducing the length of the list and we've also heard some comment maybe they shouldn't reduce the length of the list, maybe it does a good job of providing reasonable reporting options for lots of different types of providers. So, I think at this point, again today we probably can't hammer all of this very interesting material and you also probably saw Peter Basch's additional comments that were circulated I think this morning into a single approach, but I would welcome just a few minutes of discussion of how you would like to solve the problem of what do we advise CMS to do about reducing the length of the list or do you think we should advise them to reduce the length of the list?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

This is Kevin Larson, I'll give one comment about the MAP criteria, there is a lot of consideration about what we should do with the MAP criteria. I'll just point out to the group that the first one meets NQF endorsement, none of the de novo strategies really will, by definition, meet the NQF endorsement criteria. So, that is just a point of clarification for the committee that by nature of creating measures for these programs they have not been through the historical endorsement process.

Tripp Bradd – Skyline Family Practice, VA

So are you suggesting, this is Tripp, that we would just use the MAP criteria notwithstanding all the good commentary associated with this document as the primary way of doing it?

Kevin Larsen — Office of the National Coordinator for Health Information Technology

There were some people in the e-mail discussion that said that MAP had done a lot of work and we're proposing that as one of the alternative ways to do this instead of the committee creating its own to use

the MAP group, and so I was just commenting on that this MAP criteria has this requirement of NQF endorsement which would eliminate all of the de novo measures.

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

Yeah, we have I think a specific question, I mean it may be that we could have a lot of MAP measures that satisfy the MAP criteria but don't help us reduce the length of the table 8 list very much, except for maybe a few that don't meet the NQF standards.

Marsha Smith - Centers for Medicare & Medicaid Services

Hello, this is Marsha.

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

Yeah, go ahead.

Marsha Smith - Centers for Medicare & Medicaid Services

What I was trying to say and I didn't get myself off of mute in time.

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

Okay.

Marsha Smith - Centers for Medicare & Medicaid Services

Was that, you know, that being considered de novo they're not going to be endorsed, but they are developed with those criteria in mind and I believe that we're interested in looking at a way to expedite that process. So, even if they are not endorsed by the time the program is implemented they would be able to be reintroduced and endorsed. So, it's not like and end all just because they're not endorsed they are automatically kicked off, I just want you to know that we're also keeping them in the back of our minds during development.

Tripp Bradd – Skyline Family Practice, VA

Correct me if I'm wrong, this is Tripp, wasn't there a method by which CQMs that got approved later could then come on-line subsequent to a final rule?

Marsha Smith - Centers for Medicare & Medicaid Services

There was a process where they had like a time-limited endorsement and then there would be an opportunity when they had the next call for the measures in that category they could go in for the full endorsement. So, with these measures that are in the NPRM and MAP is aware of the measures that are considered for use in our programs, but we would be interested in process of perhaps expediting that review process to say if those measures do end up being I guess specified and ready for implementation that they could get that endorsement.

Tripp Bradd – Skyline Family Practice, VA

Kind of like they're on probation?

Marsha Smith - Centers for Medicare & Medicaid Services

Sort of I guess, but I just wanted to...you know, I mean what Kevin was saying is that it shouldn't be that they're not endorsed that they are automatically kicked out. Do you know what I mean? So, I just want you also to know that we do consider that as a criteria but it's not end all for being in the program. Does that make sense?

Tripp Bradd – Skyline Family Practice, VA

Yes.

Marsha Smith - Centers for Medicare & Medicaid Services

Okay.

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

Sure, and also it's worth noting probably that the MAP criteria don't specifically address the HIT relevance which obviously is one of our considerations.

Josh Seidman – Office of the National Coordinator for Health Information Technology

Yeah, this is Josh Seidman, just to build on that. When the MAP coordinating committee was discussing those elements, I had talked with NQF about that issue and we agreed to kind of table that and then on the following MAP coordinating committee we sort of reintroduced those issues, the issues of HIT sensitive, HIT enabled, and HIT feasible measures and there was general consensus that those were important things to consider as well.

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

Yeah.

M

So, that would be the addendum then.

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

Well let me ask a threshold question, do you all feel like you think CMS should shorten the list of eligible measures that is now in table eight or do you think leaving it as is an acceptable outcome?

Jim Walker – Chief Information Officer – Geisinger Health System

David, this is Jim, may be an alternative form of the question would be, do we want to prioritize the list so that we make sure that we get the ones that are most likely to have an impact to have face validity for physicians and others, those sorts of things?

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

That may add more complexity to the rule and the provider's decision-making.

Jim Walker – Chief Information Officer – Geisinger Health System

Okay, good point.

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

Anybody want to speak in favor of not shortening the list, just leaving it as it currently is more or less, obviously there will be content issues to consider in keeping or losing a measure, but in terms of inherently making is shorter is that a good thing?

Tripp Bradd – Skyline Family Practice, VA

Using the KISS principle, I would say yes. This is Tripp.

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

All right, so Tripp then you are on the hook for proposing the criteria to use.

Tripp Bradd – Skyline Family Practice, VA

Oh, thanks. I don't think I have the expertise to do so but I think by, you know, applying some filters as we've just tried to do, I think that would shorten the list some anyway. I will say, from an emotional first pass by a group of providers that I had occasion to pass this by, you know, they're feeling overwhelmed and I guess, you know, and that's primary care providers, having a shorter list doesn't upset them any and like Jim mentioned, it's not just the providers that have to be considered with this too I suppose. And I think the priority things are important as he alluded to.

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

Well, I think the...way to prioritize is to go back to option 1B and say there are these dozen or so measures that are essentially universal and they are the priorities and so, you know, the philosophical alternative is to say we have this wide open list and you can find yourself on here somewhere suitable to your practice interests and the alternative is to say no everybody has to do these 10 or 12 core measures that are general applicability.

Jim Walker – Chief Information Officer – Geisinger Health System

So, David, I've said it before, but I'll say it quick, this is Jim, it seems to me if remedial burden of illness, defines specifically as improvable quality adjusted life years in the population, if that isn't one of the three or four criteria then all of the many people who have to spend a notion of money or work incredibly hard and change everything they do to achieve these are going to be far less motivated to do it and we're going to be far less likely to succeed and it'll be far harder to explain to Congress and the public.

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

Right that's your first criteria on our list. Any other comments about whether to reduce...in reducing the list? I don't know if we've sought or have a consensus on whether we would encourage CMS to reduce the list or what is beyond this general discussion of criteria...Kevin about a way to get some broader input on whether we have something specific to say to this question. We have quite a range of opinions on our list of the draft criteria and quite a lot of different material on it.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, this is Kevin. I didn't actually take any time really to try to align these or summarize them into themes. I just kind of put them out as people had proposed.

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

Right, understood. It's a complex problem; obviously there have been plenty of very smart people on committees that have spent months and months on this question rather than a half hour. So, I think we will not speak to it in the next week except to maybe acknowledge that it's an important question, but we haven't yet come to a consensus. Well we only have a relative few minutes left. We have to take a little bit of public comment. Jim could you or maybe others on the staff could take us through the items that have been listed here with some topics that the Clinical Quality Committee on the Standards Committee has been discussing. I see there are half a dozen specific suggestions here that you wanted us to comment or at least be aware of?

Jim Walker – Chief Information Officer – Geisinger Health System

I'm sorry, which document are you on David?

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

Well, I'm back on the Summary of Quality Measures Workgroup discussion from our very first piece of paper this morning and item #3 that said additional items identified in the HITPS request for the Workgroup to comment on and maybe I'm getting everyone confused, Kevin or Jesse is this something you added?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, the very first document we started was Summary of Quality Measures Workgroup from the Health IT Policy Committee, the kind of second bullet, issues for follow up, these were items that were called out in that Health IT Policy Committee working spreadsheet around comments and there were sections that we were asked, the Quality Measure Workgroup was asked to comment on and there are really four different items there or excuse me, about 5 that we were asked to comment on, but there was no comment from our last meeting.

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

Oh, I see, I thought these were things from the Workgroup that Jim was chairing, so my apologies.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, and so if you go down to bullet #3 clinical quality measures, core menu no longer allowing zero was something that we were asked to comment on.

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

Right and I think we did go through all of these very briefly last call and people didn't speak up to them, so I don't know, maybe we'll run through them again now and see if we have comments people want to

share. We don't have to comment on anything we don't feel moved to comment on, but here is another opportunity. Yeah, do you want to just run down the list and ask people for any additional opinions?

Kevin Larsen — Office of the National Coordinator for Health Information Technology

Certainly, so again we're in that spreadsheet, item #3 and it says A, B, C, D, E and F, so the first one was no longer allowing zero scores for the clinical quality measures on the core menu options. Is that something that we want to comment on?

Tripp Bradd – Skyline Family Practice, VA

Was this reflecting, this is Tripp, a provider behavior of just choosing ones they automatically fail on?

Kevin Larsen – – Office of the National Coordinator for Health Information Technology

So, I think that currently, if you get a zero score, you would test that you still can do the measure and so in the future the question is, is this the way we want to move forward as well? And, so I suppose that providers could choose scores, choose measures intentionally that they get zero scores on. I don't know that this has been anybody's concern in particular, but I think that the concern would more likely be that measures that always return zeros are unlikely to be giving us valuable data.

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

This also goes to one of Peter Basch's comments was that the purpose of this program in his mind is to generally engage people in meaningful self-evaluations and improvement and if people are reporting zero scores, probably not on the pathway to meaningful improvement.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, it seems reasonable that we don't allow zeros anymore to the extent that I understand it.

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

I'm with you.

Russ Branzell – Poudre Valley Critical Access Hospital, CO

Yeah, this is Russ, I would support that, it would only make sense that measures could be used that were reportable, actual real data, zeros not data.

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

Okay, next.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

So, the next one was for the 2013 measure, there is a requirement of 15 clinical quality measures for eligible hospitals, is that the right number? And similarly, in 2014 that goes up to 24 clinical quality measures and so the Policy Committee had asked for our comment on those questions.

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

Was there a rationale for staging the number of measures over time and just a burden or a coding problem?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, I don't know the history and it didn't state that in the spreadsheet that I was working from. I assume that it's something about burden of measurement and that the program requires more with each subsequent year.

Russ Branzell – Poudre Valley Critical Access Hospital, CO

This is Russ again, I think it would be difficult to say what the right number is but rather it's more of a philosophical question as it was asked a minute ago. It's hard to say what the right number is without defining what they are.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Okay.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, I agree. I think it would be fair to say 15 and 24 don't seem unreasonable, but that's all. You know, at some point, David, maybe the policy, well at some point...well never mind.

M

Do we have any feedback from vendors on that? That would be another way of looking at it.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim, you know, if you can do...you know, in fact I think David mentioned something about creating the structure to do these with. It's like, you know, do we do warfarin or 10 medications to start with, I mean if we make it clear that we're getting to 10 or 20 medications or whatever it is, and the certification is written so that to be certified you have to have the infrastructure to do warfarin in the next 20, then how many we start with becomes less of an issue as long as we can make that signal clear and persuasive and build it in certification, you know, people will be managing hundreds of quality measures in a few years and I mean EHRs, because if you can do one warfarin you can do the next one.

Tripp Bradd – Skyline Family Practice, VA

I guess that goes, this is Tripp again, to the E, which is the CMS portal concept, which I think David mentioned is a middle way or kind of way of getting things done quickly.

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

But, I think the...15 to 24 pathway is what they propose in the rule and it seems none of us have so far verbalized any big problem with that, it seems like a reasonable path and to Jim's point the fact that you know it's 24 by 2014 gives you a predictability in the requirement and if it takes you a year to get there, that's not a problem from our point of view. So, hearing no decent on supporting what is proposed let's go onto the next topic which is the specialty hospitals.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, there apparently were a number of exceptions in the Stage 1 and this would be to limiting the case threshold exemption only to children's cancer hospitals and a subset of hospitals in the Indian Health System, but the rest of the exemptions would essentially be eliminated.

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

Anybody have concerns about that?

Jim Walker – Chief Information Officer – Geisinger Health System

What is the rationale for keeping these exemptions?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Again, the document doesn't say. Let's see they have much more narrow patient base than acute care and critical access hospitals, that was the rationale.

Jim Walker – Chief Information Officer – Geisinger Health System

Well, you know, this is back to that core and non-core. I mean, kids smoke and ought to be asked, kids have blood pressure and it matters.

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

This is hospital I think; this is just hospital, Jim.

Jim Walker – Chief Information Officer – Geisinger Health System

Well, that's what I mean, hospital.

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

For example in the notes they said they only have a typical children's hospital only has two strokes a year, so they don't have enough cases to be reporting stroke measures for example.

Jim Walker – Chief Information Officer – Geisinger Health System

Well, then I think, you know, then we ought to say, the exemption would be based on...you know, if you say our denominator is 2 then that's an exclusion criteria, but not for a children's hospital. I mean, children's hospitals have huge safety problems, kids are very tricky, medications especially are incredibly tricky and all kinds of errors get made. I think it sends the wrong single to say if you've got cancer or you're a kid this isn't for you. Indian Health probably is a different kettle of fish I'm guessing. And I don't know what cancer hospitals wouldn't have plenty of them.

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

Well, the rule notes that people are allowed to report zeros on these measures, so you could have a reportable measure rather than exempt from it and you're basically reporting zeros. Any other comments on this one besides Jim's caution or hesitation on proceeding this way?

Tripp Bradd – Skyline Family Practice, VA

This is Tripp, especially with children, I'd like to sort of emphasize what he said about that, you know, I don't think that should be an exception, that's a group that can't always advocate for themselves.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, and my understanding of this is that the exemption is that they have a case number threshold that then they get exempt not just because they're a children's hospital or a cancer hospital; they have to be children's and have a case threshold. Previously, you could have a case threshold and be a different type of hospital as well.

Jim Walker – Chief Information Officer – Geisinger Health System

Is there a reason we just wouldn't make the case threshold?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

I think that's what it was. Again, I don't understand these as well, the details, but I think that's what it was and this is saying we're no longer going to allow that for a wide range of hospitals only these three types of hospitals.

Jim Walker – Chief Information Officer – Geisinger Health System

But if some other kind of, you know, say a mill that does nothing except one kind of surgery and doesn't have any strokes either, you know, it just seems to me if we said if you do not have enough to report then you don't have to report it that is clear and unambiguous and easily defended. Somebody sees this and says children's hospitals aren't part of this quality effort, that just is a nonstarter.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Do want me to find more details and we can talk about this at the next meeting?

Jim Walker – Chief Information Officer – Geisinger Health System

Yeah or maybe all policy wants us to do is raise the flag, I don't know about that, David you would know more about that.

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

Well, this is a fairly, as we are already discussing, a fairly technical issue where we'd have to probably get into the weeds a little bit on the different types of institutions, what the history was in Stage 1 that is driving this proposed change. I don't have enough knowledge to really have an opinion about it, but I think if the staff wants to come back or ask someone from CMS to give us a sense of what they need from us that would be helpful, it sounds like we're happy to think it through a little further.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Okay.

Marsha Smith - Centers for Medicare & Medicaid Services

I'm sorry; this is Marsha, what was the question again?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

This is about the case threshold, changing the case threshold that the exemptions would only allow children's cancer hospitals and some Indian Health System Hospitals as opposed to allowing case threshold in a broader range of hospitals.

Marsha Smith - Centers for Medicare & Medicaid Services

Okay and then are we referring to a particular document, I'll see if I can pull that up?

Kevin Larsen — Office of the National Coordinator for Health Information Technology

It is from page 220 and I have it in the HITSP recommendations, the comments that were solicited in the NPRM.

Marsha Smith - Centers for Medicare & Medicaid Services

Okay, all right, let me see, so the reason is why are we just saying children's hospital and certain cancer hospitals, is that correct?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Correct. Why is there a proposal to change this from just a case threshold limitation, which sounds like it is more straightforward, then to a case threshold for only certain types of hospitals, everybody else must report regardless of their case threshold?

Marsha Smith - Centers for Medicare & Medicaid Services

Okay, all right, I'll see if I can find that for you, okay.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Shall we move on while she's looking for it?

Marsha Smith - Centers for Medicare & Medicaid Services

Yes.

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

Yes, please.

Kevin Larsen — Office of the National Coordinator for Health Information Technology

So, the next one is the CQM reporting in 2014, could it be via the CMS portal or would it have to be as it is in Stage 1?

Tripp Bradd – Skyline Family Practice, VA

This is Tripp, is that obtainable by 2014?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

I again don't have enough background knowledge to tell you.

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

I think...would be to answer the question, would we prefer that the CMS portal be the primary way of reporting?

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Yeah, so here it says the...proposing is submit the selected 24 clinical measures through a CMS designated portal for this option the data would be submitted in an XML-base format on an aggregate basis reflective of all patients without regard to payer. This would require eligible hospitals to log into a CMS designated portal. Once the eligible hospitals have logged into the portal they would be required to

submit to an upload process. So they would no longer be reporting on only Medicare patients, they would be reporting on all patients.

Jim Walker – Chief Information Officer – Geisinger Health System

This is Jim. I don't feel like I understand it well enough to have an opinion.

M

...

Jim Walker – Chief Information Officer – Geisinger Health System

Can we get a little more background?

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

Yeah, that ties into item F as well which is about payer, where it says Medicare only question. So, I don't know if anyone on the call has strong feelings that they want to share about this reporting methodology question? I think we can hold it until we have a little more information about it? All right, so I see we're getting down to the last minute or so here before the public comment opportunity. We had had on here the opportunity possibly from CMS to discuss the measure authoring tool, anything pressing about having that discussion today Kevin or others?

Kevin Larsen — Office of the National Coordinator for Health Information Technology

No, it was just to kind of update the group that there has been considerable maturation of the output of the measure authoring tool and explaining some of the details of that, but we can put that into a future time.

Marsha Smith - Centers for Medicare & Medicaid Services

The statement was put in by Medicaid. So, I'd have to follow-up with someone there to get you additional information.

Kevin Larsen – – Office of the National Coordinator for Health Information Technology

And this is back to the two types of hospitals?

Marsha Smith - Centers for Medicare & Medicaid Services

Yeah, I'm sorry, yes, yes, yes.

Kevin Larsen – Office of the National Coordinator for Health Information Technology

Okay.

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

Okay, well we'll parking lot that.

Marsha Smith - Centers for Medicare & Medicaid Services

Okay.

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

So, just to summarize where we seem to be at for today's discussion, we have reviewed and updated some of the principle findings from our previous call. We went through and assessed the mapping to the original Tiger Team recommendations. We have a number of comments which we have to distill into something that we can succinctly communicate, I guess conceptually about the red, yellow, green progress to date and the key areas we've talked about today that we want to continue to make progress. We've again kind of deferred the criteria question. I don't off hand know, I think we'll have to take the document that we had for today, which lists many criteria approaches and in light of the conversation see if we can compress this into a few succinct statements that capture some of the key generally agreed to points and we'll try to do that before the next call, but I don't think we'll try to speak to that at the Policy Committee meeting next week.

And then we talked about some of the details and issues that require comment which we'll try to fold back into the summary of the overall response to CMS. So, I think what the challenge will be is to develop a few slides to present to the Policy Committee next week fulfilling what we've talked about in the last few weeks and if I have a chance, and I will talk to Kevin about this, try to circulate those key talking points to this group before we have to present them to the full Policy Committee so people can have the chance to make sure it's consistent with what you're comfortable saying.

So, I think that our job in the few days, Kevin and company, is to somehow capture all this into a few key messages for the Policy Committee and particularly areas where we would like to get any input from the Policy Committee that will help us get closure on a few of the loose ends we have. So, that's where I think we're at. Any last words before we open for any public comment? All right, once again I thank everybody for a very thoughtful and deep discussion on many, many, many complex questions and with that I think Mary Jo let's see if there are any public comments today.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Thank you very much, David. Operator would you open the lines?

Caitlin Collins – Altarum Institute

Yes, if you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time.

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

All right, well thank you all very much again for your time and we'll try to circulate our draft comments with the Policy Committee in time for you to react to them and we'll talk to you again before long.

M

Thank you so much.

W

Thank you.

M

Thank you

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

Bye-bye.