

**Clinical Quality Workgroup's
Characteristics of Optimal Clinical
Quality Measures for HIT Tiger Team
Draft Transcript
April 5, 2012**

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

Good morning everyone. This is Mackenzie Robertson in the Office of the National Coordinator for Health Information Technology. This is a meeting of the Health Information Technology Standards Committee, Clinical Quality Workgroup, Characteristics of Optimal Clinical Quality Measures for Health IT Tiger Team meeting. This is a public call so there will be time for public comment at the end. This call is also being transcribed, so please make sure you identify yourselves before speaking. Now I am going to take roll, and at the end I am going to ask any staff to identify themselves as well. Karen Kmetik?

Karen Kmetik – American Medical Association

Present.

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

Anne Castro?

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

Present.

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

Thanks Ann. John Derr?

John Derr - Golden Living, LLC

Here.

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

Thanks John. Bob Dolin? Rosemary Kennedy? David Lansky? Robert McClure?

Robert McClure – Chief Medical Officer - Apelon, Inc.

I'm present.

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

Thanks Robert. Eva Powell?

Eva Powell – National Partnership

Here.

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

Thanks Eva. Eric Rose?

Eric Rose – Intelligent Medical Objects

Hello.

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

Hi Eric. Danny Rosenthal?

Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System

Present.

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

Thanks Danny. Randy Woodward?

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

The Ex Officio's Kim Schwartz? Patrice Holtz?

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

Here.

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

Thanks Patrice. If there are any staff on the line if they could please identify themselves?

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

This is Jacob Reider from ONC.

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

Thank you Jacob. Okay Karen, I'll turn it over to you.

Karen Kmetik – American Medical Association

Okay. Thanks very much everyone for joining us. If we look at slide 2, the Agenda, we have made some changes. The time flew by very quickly from when we just spoke earlier this week, so, with asking your forgiveness, we are going to slow it down a bit and today review our definitions of optimal characteristics, based on the feedback you all gave us last call, and maybe begin to talk a little bit about how we would then use results, findings, about how Measures meet those characteristics to informed decision making. We'll then put off the vetting of examples to our next call so that we can send you some examples a few days in advance of the call, to make it a more productive call. So, I hope you all will be alright with that.

So, moving ahead, the next slide is just the purpose that we talked about last time, but then on slide 4, we have edited it a bit, embellished it a bit, based on what we heard from you all. So, on slide 4, we heard that the Characteristics of Optimal Clinical Quality Measures evaluated by this Tiger Team. We talked about our work being from a technical lens, not from the perspective of the importance of the Quality Measure per se, and we said that we're interested in applying the technical lens to Measures we have and those we seek. I think Eva originally brought this up and several others added to it. As I was thinking about this more, I know that's a difficult thing to separate because, we're always going to be, I think, looking at is this the Measure that we want, that we believe is meaningful to actually close a gap, improve care, stretch us. And yet, I think we do need to try to stay focused on the technical lens, because there will come a time when we will have the Measures we want, but we will still need to apply this technical lens so we understand are we in the right (cuts off here 3:30) to have these Measures work in an EHR IT environment. Let me stop there and just do a check in, are we good with framing in that way or should we have some more discussion on this?

Eva Powell – National Partnership

Karen, this is Eva. I think this is good and maybe one way to keep us focused on the technical aspect of this, as you are right it's really hard to keep those separate, is to think about the capabilities that Health IT is going to have to have in order to give us the kind of Measures that we want, and that kind of, at least in my mind, that grounds us to a more technical discussion, as opposed to a discussion about what exactly it is that we're measuring. Does that make sense?

Karen Kmetik – American Medical Association

I think so. I like those words, the capability of the IT, the EHR to support what we want, and of course, it also involves the workflow, etc. But, to keep that technical lens, that makes sense to me. Any other comments this far?

Eric Rose – Intelligent Medical Objects

This is Eric Rose. I apologize for not being able to attend the meeting on Tuesday. I just was going to ask if there are going to be minutes from that meeting?

Karen Kmetik – American Medical Association

MacKenzie, do we make the minutes available?

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

They will be available posted on-line, there is just going to be a lag before they get up and posted.

Eric Rose – Intelligent Medical Objects

Okay, so there will be an e-mail that goes out.

Caitlin Collins – Altarum Institute

The transcripts are always available on the ONC website about 3-7 days usually after the meeting.

Eric Rose – Intelligent Medical Objects

Thank you.

Karen Kmetik – American Medical Association

And I'm also happy to talk with you off-line just to try to fill you in on the first call if that would be helpful some time. All right. So, the next slide then was what we saw last week, where we started to think about, well, what are these characteristics of Optimal Measures through a technical lens, and we spent a lot of time talking about well, how would we really want to define these. So, if we move ahead, we tried to capture, and my thanks to Amy for working with me quickly to try to capture what we thought we heard.

So, we talked about this concept about availability, usability, excuse me, usability and we said, well what does usability mean? And, we heard that the data must be captured in traditional workflow, but that workflow might include the data coming from some other source, we do not want to forget that, outside the practice sites. The data may be available now, or could be available with reasonable workflow changes. This is Eva's point, I think about capability. If the data though, at the end of the day, are not realistically captured, then they're not going to be available. We talked about examples of lack of something is hard to capture, time stamps being hard to capture, and then we brought up this notion of redundancy, that the data capture should not be redundant. I added this and would love reactions to it. Unless, perhaps tied to clinical decisions or some type of care coordination. I guess I was just thinking, just for measurement sake, we don't want providers to be redundant in having to put information down. I mean, if something's on an allergy list, we should find it there and not ask them necessarily to capture it again for measurement sake. But, I was just thinking, I have seen some very sophisticated clinical decision supports where you are prompting someone to proactively enter something to engage them in that decision making. But, I might be sending us astray here, so. Any reactions to this definition now of usability?

John Derr - Golden Living, LLC

This is John . . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

This is Rob.

John Derr - Golden Living, LLC

Go ahead Rob.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Okay. So, the one thing I would mention is that the use of the word redundancy and the idea that you were just discussing, I think I would typically use the work reusability, although that might not even be the perfect word, but the intent there is that you capture once, use everywhere, and I think that's, you're trying to, I think reduce re-entry. It is a sophisticated thing in that sometimes if there is a piece of information that is available, you want to find it if it is germane to that particular thing, so you want to be able to

identify what that information is. And then you have to make it available so that the person can decide whether that's changed or not, there is. . .

Karen Kmetik – American Medical Association

Yeah.

Robert McClure – Chief Medical Officer - Apelon, Inc.

. . . I think we're discovering that one of the things about EHR is just that they, unfortunately, make it very easy to assume that any information that exists in the system is correct and can be reused, and that is probably not a great outcome of this. So, I don't know what the right word is, I don't know if redundancy really captures it, but it's this idea of we absolutely want to promote reuse of existing information, but that reuse has to be reviewed.

John Derr - Golden Living, LLC

(Indiscernible)

Karen Kmetik – American Medical Association

I like that, reuse and review.

John Derr - Golden Living, LLC

There is a term called one true data or something like that, what we want is whatever somebody reads is the true data, not someplace else or anything else. My point, and I don't know whether, this is John Derr, I do not know whether to bring it up now, but, I am looking more for longitudinal care where we can get trending and I don't know whether this goes into definitions that that the data has to be correlated with other similar data, so we can start doing trending and work on proaction and wellness. It might be too early to introduce that, but. . .

Karen Kmetik – American Medical Association

John, I hear you. I interpret that as trending would be the type of thing we want to do, just like we talked about changes in blood pressure, patient reported outcomes. All of those things are what we want to do, so we want to make sure that whatever technical lens we create, it would accommodate that kind of use as well.

John Derr - Golden Living, LLC

That's the ultimate, to do that so we prevent episodics and proact on them, not wait until they are about to happen.

Eva Powell – National Partnership

Well and, this is Eva, I think of that as one of those functionalities that can help us target these technical aspects, that Health IT needs to be able to do, it needs to be able to look back over time and do trending and from a technical standpoint, I am sure that that requires more specific definition, but, and I don't know if that is on this call, to flag those things, but I absolutely see that as critical, like John said, and kind of put that in the bucket of this is something we have to enable, that our system's today are not able to do, generally anyway. And the other thing that I think of, when I am thinking about this issue of the sweet spot between redundancy and usability of information that is already there, and making sure that the information is currently correct.

I think of using the patient as a check, for some things the patient may not necessarily know if it is a highly clinical thing, but for the most part, in the paper world, if you are checking whether something is still correct or not, basically you are asking the patient. And so, we just need to translate that into an electronic environment where patients, not in the context of the visit, either in a kiosk in the waiting room, or from home, can review information and say yes this is correct or make corrections where those are necessary, and that not only helps with the accuracy of the data, but it also removes that burden from the provider, who has plenty of other stuff to do.

Eric Rose – Intelligent Medical Objects

This is Eric Rose. I may be confused about the mission of this workgroup, but, I thought that we were trying to identify attributes, desirable attributes of Clinical Quality Measures from a technical perspective, and, the first bullet here, “availability of data” certainly seems to address that. The second bullet there seems to be an attribute of information systems, that is to say, that clinical information systems shouldn’t require duplicate data entry, if a datum is available and it needs to be used in a Clinical Quality Measure, the system should be able to do that. But, that would seem to be out of scope for what we are trying to address, unless I am confused.

Karen Kmetik – American Medical Association

It’s a good point, Eric, I guess to me it’s a little gray, I am just imaging, so we try to assess whether a measure we want is useable. So, we go out and we find out are the data captured and then would we ask at that point, well, is this data element we need found in multiple places and maybe that is a risk for accuracy.

Eric Rose – Intelligent Medical Objects

Oh, I see. So, the concern is that. . . Well, I’d say that that again is probably not an attribute of a Quality Measure, as such. Or, to put it another way, I don’t think you can say for a particular datum, this datum tends to exist in multiple places in Clinical Information Systems. I mean, there are Clinical Information Systems that have the ability to put a particular piece of information in multiple places which makes it difficult for Quality Measurement because you can have essentially contradictory information about the same piece of data, because there is more than one place to put it. But, that’s really . . . I don’t think it . . . to my knowledge it’s not possible to make a characterization of the likelihood of that kind of redundancy for one particular type of data versus another. Maybe one exception is problems because it tends to be the idea of a longitudinal problem and as a diagnoses you could have, no history of hypertension in a problem list, or something, and hypertension as a visit diagnosis. But other than that, I’m not really sure that it’s possible to generalize.

Karen Kmetik – American Medical Association

Uh huh.

Danny Rosenthal – Director of Healthcare Intelligence - INVOA Health System

This is Danny Rosenthal. I agree with Eric’s comments. I think Karen, you are concerned about the multiple sources of a single piece of datum would be covered on the slide #8 under accuracy definition, process of collection has few errors. I think . . .

Karen Kmetik – American Medical Association

Yeah, okay.

Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System

. . . that would be covered well over there.

Karen Kmetik – American Medical Association

Good. I see the point. Redundancy does have a little bit of a different tone here, we might want to put that in a parking lot when we think about the actual Measure. I think I see your point Eric. Other comments on usability? Well then, moving down to some other definitions we talked about regarding feasibility. So, we had EHR-feasible, this notion of the functionality in data to support the Measure would be expected to exist in most EHR’s and could exist, within reason, for the stretch Quality Measures. We talked about the data being accessible. Then we talked about EHR-enabled and this might be where the trending in the patient review aspects come in, the Quality Measure is enabled due to data being electronically formatted would be awfully difficult to do this if we were not in an electronic format.

And then we talked about EHR-sensitive, and I have to admit, I keep reading this one and to me, it does take us a little more into that evaluation of the Measure, not necessarily through a technical lens. So, I am personally just struggling a little bit with that. But, let me open it up to comments on these definitions.

Eric Rose – Intelligent Medical Objects

This is Eric Rose again. Under EHR-feasibility, it says functionality and data to support the Quality Measure exists. Isn't the end data, that would seem to overlap with the previous slide, I think, although functionality to support the Quality Measure, that certainly is separate.

Karen Kmetik – American Medical Association

Um huh. Is there a difference between, from an IT perspective it is feasible, meaning there's a place to put it and it is in a discrete queryable field and behind the scenes is the right standard vocabulary, but it's not really populated available because it does not fit into workflow and so the data are never even entered.

Eric Rose – Intelligent Medical Objects

Well there's that. I think functionality might apply to the ability to support certain types of Measures logic. You know, like a great example would be the Behavioral Health Quality Measures under Stage 1 which talk about certain events need to occur within a certain amount of time related to another event, and that is very challenging for some EHR's. You have to have a follow up visit within a certain amount of time after first starting antidepressants, and so the data might be in there, but the ability to support a particular type of Measures logic is sort of a separate issue. So, I think that the EHR-feasibility bullet really is a separate thing, except for the end data possibly.

Karen Kmetik – American Medical Association

I do like your introduction of the logic, because that is part of it.

Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System

This is Danny again. I am hearing the conversation, and as I'm comparing the definitions on slide 6 and 7 with the diagram on slide 5; I think that some of the, I don't want to call it confusion, but I think that some of the conversation is around usability and feasibility from a pure data perspective and usability and feasibility from a pure workflow perspective, and I think that what we are talking about is that for a Optimal Quality Measured in EHR, it needs to be both useable and feasible and amenable to the data perspective as well as to a streamline workflow perspective. And if I am wrong on that, that does that constrain our conversation to simply data and workflow is out of scope. And the reason I am bringing this up is because on slide #5, the usability says "fits into the traditional workflow," whereas the feasibility is talking about the data being captured.

Karen Kmetik – American Medical Association

Yeah Danny, good point. My personal opinion is workflow and technical/data are both within scope. Other thoughts. Jacob would you agree with that?

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

Yes, I would.

Karen Kmetik – American Medical Association

So, I think you have raised a good point. I think for each of these definitions, we have to be clear which one are we talking about, or are we talking about both in each case.

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

And Eric, I don't want to speak for you, but I can imagine you're thinking that you can take a perfectly good Measure and implement it in a perfectly bad way. That doesn't mean that the Measure itself wasn't Optimal, it is just a poor implementation. So, what I think that our conversation around workflow that it's important to sort of narrow down, is typical workflow in a typically and you know, there is a Gestalt factor here, in a typical EHR that has, traditional workflows that are the base, common denominator across multiple sites, what is that minimum workflow that most people are already doing, where we can sort of capture data and have these measures available. So, there's a certain depth to which the workflow conversations should be out of scope, but, what's that sort of bare minimum, where yeah, we're all doing this anyway, let's go ahead and leverage that.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Yeah. This is Rob. So, I certainly agree with Jacob and I think the others, although I am not starting to get lost that workflow belongs in the scope. I think that we are focused on trying to identify the sort of technical capabilities we expect of EHR Systems in order to support E-Measures and, to be honest, I am not even sure exactly what all of the workflow things might be. But, we're not measuring workflow other than what we're saying is that there is an expectation in order to do good Quality Measures, that something in EHR is done that supports observing workflow. So, the example that you had back on the earlier slide that I had cited about event tracking, that's something that most EHR's right now, if they do it, it's a very haphazard thing and usually it's not because it's in their support workflow tracking, it is in there because; well, actually, I take that back, it might be, because somebody needed something. It is certainly true in some of the lab systems and other things like that, but, it hasn't been a normal part of EHR functionality, because it is not something that people have considered important, probably, in the delivery of patient care.

I think one of the things that we're going to decide is, it is, and so we would expect that they have the ability to time stamp events. Other than that, I am not sure what else we would say and how that gets done to prove one workflow works better than another is completely out of our scope. But, I think we're just simply saying there needs to be a way to measure workflow, and that's probably, I mean if we're going to extend this, and I think it is reasonable to consider doing that, it would be things like event stamps. Maybe there're some other things that people who are smarter than me can also add to that list, and that's really what our scope is, I would assume.

Karen Kmetik – American Medical Association

That's interesting that you're using workflow to mean measure the workflow, that were things done at a certain time.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Right.

Karen Kmetik – American Medical Association

I was actually thinking of the word more broadly, to say as we look at a Measure through a technical lens, we want to know what's the likelihood that the EHR will support this; the data will be available, the logic is feasible to calculate in EHR, but I was adding, we also want to ask what is the likelihood that the workflow within the practice site today is such that we feel that the data will be entered in a reasonable, accurate way.

Robert McClure – Chief Medical Officer - Apelon, Inc.

Yeah, and that is, I think, a gray area between what's in our scope and what's in the other Tiger Team's scope. In the context of that, it is something that one considers when you look at existing Quality Measures, to try and figure out how do you represent that in the way data is currently captured. But, that gray area, I think, is mostly on the other side and this is an iterative process, no surprise here, we're not going to get all this figured out in one week, and so, there are a series of things right now that EHR's provide that probably it would be good to discuss a little bit about, that are a part of documenting information right. And when you talk about, other than the obvious, like when you do things that are a normal part of clinical care, you're putting in orders, you're documenting an encounter, you're interacting and these are some of the new things.

For example, some of the work that I've done, you have alerts, right, that is a new thing with regards to EHR's and so you have an interaction with an alert, or an interaction with a message. Those are the kind of technical capabilities that would be in our purview to say yes, that is a requirement, you have to have the ability to have an EHR System alert or communicate with a provider and have that provider then interact with that alert and record that, because guess what, that's a kind of common bucket that a number of quality activities were utilized in order to be able to kind of assert themselves into the process. It is actually a somewhat disruptive activity. If we have other things that we know of, or that currently exist, that should also be on our list because certainly that is a part of what we are doing. In terms of the

stretch goals, if we know of some things that potentially have already been evaluated and therefore are reasonable stretch goals, we should also add those to the list. That is the kind of technical framework that I thought we had in scope.

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

This is Jacob. I am trying to digest what you just said Rob. I think, my sense is that that might be a little bit broader than the scope of this team, because, although I think we need to consider those kinds of downstream activities, we actually want to focus on the Measure itself and then, as you're describing, consider the impact that it may have, right. So is this Measure something that is likely to cause disruption, so if a Measure requests a specific piece of information in a way that would cause a provider to need to answer a question, then what we get is check-box Measures, or alert Measures, right. So we say, did the provider do X, instead of, and I think Karen's group has done some work along these lines, is there evidence that X happened.

The two are very different questions and the Measure can actually explicitly require that X happened in some way, and I would argue that's the kind of scope that I was thinking we may want to chip away at, so that we could understand how to guide Measure developers to sidestep some of those potholes. Because if one makes assumptions as a Measure developer, about specifically where one would find data or what kind of activity would cause the data to exist, those assumptions may actually be flawed. And so, as much as possible, I would think we'd want to be able to guide Measure developers to avoid making those assumptions and is there something that we can say about the Quality of a Measure that would help them, if I am making any sense, and I know Karen, we've talked about this some. And Rob, did that make sense to you?

Robert McClure – Chief Medical Officer - Apelon, Inc.

Well, yeah, it does, it makes a lot of sense, but, and this important, what you just said makes sense for the other Tiger Team, it talks about the expectations of what makes a good Measure. And so, what I was talking about was having decided that, what are the kinds of technical expectations we would (breaks up) say, about EHR's that would then support these approaches. So, for example, the other Tiger Team in evaluating what makes a good measure, and discussing the sort of things you just alluded to, would say, we would expect that these kinds of data and these kinds of interactions are available to Measure developers so that they can utilize them when they develop a measure, and we would be complimenting that and saying, yes, this kind of EHR interaction, this kind of data collection process, needs to be in EHR Systems in order for them to be compliant.

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

My sense is . . .

Robert McClure – Chief Medical Officer - Apelon, Inc.

But, I might be wrong, I mean.

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

Well, my sense is that the other Tiger Team is really focused on value sets and essential components so, what's the recipe for baking cookies, you know, how much sugar do you need and how many chocolate chips, and most of the focus of that Tiger Team is focused right now on value sets, because those are the core essential components, and how are we going to get and serve and modify and maintain. So, I actually think that what you just described is in scope for this Tiger Team, because this is what are the characteristics of the Measure itself, from a technical perspective that would help structure it. So, I think you just expressed it really well, and I actually think that is, and I will look to Karen to either agree or disagree because she is the Chair and I am just a worker bee.

Karen Kmetik – American Medical Association

Yeah, I think so, and so I would ask Rob maybe if we could press on with this in mind, that we definitely want to have our attributes for the technical, pure technical side of the EHR, but I don't think there's anything wrong if this group also has suggestions about how we would look at it from the workflow perspective, and it gets to, how would we collect this information and it's kind of hard in my mind to think we're only going to collect it from the technical EHR perspective and we're not going to ask the other questions at the same time. So, could I ask that I've got good notes on that, and we'll come back to it. My sense right now is both are within scope, but we need to be clear what are we answering with each attribute.

So, let me just say, just for the sake of time, let's go to accuracy for a minute. I think these next ones might be a little more straightforward. So accuracy, we were saying, was all good and fine if you've got a place to put it and it is using terminology, but, I think Danny you brought this up, what is our sense that that piece of information, how it came to be, is accurate. Now, you might say again Rob, this is not so much the EHR technical piece of it, but, any reactions to accuracy?

Eric Rose – Intelligent Medical Objects

This is Eric. I think I understand why this is in there and I think it makes sense to me. I wonder how accuracy would be assessed and, I think we would want to probably make some suggestions along those lines and maybe there's actually a need for someone to study, to actually look at for different types of data, and then going back to the review of the full medical record, how often there are inaccuracies in a particular datum. I don't know how you would determine that a priori, other than just by guessing.

Karen Kmetik – American Medical Association

Um huh.

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

Karen, this is Patrice. I also don't understand on the last point, how capturing this in an EHR would be that much different than what's captured in a paper medical record. We can only assume that something's as accurate as it was provided to us, so, the patient tells you the time of their last meal, but isn't sure and doesn't say that, it's not captured in a paper record either.

Karen Kmetik – American Medical Association

Um huh.

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

So isn't this taking it to a level that may be not possible?

Karen Kmetik – American Medical Association

That's a very good point. Other reactions.

Eric Rose – Intelligent Medical Objects

This is Eric. If there is data that certain types of information in EHR's tend to be wildly inaccurate and we can reference that, I think that would be useful. When I was a resident, I remember our clinic biller in residency clinic actually told the residents, "If you can't find a good ICD-9 code for when you see a patient, just use 401.9 essential hypertension, because you will always get reimbursed for that." So, the visit diagnoses would have been a very inaccurate source of data for that particular clinic, and I think, I don't know, if there is evidence out there then it would be appropriate to apply it.

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

This is Jacob. I think those are good points and I think Patrice, you make a really good point about the fact that bad data can exist in both places, and I think that's kind of what Eric's saying. The key though is that there is an expectation that the EHR actually has it, where there really wasn't an expectation in the paper world, because an abstractor would sit in the middle and would actually make a decision and say,

either there is information that's of value here or there is not. And so, I don't have a solution to the problem, but I think that is part of why there's this expectation in the electronic form that, if there's data, it's good and if it's absent, then that's someone's fault.

Karen Kmetik – American Medical Association

I'm just wondering maybe these two examples are not the best, but are there examples of data elements where, by virtue of it being in an EHR, it raises accuracy issues.

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

I think that's true when we don't have the place in the EHR to capture that particular question. So, if an EHR has a place for allergies and it doesn't include non-medication allergies, then typically the provider at least when I was practicing, we would squish it somewhere else that didn't provide the accurate answer; it would have been a non-medication allergy listed in a place that had nothing to do with allergies.

Karen Kmetik – American Medical Association

Um huh. Yes, to me that seems like a good example. Other thoughts on accuracy? All right, very good points. We will work on massaging that a bit. Standard terminology, we talked about this being shared meaning. I think of this, personally, as I give the same set of specifications in terminology to one practice with one EHR and I give the same to another practice, another EHR, I have a confidence that I'm getting the same interpretation there. Other reactions to this?

Eric Rose – Intelligent Medical Objects

This is Eric. I am sorry I seem to be making so many comments, but, the one thing that struck me working with Quality Measures in the past was from the EHR developer and is the need to field these very, very large value sets, because the Measure developers in an attempt to be helpful, would provide every single darn CPT or IDC-9 or in some cases, NDC codes, for the data elements. So to use this logic in an attempt to be helpful, they actually boxed the Measure implementers into an approach where they had to search among very, very large value sets and did not have the option of using subsumption in the structured ontology, so, what I would propose that a characteristic of a good Quality Measure is, has flexibility to allow different approaches and in particular, to allow use of hierarchical vocabularies to subsume queries under high level concepts. So, if you are looking for an ACE inhibitor, you could just . . . if your vocabulary can support, is the patient on an ACE inhibitor, rather than is the patient on one of these 300 medications, then the Measure should allow for that.

Karen Kmetik – American Medical Association

That's a really interesting concept and I think that probably will come up in the value set Tiger Team as well. I think of that as adding some intelligence to our, as you said, hierarchical ontology, I mean, it takes a little more thought than just pulling everything under a certain category. I think that's a very good point. Other comments?

Robert McClure – Chief Medical Officer - Apelon, Inc.

This is Rob. I think you do cover two very different things here, which is great, and perhaps it needs to be even more clearly identified as being two different things in that we're talking about people using the same terminology, so there's shared meanings, same codes with the same intent, if I can be so bold, and it gets to some of the things that Eric is talking about, although that's not explicitly stated here with regards to the use of subsumption. But the second bullet, is a different thing, in that you are talking about shared value sets, which is kind of a meta-meaning, right, you've got the same set of codes, but then you've grouped those codes and that code grouping has a meaning, and that is a really powerful thing, that obviously is important, that is why we're doing some of those things.

So, I almost want us to be able to communicate that there's two pieces to this. One is the use of a shared common vocabulary, shared common set of code systems and, shared common value sets. So, those are your two bullet points, I think almost need headers.

Karen Kmetik – American Medical Association

I would certainly agree with that. Others agree? Or not?

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

Yes.

Karen Kmetik – American Medical Association

Okay.

M

Yes.

Karen Kmetik – American Medical Association

Okay. All right, I want to press on because I do want to get some reactions to the next couple of slides, I think it'll help us frame the next discussion we have. If we assume that we will massage these definitions and I think someone said it's very iterative. I think as we learn we're going to keep coming back to tweaking these, what exactly do we mean. But at some point then, I am imagining, in full disclosure, we are doing some of this work now and there is probably better ways to do it, but at some point, we're going to have these Measures that we want, and we're going to gather information about the Measures against our attributes we just discussed, and there's probably multiple ways to do it, but we might think that maybe we go out to multiple practice sites with different EHR's, it's something I have experience with, some of you do as well. You might do it differently, you might survey vendors and practice sites, but, let's say we gather the information, we ask the questions, how will we then interpret bucket, use the results to inform our next steps.

So, the last slide just tries to T-up an example there. So, if we just focused on feasibility, and obviously we'd have to look at this in connection with usability, standard terminology, accuracy, etcetera, but, to get our arms around it, if we just start with feasibility, and we say well, we have this Measure and we want to feel like it's feasible in majority of EHR's in sites. How would we determine that? Would we say, well, if we've got consensus from a sample of sites with different EHR's, then we can feel pretty good about that. If we then also, again going back to what earlier discussion, I know there's still a question in our minds about technical EHR, functionalities and workflow, but if we wanted to ask workflow, again, if we go to several sites, different types of sites, different locations, different EHR's and we find that information about this, what do we do with those findings? From whose perspective do we put the value?

Similarly, if we say well, this could be feasible, it's a stretch goal, but it could be feasible with a reasonable technical change, and in fact, in most cases, the sites could make that change, working with their EHR vendor or themselves. How do we evaluate that, if we get information on that? Or if we learn, you know, this really would require a technical change from the EHR provider, do we then talk to EHR vendors and get some acknowledgement that it is, in fact, possible and they could do it in a reasonable way that would not upset the whole workflow of the practice. So what I am trying to get at here is, once we further tweak our definitions, I think we're then going to want to test this, we are going to want to find out about a Measure we want, put it through this technical workflow lens, but how will we interpret then, the information we've learned?

Eric Rose – Intelligent Medical Objects

That's a great question. This is Eric. I think we need to acknowledge that workflow differs very, very widely among different types of clinical practices and different practice settings and what works in an urban safety net clinic in a large city, may be different from what works in a solo private practice in rural Oklahoma, and, there may be a need for sort of a permanent, standing set of processes to evaluate Quality Measures, just like there are a permanent set of processes to evaluate EHR technology, and that might need to include representatives of different types of practices and ultimately it will be a subjective analysis, but hopefully, I think it could be pretty reliable where you get a bunch of practicing clinicians and healthcare professionals together and you say, how disruptive would it be to have to collect, have to somehow enter discretely these pieces of data, or do something that will cause that data to be captured? I think that that's feasible, but you'd need the actual people in the trenches to tell you. It may be that that needs to be just as much a part of Measure development as the rigorous evaluation of evidence.

Eva Powell – National Partnership

This is Eva. I think this is really hard because it's a really good question and I think one that is important to answer and I agree that feasibility probably needs to be measured from more of a boots on the ground perspective, but at the same time, much of why we are where we are is because change boots on the ground is really hard, and yet it needs to happen. And so, what I wouldn't want to have happen is to label something as being not feasible, when really it is just hard, and that's where I'm not sure the best way to approach this. Because I think what we'll find is anything other than the status quo is going to be considered not feasible. But, I don't know, other's might have different ideas.

Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System

Yes. This is Danny. It's a question of how do you evaluate the impact. People seem to respond to dollars and cents, so is it getting a consensus or a sense of the estimated billed workflow changes, training, report writing, that would have to go into this and at the end of the day, I guess optimally we're looking for Measures where most of the HR vendors would say, "Yeah, we can do that today," right out of the box, no changes necessary and we want to differentiate that from, "Whoa, whoa, whoa, that's an enormous change to everything that we do," and we want to hopefully choose the ones that are going to be easier. But, I think, who was speaking last?

Eva Powell – National Partnership

It's Eva.

Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System

Hey, how are you doing? In response to that, you know, what if there's a piece of data that's so, so important and so, so critical to measuring Quality, yet it does require changes, how do we not eliminate those as being suboptimal, when in actuality, it needs to be made optimally and I think if we can present some type of data that are objective, and saying here is the benefit of the Measure, here is the consensus thoughts about cost to implementing these measures, and then that goes into the weighing of does the Measure go forward or not.

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

Danny, I think . . .

Eva Powell – National Partnership

I like that . . .

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

Go ahead Karen.

Karen Kmetik – American Medical Association

That was Eva, but I did want to jump in. I really like what all three have said, Eric, Eva and Danny. It's, I think, we are trying to get the most objective assessment we, again we've got to start from the premise of we want this measure, or, I think Eva you're right, we'll keep sliding back. If we force ourselves to say we are talking about a Measure we really want, to the extent we can be objective, answer our attribute questions and present the scenario that either it's not today but here's how it could be, this is who would have to change, whether it's the provider, the Measure steward, the EHR vendor, the patient, this is what would be the cost, this would be what could result, this is the time frame, then at least we're giving the government information on which to drive decision. I relate to that. Other's thoughts?

Eric Rose – Intelligent Medical Objects

This is Eric. I strongly agree and I don't think we want to talk about feasible versus infeasible, I think there is a continuum of feasibility or infeasibility and when you talk about things being of low or high feasibility and, all other things being equal, the more feasible a Measure is, the better. But, I think we

need to, in whatever work... create, we need to acknowledge that there are may be compelling reasons why a Measure of low feasibility is appropriate.

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

Eric, I think that's a great concept. Some will remember that we, at one point, many years ago Karen, talked about, this is Jacob by the way, talked about priority equals value over work, and so, what we're talking about here is the value of a Measure, as Danny described earlier, may make it imperative that it be included and so the value there would be very high. So, even if the work to cause it to be capturable, achievable, feasible, is fairly high, the value of that is so important that it makes that Measure much more of a priority. And so what I think Eric is describing is some method of applying a metric, and I think that might actually be good for our next conversation Karen, is what are the metrics to define where something falls along that continuum that Eric just described.

Karen Kmetik – American Medical Association

Right. And I think by T-ing up an example, we'll just see if it rates high, low on all these different attributes, how do we translate that into that equation. I think this would be a . . . we'd learn from it . .

John Derr - Golden Living, LLC

Karen, this is John Derr. Where in here, maybe I missed it, do we look at what's already existing out there? I know in my sector, you know, long term post-acute care, I have a file called "piling on," because everyone has got their own ideas about Quality Measures, and so, you get them coming from every different direction and, don't we, at the end of the day, want to end up with one Quality Measure for each thing that we want to measure, and not multiple ones, as the only place where we check and maybe it's under feasibility, to see if something already exists?

Karen Kmetik – American Medical Association

John, I hear you. I'm going on the assumption that that has happened, that that is not our scope.

John Derr - Golden Living, LLC

Okay.

Karen Kmetik – American Medical Association

I'm going on the assumption that others have said, this is the Measure and it's not the tenth Measure on the same theme.

John Derr - Golden Living, LLC

Okay.

Karen Kmetik – American Medical Association

And now I'm trying to say, how will we determine where are we from a technical workflow issue to make that happen.

John Derr - Golden Living, LLC

Okay.

Karen Kmetik – American Medical Association

I think this has been a great conversation myself, thank you so much. I think we have enough here to be able to T-up our next discussion, and again, we will try to send something out to you a few days in advance so we could all digest it a bit. But, I'm always amazed by just all of your smartness. So, thank you for sharing. I think we need to go to public comment please.

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

Sure, before I go to public comment, I just wanted to see if anyone else had joined the call that wasn't here for roll?

Randy Woodward – Director of Business Intelligence Systems - Healthbridge

Hi, this is Randy Woodward.

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

Hi Randy, thanks for joining. Anyone else? Okay, operator, can you please open the line for public comment?

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. And we do have a comment from Steven Waldren.

Steven Waldren – American Academy of Family Physicians

Hello. First, thanks for taking up the task here, you guys don't have an easy, simple task, so, I appreciate that. A couple of quick just specific comments about the stuff that was mentioned, and then a couple of comments on a little bit larger, kind of scope standpoint. So, the first deals with from the last slides about the standard terminology, just a couple of things. One, there is a comment about avoiding variation, if by using standard terminologies, make sure that you change that to reduce, because we're not avoiding that. I think Dr. Rose's comment about 401.9, essential hypertension, kind of states that particular issue in spades.

The other is, the second bullet point about the value set piece. Make sure that you don't conflate the issues of value set with the issues of the ontology, again as Dr. Rose had mentioned, I think the example there on diabetes is more of an ontology issue than it is a value set issue. I agree, both of those are critical things, just make sure to talk through those a little bit more, if you could.

The final quick point on feasibility. When you talk about EHR's, I think it would make sense to really hone down on EHR to something that's a little bit more homogeneous and certified EHR technology could be a way to do that, because then you have at least a set of functionality and data classes and terminologies that need to be common across those, and that may help you with kind of figuring out well is it majority or that? On a little bit higher kind of perspective, I encourage you . . . , I agree with the notion of the traditional workflows and making sure that it works in what we're doing today is important, but, I would also make sure that "must" seems pretty strong in our current workflows and current processes have got us in the mess that we're currently into, and if we keep thinking that way, it's going to be a little bit more challenging, but I understand why you're talking about that, and that could be part of the discussion.

And then, one last thing, at the high level, I am struggling, and I haven't participated in the other meeting, so this may be just my naivety, but, it sounded like you kind of started at the very beginning talking about the input, what's the Quality Measure look like, what are the characteristics of it, and then sort of talk about the actual implementation, what does the technology do, what does the technology have to have, how do you actually implement that? And, it seemed like anytime I build a system, or talk about systems, you're talking about input and output. So, the output is what are those things you want the system to do with the Measure, what do you want? If you standardize on that, or at least put that into perspective, then you can talk about well what are the inputs needed, what does the Measure actually have to have, and you don't get kind of bogged down into the middle part of process, which I think is a mess currently in the industry. So, just some comments, and again, thanks for the hard work here. We appreciate it.

Karen Kmetik – American Medical Association

Thank you. Could I follow up with a question back to you? When you say the, in the middle, what do you mean?

Steven Waldren – American Academy of Family Physicians

Well, when you were talking about what does the technology need to do, and there was a lot of discussion about and how it would be implemented, what I was thinking about is if you talked about the output, what do you want? Well, you want the notion for the data not to have to be redundantly entered. So, what does that mean, what does the Measure have to do to support that. Is it using standard

vocabularies that are being used, for example, for meaningful use, as opposed to using a different vocabulary or its own value set, you know, is there a standard value set that could be used as opposed to a specific value set for that Measure. So, if you focus on the output, you can say, okay, well then what does the Measure need to do to be able to support that, and make it easier for an EHR vendor to actually use that Measure to implement to get the outcome, as opposed to working on well, what does the EHR vendor have to do . . .

Karen Kmetik – American Medical Association

Okay.

Steven Waldren – American Academy of Family Physicians

. . . just makes it easier.

Karen Kmetik – American Medical Association

Okay, thank you. Thank you very much.

Caitlin Collins – Altarum Institute

We have no more comments at this time.

Karen Kmetik – American Medical Association

All right, any other comments from the Tiger Team? Thank you all so very much for being on this journey and we'll talk to you again on April 19th.

M

Thank you

W

Thank you Karen.

Karen Kmetik – American Medical Association

Bye.

Public Comment Received During the Meeting

1. May consider the concept of the Life Cycle of the Value Set. After a long time, it may be no longer valid.
2. On the slides, one may wish to also include the concept of the Data Dictionary. This is so important in aligning expectation regarding communication among the stakeholders.
3. Use of the hierarchy (when available) will help reduce changes from year to year as the vocabulary changes