

**HIT Standards Committee
Clinical Quality Workgroup's
Characteristics of Optimal Clinical
Quality Measures for HIT Tiger Team**
Draft Transcript
April 2, 2012

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

Good afternoon, this is Mary Jo Deering in the Office of the National Coordinator for Health IT and this is a meeting of the HIT Standards Committee Clinical Quality Workgroup and it is Tiger Team on the Characteristics of Optimal Clinical Quality Measures for Health IT. This is a public meeting and there will be a chance at the end of the call for the public to make comments. I will also ask the members to please identify yourselves when speaking. Now making a transcript. So I will begin by taking the roll, Karen Kmetik?

Karen Kmetik – American Medical Association

Here.

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

Anne Castro?

Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect

Here.

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

John Derr? Bob Dolin? On mute, but I know he is here (laugh). Rosemary Kennedy?

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

Present.

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

David Lansky? Rob McClure?

Robert McClure – Chief Medical Officer - Apelon, Inc.

Present.

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

Eva Powell?

Eva Powell – National Partnership

Here.

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

Eric Rose? Danny Rosenthal? Randy Woodward? And could I have other staff on the line please identify themselves and their Agencies?

W

[Unintelligible.]

Kevin Larsen – Office of the National Coordinator

Kevin Larsen, ONC

Patrice Holtz, RN, MBA – Office of Clinical Standards and Quality – Centers for Medicare & Medicaid Services

Patrice Holtz, CMS

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Jacob Reider, ONC

MacKenzie Robertson – Office of the National Coordinator

MacKenzie Robertson, ONC

Amy Gleason – Office of the National Coordinator

Amy Gleason, ONC

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

Okay, back to you Karen.

Karen Kmetik – American Medical Association

Well thank you everyone for taking time out of your busy schedules to be with us today. You have the agenda before you and I think it might be best to just go through the slides, which will by nature take us through the agenda. So if I could go to the next slide, and the next one after our team. So just to put the context out there, we are scheduled to have three conversations; one today, one on April 5th and one on April 19th, and I am proposing a way to divide our time is today to focus on what's on the agenda, which is thinking about our purpose, I am going to say a little bit about perspectives and then think about the attributes of Optimal Clinical Quality Measures. Perhaps on the 5th I thought it might be worthwhile to then take some examples of measures and vet them against the criteria that we talk about today. I don't know for me, it always helps ground me when I bring some real world examples to the conversation and then, between the 5th and the 19th, to try to put together our recommendations to get out to you so that on the 19th we can focus on specific refinement of recommendations that we would want to make back to the higher order work group. Any initial reactions or comments on that laying out of our schedule?

Eva Powell – National Partnership

Hey Karen, this is Eva, just a question, I know that the primary purpose of this is to identify Measures for Stage 2, is that correct?

Karen Kmetik – American Medical Association

I would say it is not so much Measures; let's go to the purpose statement Eva, the next slide, and let me just say a few words and see if this addresses your comments. So, we are to focus on identifying attributes of Optimal Clinical Quality Measures that are created or exist and are being retooled, if you will, for use in Health IT, particularly EHR's. So I look at this as, and I want to get your and others reactions, there have been many conversations, committees that have talked about what are our criteria for good Measures. I think here we want to put a little bit of a technical lens on it, that is to say that a fair amount of work has been done now, sponsored by CMS and ONC and even AHRQ to create the specifications for Measures in EHR's, to test those measures in an EHR environment, but at the end of the day then, I think we need to take that information and figure out what do we do with it, you know, what does it mean to say something is EHR-feasible, EHR-enabled. It may have met other criteria of being important, it may have met other criteria of being a gap in care, it may have met other criteria of being evidence-based, but here to focus on that technical lens. Does that make sense or would you look at it another way?

Eva Powell – National Partnership

No, I think that makes perfect sense, and I guess what I was getting at in terms of asking that question is, I worry sometimes when we talk about kind of a yardstick approach, which I do not think is a bad idea, but putting that up only against the Quality Measures that we have today. Because I feel like often times we are in the kind of chasing our tails mode where from the policy end, we can't recommend certain measures because they are either not endorsed or there are specifications involved and standards involved from the standards perspective that haven't been achieved yet, but then from the standards end, following some policy which is as we have been directed to do. I do not know how we are ever going to get there to this sweet spot of actually having EHR's enable new and different kinds of Quality Measures.

So, for the purposes of Stage 2, I know that it is probably still most realistic to think that the list that we come up with, in terms of the attributes of Optimal Clinical Quality Measures, in large part may be confined to the Measures we have today, but, I feel like part of our conversation should be broader, in other words, not tied to what we have today and where there are clear gaps and we have talked ad nauseum I feel like about gaps, just "we" collectively, across time, such that I feel like perhaps part of our conversation about the EHR-enabled part, and maybe it is the difference between EHR-enabled and EHR-feasible that certain things, for example longitudinal Measures are EHR-enabled but they are not EHR-feasible, because we don't have the infrastructure yet to do that. And so I feel like naming those very specific gaps, whether it is, we need a Standard for X, is going to be critically important, and I don't know if that piece of the work is for this team to do.

But when I looked at the slides and saw, and we'll get to this in discussing the Criteria for Good Measures, I did not see anything in there talking about, you know, it's actually measuring something that is meaningful, that matters, and I feel like that is probably an A number 1 question we need to be asking, what do we need to be measuring that we are not and for those things we are not measuring that we need to be, that are that way because we don't have standards or because there is a technical reason, then that's part of what we need to draw attention to. Sorry, I am rambling . . .

Karen Kmetik – American Medical Association

No, this is Karen, Eva. I understand completely and I am going to ask others to comment. I guess my initial reaction to that would be we do not want to be chasing our tail, as you said, that we would not want to limit our thinking to a set of defined Measures today, if we think we defined those Measures because we thought they were feasible. I mean, we are trying to get out of that box a little bit.

Eva Powell – National Partnership

Right.

Karen Kmetik – American Medical Association

So maybe one way we might address that is when we go to vet some examples, to pick some that are, maybe proposed today, but are more on that forward edge of things or just, you know, create a Measure just for purpose of discussion that we know would pass those other criteria of importance, patient engagement, those other attributes we have and sort of run it through this filter of technical and what it would mean here, but I welcome other comments.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

This is Rosemary, just to clarify Karen what you said and Eva, the scope here speaks to Measures that have been created for use, or are being created for use in Health IT or retooled for use in Health IT, but you're saying that it would be good, Eva, for all the reasons that you stated, to take a measure that may not fall within this category, but is meaningful and important and run that through the criteria, or the attributes that we identify?

Eva Powell – National Partnership

Yeah, I guess what I am saying is that one of the attributes, and I feel like I am getting ahead of ourselves a little bit because we have not gotten to the slides yet, but that one of the attributes should be, is what we are measuring meaningful and is it useful.

Karen Kmetik – American Medical Association

And I am just saying that I am assuming that filter has applied or will be applied? And that if we have something that is absolutely meaningful, and meets all of our other criteria, then how do we view it from this more technical lens.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

Right.

Eva Powell – National Partnership

That makes sense. I guess where I still worry a little bit, and maybe it is beyond the scope of this group, is getting at those things, like longitudinal Measures, that we know are only going to be enabled by Health IT and yet they're not going to be developed if the Health IT is not ready to do that. And so, I don't know, and maybe it'll work itself out as we go through our conversation, I don't want to hold things up, but,

Robert McClure – Chief Medical Officer - Apelon, Inc.

This is Rob McClure, I have heard a couple of things that I thought were really important elements of the discussion, I guess. So one of them is, this idea of having something to say about what we think can be done now, granted now in one institution isn't sometimes now in another institution, so I think there is obviously a little bit of subjectivity to that, based on the panel members experience with what truly can be done right now and then there is the stretch goals, I forget the name that somebody else used around that, but the idea that maybe this isn't now for the majority of current EHR implementations, maybe not for anybody, but it's a realistic stretch goal. And so I think that's a really good thing to kind of keep track of, because I think we should be providing feedback on stretch goals as well as being clear about the fact that there are certain things that we think should be possible now, in, I want to be a little cautious about saying any EHR System, but most EHR Systems.

The other thing that I just wanted to clarify for myself is that there have been a number of times in this past conversation that people talked about MU2 as a benchmark or something, and I do not see that here, and that gets to this issue of stretch goals and things like that. I think, I would suspect that the sort of things that we should focus on for now would be consistent with what we would expect are reasonable MU2 Quality Measures or assessments and that sort of thing. But that, again the importance of this stretch goal would take us beyond that, so I just want to clarify if that's, am I on target or not?

Karen Kmetik – American Medical Association

Rob, this is Karen, I think you're on target very much. I'd ask if the team from ONC or CMS want to comment, I mean, we do have a proposed document on Meaningful Use 2 before us, and so I think any guidance that we give would be helpful there, but also adding a component of stretch to relate to what Eva is saying, I think makes sense.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

This is Jacob from ONC. I would agree, Karen. I think that in general our thought about what this activity would focus on in terms of guidance to us would be, as you describe, the more technical ones. But there is a balance there, because you have to actually see, and I think this is where Eva was driving to, you have to see what you want to be capable of doing in order to have the technical infrastructure so that it can be done. So, there does need to be a bit of an understanding of what the content is going to look like, but I don't think this workgroup's charge is to do any assessment of that content, because I think that is more in the purview of the Policy Committee's Quality Measures workgroup. Does that make sense?

Eva Powell – National Partnership

This is Eva. I think from my perspective, I would agree with that, first of all. I think my thinking on the technical hook to all of this though, is exactly what you said, about having the technical capacity to do it and since there has been so much past work done on Measure gaps, I do not think we need to waste any more time on identifying gaps, because we know what they are. We have got enough information to be able to at least have some vision about the types of things that EHR's are going to have to be able to do in order to calculate Quality Measures in the future that are more meaningful. And I keep getting hung up on the Optimal Clinical Quality Measures, I don't think we have any right now, (laugh) that is kind of what I am getting at. In that if we are talking about quality measurement that is going to support new care models and new payment models, the Quality Measures we have now for the most part are not optimal, and so what are the technical aspects of EHR's that we need to be sure are still in from a standards perspective and from a certifications perspective so that in Stage 3, we have at least enabled the capacity to do some work on some of these Clinical Quality Measures.

The lead times are so long, it is hard to figure out what thing needs to come first, but nobody is going to create a measure that's not possible to be collected with current EHR technology. And so I think we need to have this visioning of, okay we know we need longitudinal measures where you calculate pre and post scores from, whatever thing matters. So what are the standards necessary for that, what is the technical capacity that we don't have, that we need to call out so that it's being built as Stage 2 goes on and so that we can have it in Stage 3?

Patrice Holtz, RN, MBA – Office of Clinical Standards and Quality – Centers for Medicare & Medicaid Services

Eva, this is Patrice from CMS. I would say what you just said is critically important. I think we would be looking for that guidance as well as far as what are the things that make those type of Measures feasible, not what is the Measure content, but what are the technical issues that need to be overcome so that we can develop Measures like that, and there is no such thing as having too much lead time for this. I mean, we all know that developing new Measures, through the whole process of testing them and everything takes approximately 18 months to 2 years, and that's without including getting them endorsed by NQS, so I think everything that you just said is right on.

Kevin Larsen – Office of the National Coordinator

This is Kevin. Ironically, I am on another conference call right now, touching base with some of our Measure developers who are facing some of these very challenges. How to represent change in an EHR is one of the key things that we're identifying, that hasn't, it's not necessarily called QDM. Another item we just stumbled upon is some Measures that we are finding don't reference a particular event, they just are a through time and so there isn't in the QDM again something that necessarily to do through time without saying here's the triggering event. So there are a number of those specific kinds of standards challenges that we are starting to uncover as we actually work to build these Measures.

Karen Kmetik – American Medical Association

This is Karen. That is all very helpful and I am thinking that maybe a way we can really circle our arms around this is when we look at examples to the points raised, the examples would not necessarily be Measures in our portfolios today, but rather these categories of Measures. So if we had a longitudinal Measure, what would it mean to say that longitudinal Measure someday is EHR-feasible, EHR-enabled, etcetera. If we had a measure of patient-reported outcome, what would it mean to say that that is; so we are not restricting ourselves to a current portfolio of Measures, but these types of Measures that have been deemed elsewhere to be of high value.

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(Indiscernible).

Kevin Larsen –Office of the National Coordinator

Karen, one of the ways we are testing that is looking at a couple of Measures developed through the VA and Indian Health Service that are currently live in EHR's, and seeing what it would take to spec those as Measures for MU. And that's partly where we run into this difference in the way they have been working

within their many times already certified Electrical Medical Record, but they haven't been through the standard process, so their contents are not reflecting the QDM always.

Karen Kmetik – American Medical Association

Sure, I can understand that. Well, let's charge ahead a little bit with these good thoughts in the front of our minds. On the next slide, I am just offering a bit of an observation to keep in mind, just like I think Eva you were saying, let's not limit our minds to a current slate of Measures, I would offer we also not necessarily limit our minds to measurement. I know that is the focus of what we are talking about, but in essence, if we had these data elements, be they from patients or providers, that are important for good clinical care and shared decision making, we would then have the tools we need, whether we are looking at Measures or decision-support or some improvement program. So, I am just offering that, I don't have a specific there, but it has just been nagging at me that again maybe we're tail-wagging the dog, but to step back for a second.

The next slide I just wanted to offer, I guess an obvious as well, in terms of perspective. We can look at this from the perspective of the practicing clinician and clinical teams, from the patient perspective, from the broader System, from the EHR vendor, the government program that's actually implementing. So, I think we just have to make sure at the end of the day, our recommendations are informed by those different perspectives, many of which are represented on this team, some may be, maybe not.

The next series of slides I give credit to Jacob, I had seen him present these previously as this gap, not gap of Measures, because as Eva said, we know where the Measure gaps are, but if you go to the next slide, to think about that we have current EHR capability, we have future EHR capability, and we've got current Quality Measures, future Quality Measures and those things, the capabilities of the EHR and the measure expectations are not necessarily aligned right now.

In the next slide we just add the additional complexity of work flow within the practices that might add to the EHR capability, and then on the next slide, it's just to make us think about, so, I think it really hits to what you were talking about Eva, do we in some cases modify our expectations because of where EHR is today, or in other cases we say absolutely want to move to these new types of Measures and therefore we need enhanced EHR capabilities, and this is, I think, the diagram that speaks to what we have been talking about, and then if you take it one more layer, the next slide, we are layering on top of this all standards, which I think as a nation we have made some great strides there in saying we want to take advantage of the availability of IT and vocabulary standards and how does that come into play.

The next slide then, I think, is just to state the reality of today in that if we look at all of the Measures that exist now or are proposed now, or are the ones we strive for, it requires a lot of crayons, meaning a lot of data elements, a lot of different functionalities in the EHR, but yet on the next slide we know that right now today, there is only certain elements and functionalities in the EHR's we have. So, it is how do we sort of reconcile this in a very thoughtful step-by-step approach.

So, the next slide is one I want to spend a little time on which is, again if we remind ourselves, as we talked about earlier, that we are not limiting ourselves to current Measures, but current as well as the Measures we aspire to, at some point, as Kevin said, we are going to go out and see where this is working, we are going to continue to do feasibility analysis in HER, in-practice sites and then at some point we are going to have some information about the feasibility, the accuracy, etcetera, of these types of measures and we are going to need to then say to ourselves, okay, if this Measure is absolutely one that we want, it met all the other criteria, but it doesn't quite yet meet one of these, what do we do with that then? Do we say, we need to educate physicians on work flow, or do we say we need to add something to the EHR certification process, or do we say we're going to delay this a while until those things come into play?

So, these are some attributes that have been pushed forward, some of them have some definitions, some don't, but the idea of, what does EHR-feasibility mean, what does EHR-enabled mean? I have also heard, I think Josh use EHR-sensitive? Accurate? Is it tied to our reference standard vocabularies and value sets? I wonder if we could talk a little now about what do these terms mean to folks? If we had a

longitudinal Measure of change in blood pressure, and we went out and found out, what does that mean in actual practices with EHR's, what would we say an EHR-feasible implementation of that kind of Measure would look like? What would we say our EHR-enabled version of that Measure would look like? Let me stop there and see what thoughts folks have. You might also want to go to the next slide where it's T'ing up some possibilities of how we would interpret these words?

Robert McClure – Chief Medical Officer - Apelon, Inc.

Actually, this is Rob McClure. I was wondering, given that those were phrases that have now been used a couple of times, what is EHR-feasibility or feasible and EHR-enabled? I don't know what that means.

Karen Kmetik – American Medical Association

So how would we . . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

It sounds like it is official.

Karen Kmetik – American Medical Association

Kevin or Jacob, I know at some point Josh Seidman I think, had offered some definitions. I don't know if you have . . .

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Yes, so we could offer some definitions. An EHR-feasible measure might be one that references data elements or capabilities that are or would be expected to be present in an EHR, and I think one of the challenges here is we're talking about 2014 capabilities in general these days and yet we are looking at Measures that are developed today. So if you look at a Measure today, and compare it to the capabilities of a 2011 EHR, it's not really a fair comparison. I have heard the metaphor, we are giving the third graders the fifth grade math test. So if we say EHR-feasible, it means the Measure understands the expected capabilities of a 2014 EHR, and makes no expectations beyond those capabilities. So, we are not referencing data that we would not expect the EHR to be able to have circa 2014.

An EHR-enabled Measure would be one that takes special advantages of the capabilities of an EHR that don't exist in the paper world, so it might be a population measure, it might be even, and I know Kevin will kick me about this one, a delta Measure, something that compares from what things were to what they are today or what they changed from one point in time to another. This was simply either not possible or very, very difficult in the paper domain, but might be quite feasible or, I'm sorry, enabled in the EHR domain. So each are sensitive as a different topic, I am going to pause there and see if there are comments or questions about those two before I get into sensitive.

Eva Powell – National Partnership

This is Eva . . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

This is Rob. I asked the question so I will jump in and ask the first follow up. So those to me are orthogonal, in other words, the idea of trying to assess what an EHR should be able to support in 2014, kind of envisions one set of criteria, then to kind of identify the capabilities that using an EHR data source would provide that is very difficult on paper is a different, it is a different look at it. So, I just want to make sure that we are kind of, once again I am following, because I could, there are certainly things that you could do now, even with third graders, in 2011, that in a data source that is from an EHR, therefore it would be difficult in a paper world, but easier in an EHR world, that doesn't require any enhancements over what we might imagine would occur in 2014. They are just two different kinds of ways of looking at the set of criteria that we might bring to bear. Am I right?

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

I agree completely. I don't think that these things are serial, which I think was your comment about their orthogonality. They are not mutually exclusive; one could be either or both, so these concepts are in a sense orthogonal, but that does not make them, I think, less useful.

Robert McClure – Chief Medical Officer - Apelon, Inc.

No, no, not at all

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Do you agree with that? Just a useful context

Robert McClure – Chief Medical Officer - Apelon, Inc.

Make sure I was not trying to think of them serially, as you suggest.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Yes.

Robert McClure – Chief Medical Officer - Apelon, Inc.

And then it does lay this other issue that we have been talking about, that I call the stretch goal, which goes beyond 2014, if I was to kind of continue the metaphor, is that right? If I was to say, here is what we expect, because we are talking about targeting what we think would be available in 2014 as kind of our standard, kind of the floor, and then if we were to say, these are things we really think are critical, that would be beyond 2014, in other words we would not necessarily expect the EHR's to deliver on that by 2014, but we would expect they need to go this direction. Right?

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

I think that makes sense.

Eva Powell – National Partnership

This is Eva. I would agree that they are orthogonal and not sequential in the sense, but I do think that it will be really important, because of the previous discussion, to perhaps look first at what is EHR-enabled and then of that, what is not yet feasible, and not necessarily to treat things sequentially, but again as a means of measuring the gap because based on what you've said, and just my own thinking about this, that's kind of the key, that's the crux of the matter, in my mind, that the things that we've all been dreaming of in terms of an EHR-enabled Health Care System, and what we could then measure for quality are largely not coming to fruition yet, is that because we are stuck in the cycle? So I think it will be critically important to look at where do those things that we've been dreaming about that are EHR-enabled, but that are not yet EHR-feasible, and what needs to be done to make them so?

Robert McClure – Chief Medical Officer - Apelon, Inc.

If I may, so one of the reasons I just asked my questions, and you've helped kind of put a light on it, and this is like any of us being particularly germane because I am dealing with building some Measures right now. So this issue of EHR-enablement, I think, that's really powerful in that it says let's think of things that we think are important that, and there is a little gray here, but that would be let's say so difficult, as to not really worth trying in the paper world, that by having an EHR you can ask these kinds of questions that you just really couldn't do in a paper world. The reason I bring up that as a real distinction cuz what I am finding is there is a lot of things you can ask in the paper world that are pretty darned tough in EHR. These are not enabled, and by the definitions that we're just saying, these are things that where there is an EHR gap and that gap is because, guess what, thank God, humans are actually pretty smart, abstractors are really good and they can figure things out that you can't write a program or go and get that data out of any EHR System yet. And so in my opinion, we've got a big gap right now in understanding the kinds of things that we need to see in EHR's that are processes that we need to be able to make sure that EHR Systems support adequately that in essence, to be able to do the same sort of things that we can do in an abstraction process. So they are not, I want to be really careful to say, I am

not saying that we can replicate the abstraction process, because that's got its own issues, but what I am saying is that there is the kinds of Quality Measures, whether you consider them good or not, that we really struggle to do in an EHR System right now that I would consider not "the enable issues," they're just simply being able to, in some way, replicate the good things we do in an abstraction process.

Karen Kmetik – American Medical Association

Hey Rob, in that scenario, would you say that what you're trying to get at there is feasibility? That those are things that either are . . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

Yes

Karen Kmetik – American Medical Association

Or expect to be, because you expect the EHR to match the paper in some way?

Robert McClure – Chief Medical Officer - Apelon, Inc.

Exactly, exactly. So I'll give you some concrete examples. So, and there's just lots of them, but a really kind of good general category fall into what I think are really important things, are process issues. So for example, very few EHR's capture all of the events that abstractors go in and look for, so it's kind of becoming a classic example, and when you are looking at prescribing antibiotics like for, and the ones that I did, for example, was around community-acquired pneumonia, there are some guidelines about timing on those things, you know some obvious ones like you really should try and do your blood draws for blood cultures before you administer antibiotics.

Well, that requires an "EHR System," and I put it kind of quotes because there's a lot of Systems in play here, that actually record things like when a blood draw was done, but guess what, very few EHR's do. And it's not simply an EHR issue, it's also a personal issue because most phlebotomists don't carry around a computer so they can say I did this now. So, it's kind of solving some of those problems is, I see, very much in our purview, and deciding, well okay, we do think that is critical, so we do expect these changes to occur, or, if that's a question that is important for quality assessment, it will always be an abstraction question.

Karen Kmetik – American Medical Association

And I would just take that a step further to say, when would we know feasibility when we see it in that scenario? I mean, I am agreeing with you that that's an aspect of feasibility, and I am trying to kind of take it a step further to say, so if we say something is feasible because it is, or we expect it to be available by 2014 . . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

Right.

Karen Kmetik – American Medical Association

How will we know that? Is it if we went into a dozen practice sites and it's there today, is it if we looked at a dozen EHR's products, but they're not necessarily implemented? That's sort of another layer of

Robert McClure – Chief Medical Officer - Apelon, Inc.

Right, right.

Karen Kmetik – American Medical Association

I think that . . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

Well there's a series of functional, you know I would expect that what would arise from this, I am hoping it will take longer than by Thursday, and we'll have more time than Thursday, but would be a set of criteria, so some of these would actually be conformance criteria. I may not be using the right official word, but they are the criteria by which Systems would be measured, and so this idea, we felt that the ability to

capture, I don't know how to make this the right broad category, but events, they obviously all capture events, but those kinds of workflow events, if we think that's really critical to assessing Quality, I for one think that it is, then we have to figure out some kind of criteria by which Systems will be measured to say that they are able to do that. Now, these like all things, are a little bit complex. For example, the one that I just suggested, it's certainly possible that in fact we modified an EHR System to support this, that it would capture an event like that. But guess what, that means that a person has to do something they weren't doing before . . .

Karen Kmetik – American Medical Association

Right. Right.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

This is Rosemary. I'd just like to add to that concept, because EHR-feasibility and EHR-enabled implies data either going into the System or the System manipulating it, but there's workflow processes on probably two levels; one is associated with the EHR in terms of what it does with the data to sequence workflow, which is very important for Quality measurement, and then also at what point in the workflow does the EHR get activated, because sometimes, I am just thinking of a study I did at Thomas Jefferson, the EHR was asking for attributes around diagnoses and risks that the clinician, at that point in time, just didn't know, it was too early in the workflow.

So, two sides to this workflow; one is the workflow itself and the EHR guiding it and then the other is the actual intrinsic workflow, that sometimes people don't know something at that point in time that may be necessary for Quality measurement, but may be they would know it later on in the workflow, and how do we take that into consideration?

Karen Kmetik – American Medical Association

All very good points, and now we're going to add even more complexity. I just, in the interest of time, Jacob, I wonder if you would give us your definition of EHR-sensitive, so we have it all out on the table.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Sure, and I'm going to actually steal from Josh, because you sighted him, so I am going to read, so it's on the record, what Josh sent to me at one point when we were talking about this. But there are, I think, NQS actually has some documentation of this also being formally defined. But Josh's note to me says, "EHR-sensitive: Evidence that measures built into EHR Systems with the implementation of relevant HIT functions, for example, clinical decisions board, result in improved outcomes and/or clinical performance." So in a sense, this is that when folks are meaningfully using Health IT, they will do better on HIT-sensitive Measures. So, I will leave it at that, or open it up for further discussion.

Karen Kmetik – American Medical Association

Personally that's a tough one for me to get my arms around.

W

Let me say Jacob, that to meaningfully use an EHR, the EHR already has to have the functionality to capture the data you want to record.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

Yes, I will agree with both of those comments, although I'll remind myself it is not my role to editorialize here. This one has been hard for me to understand and in fact, the first time that I heard it, back when I was a member of the HIT Policy Committee's Quality Measures Workgroup, I thought that HIT-sensitive meant what we are describing as HIT-feasible, so, I misunderstood and that is part of why I've tried so hard to get a very clear definition of HIT-sensitive. But, I think those are both good points about HIT-sensitive as a concept.

Karen Kmetik – American Medical Association

So maybe here again, when we go through some examples we'll see what we'd apply to that and do we end up saying the same things we do with feasibility? I do want to go through the other terms, just so we've got these out on the table. So we have usability, accuracy and standard terminology as well. On slide 14 being projected, usability is talking about within workflow, so this came up before in our conversation and maybe this is the criterion we hang our hat on there. I am not sure I understand the "does not require users to capture information," I think what we are saying there is just not redundancy perhaps, in data capture because somebody has to enter the information.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

It could come automatically from another source, from a data source where they may not have to redundantly enter it in again.

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

I think that . . .

Karen Kmetik – American Medical Association

. . . around the word redundancy

Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology

I think that was one of the thoughts around that bullet was just what Rosemary said, sorry, this is Jacob speaking, but these are all, of course, free for editing, we don't have to stick with anything that's on any of these slides, so I encourage folks to make recommendations for how these change. If there is data in the record that would reflect something, rather than asking a question and having somebody check a box and then we have Measures of clinician's ability to check boxes rather than Measures of the quality of the care that they have provided, I think that is one of the things that this was trying to squeeze out.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

And it could, this is Rosemary, potentially enhance workflow. So if there is a data element that's in there, for instance, giving an IV infusion bolus and there is a data element of a lab result, it could automatically, proactively enhance the workflow by putting that forward to the clinician. So it may not always be data entry, but two-way in terms of the data, to actually enhance the workflow.

W

Uh huh.

Karen Kmetik – American Medical Association

Other comments on usability?

Randy Woodward - Healthbridge

This is Randy. I do have a comment on a category I think that may be missing from the slide, but, I am happy to wait if you want to go through the rest of the categories first.

Karen Kmetik – American Medical Association

Thanks Randy. Let's hold on that one second. Let's go to accuracy, data reported are captured accurately, recording data for reporting has few errors. I can imagine there would be a lot of things that might influence the accuracy.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Yes, usability.

Karen Kmetik – American Medical Association

A part of it would be the extent to which the Measure and it's specifications are very clear.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Right, which I see as a usability issue. I think one of the things that we've seen is that the sort of information, again, I should qualify by saying, the vast majority of the situations that I have been involved in, have been translating existing abstraction Measures, which places a whole particular kind of constraint on the process. But, in my opinion, other than just technical issues about doing it right or doing it wrong, I think a lot of the accuracy is subservient to usability. If you . . .

Karen Kmetik – American Medical Association

Yes I mean the one way just to be sure we have looked at this, is so if we asked where the EHR automatically calculate Measure results, and then we actually do send someone in to look around that EHR, just like you might do in paper records, to what extent does that automatic recording match what one would find if they manually looked through the EHR?

Danny Rosenthal - Inova Health System

Hi, this is Danny Rosenthal, sorry I am a little late for the conversation, but listening to the great dialogue for the past probably 20 minutes, I just had a comment on the accuracy. I think that something that is missing from this definition is talking about the variability of the data itself, meaning that you can have data capture correctly and still have inaccurate data. A good example of this, I think, is time last known well. You can capture this down to the millisecond of when the patient is reporting that information, but it still may be inaccurate data.

Karen Kmetik – American Medical Association

Inaccurate Danny because?

Danny Rosenthal - Inova Health System

Due to the inherent characteristic of the piece of information itself, not because of how it was captured. So I think that accuracy has two components; accuracy of the information irrespective of its capture mechanism . . .

Karen Kmetik – American Medical Association

Ah, okay.

Danny Rosenthal - Inova Health System

And then accuracy of capture mechanism. So, for example, if you look at ICD-9 as a blunt tool, it can be fairly inaccurate if you are looking to capture a more specific concept. The data can be captured correctly, you have a nice drop-down and you choose 250, but that might not get you to the accuracy of the true information, if that makes sense.

Karen Kmetik – American Medical Association

I think I understand, um hmm.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

Does that also take into consideration validity of the data?

Danny Rosenthal - Inova Health System

You know Rosemary, maybe that's actually more what I'm trying to communicate, that the data must be both valid and accurate.

Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University

Your remarks. . .

Karen Kmetik – American Medical Association

I am going to push us to see, does anyone have any comments on standard terminology? To me, I take this to mean are we emphasizing in the specifications for this Measure that's trying to be EHR-feasible and enabled and sensitive and everything else, standard terminology so that we would have more consistency in the interpretation of the Measures.

Robert McClure – Chief Medical Officer - Apelon, Inc.

So, this is Rob McClure, so, I mean, that would be my interpretation, the idea of standard terminology is to have one key component of shared understanding, right, so really the core use case for using standardized terminology is, there are two elements to this. One is that when you use it that you use it consistently because of a expected understanding of that particular concept or set of concepts. And there is a flavor to that in a sense to say that the critical value there is that two separate organizations, two separate entities, two separate times and places, can record information and as long as they are using a standard terminology which they understand, then they should be using the terminology to mean the same thing. And so, if you can render the Quality Measure using standard terminology, you are using a common interlingua to specify what you mean, and that's extremely important. Now . . .

Karen Kmetik – American Medical Association

I would put the notion of value sets in this definition, just as another example, if this holds true . . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

Right.

Karen Kmetik – American Medical Association

For others. So, if we have six Measures that require us to find people with diabetes; we'd want Northwestern to find people in the same way as Rush, as Intermountain, as a small practice in Idaho, and so if we give them all the same set of codes by which to find those individuals, we would have a better chance of that.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Exactly, so that a value set in essence takes the same idea of shared meaning of a single concept to a shared meaning of a group and a larger collection, and so, absolutely correct. I think it should say value sets there because in almost all cases, every Quality Measure is going to be both some individual codes and some value sets which are intended to communicate a shared meaning of a general idea.

Karen Kmetik – American Medical Association

I am going to go to Randy in a second on things to add. Any other comments right now on the words we've been talking about, feasibility, enabled, sensitive, accurate, valid, usable, standard terminology, shared meaning?

Robert McClure – Chief Medical Officer - Apelon, Inc.

I wanted to make one comment that was, we had a conversation about the fact that sensitive in a EHR-sensitive Measure, I think I kind of get the meaning there and I would actually be really cautious not to make our job harder, that it shouldn't be restricted to feasible because I think what we're going to find is that many of the Quality Measures that one could imagine, you know, that the other Tiger Team might in fact kind of come up with, will require something beyond what's currently feasible.

The critical element to that sensitive piece, in my interpretation, is that you're identifying things with that Quality Measure that the use of the EHR specifically enables?, so, that you can change it by utilizing the EHR and that's an interesting construct that I think probably most of us don't quite grasp yet, but I certainly get it, and that as people become more and more comfortable using EHR's, that this issue it comes to, for example, the idea of like bar-code medication administration issues. Now that's certainly in the feasible category now, but you can imagine those kinds of things that might need to occur in order to really impact Quality, that are directly feasible only by beyond what we can do in our current feasible EHR.

Karen Kmetik – American Medical Association

Yes, I think I am beginning to see it like maybe if we also knew about adherence, that would help to –

Robert McClure – Chief Medical Officer - Apelon, Inc.

Yes

Karen Kmetik – American Medical Association

(unintelligible) on. . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

Exactly

Karen Kmetik – American Medical Association

I do have to be sensitive to time. Randy, back to you. You wanted to add something.

Randy Woodward - Healthbridge

Sure, and I will try to be quick, I know we are running a little late. The other category I am thinking of is accessibility or accessible. And what I mean by that, for example, in our work aggregating data across multiple EHR's for common measurement, we find that EHR users can get very creative with where they choose to record information within their system, and as a result, we spend a tremendous amount of time simply tracking down where specific data are stored, and all the variations of where different users, even within the same system, choose to store information. Some of that comes back to standard terminology and usability and workflow, but as a result, it can be very difficult to really report good, complete, accurate information out of one EHR, much less across multiple EHR's without developing those types of roadmaps to where data are stored, and wouldn't it be fantastic if we could ask EHR vendors to build in tools within their own products that would map their data elements to common terminology libraries or concepts, like the QDM.

Karen Kmetik – American Medical Association

Sure, sure, I would certainly agree with that and we just need to think about is there a component of feasibility but like you said it also touches the standard terminology, but is it accessible for calculation, for reporting out? That certainly makes sense to me.

Randy Woodward - Healthbridge

Yes, it is one thing for it to be accessible to an IT person or an analyst, but taking it a little further, I think it would be fantastic if clinicians and office staff could query their own EHR because it was accessible, they knew where information was recorded and how to interpret their system to a measurement standard.

Karen Kmetik – American Medical Association

Absolutely, I mean, I think in the future right, we would want systems such that any location could develop their own measure that is relevant to their practice population, in addition to contributing to the National Measures. So, I think that is very important. I do want to be sensitive to time, we do need to open up for public comment, so Mary-Jo, would you do that.

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

Yes, I certainly will. I'll actually ask the operator to open the lines please.

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.

Karen Kmetik – American Medical Association

Thank you. Then by way of just brief recap, I know it never seems like we have enough time. I thank you all. What I might suggest is that I'll work with others to try to revise these words we have been talking about, maybe add to the definitions based on what you all have said, because I think we'll need that to

guide us; these definitions of criteria, and then if folks agree, I thought I will just throw out an example, so that when we gather again in a few days, that would be Thursday, we see how these definitions of these criteria hold up when we actually look at a type of measure. Does that make sense?

M

Absolutely.

M

Yes.

Karen Kmetik – American Medical Association

Does anybody want to add anything else that we do between now and Thursday that I could help with? All right, that will be our plan. I thank you all and I hope to hear you all back again on the call Thursday.

M

Thank you

M

Thanks.

W

Thanks.

Karen Kmetik – American Medical Association

Bye bye.