

**Quality Measures Workgroup
Draft Transcript
September 29, 2010**

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good afternoon, everybody and welcome to the HIT Policy Committee's Quality Measures Workgroup. This is a federal advisory committee, which means that at the conclusion of this call there will be an opportunity for the public to make comments. There also will be a transcript made available of the meeting on the ONC Website. Just a reminder for members to please identify yourselves when talking so we can have proper attribution. This call will end at 3 o'clock; the public call will end at 3 o'clock.

With that let me just do a roll call. David Blumenthal will be on momentarily. David Lansky?

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

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Peter Basch?

Peter Basch – MedStar Health – Medical Director

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Eva Powell?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Tripp Bradd? Russ Branzell?

Russ Branzell – Poudre Valley Health System – CIO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Helen Burstin?

Helen Burstin – NQF – Senior VP, Performance Measures

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Carol Diamond?

Carol Diamond – Markle Foundation – Managing Director Healthcare Program

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Tim Ferris?

Timothy Ferris – Massachusetts General – Medical Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Patrick Gordon?

Patrick Gordon – Colorado Beacon Consortium – Executive Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Kendrick? Charles Kennedy? Karen Kmetik? Bob Kocher?

Bob Kocher – McKinsey & Company – Associate Principal

Hello.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marc Overhage?

Marc Overhage – Regenstrief – Director

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Laura Petersen?

Laura Petersen – Baylor College of Medicine – Chief, Health Services Research

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jacob Reider?

Jacob Reider – Allscripts – Chief Medical Informatics Officer

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Sarah Scholle?

Sarah Scholle – NCQA – Assistant Vice President, Research

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Cary Sennett? Jesse Singer? Paul Tang? Kalahn Taylor-Clark?

Kalahn Taylor-Clark – Brookings Institute – Research Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Walker? Paul Wallace?

Paul Wallace – Kaiser Permanente – Medical Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

John White?

John White

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Westley Clark? Tom Tsang?

Tom Tsang – ONC

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Terry Cullen?

Terry Cullen – Indian Health Service – Chief Information Officer

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Judy Hibbard?

Judith Hibbard – University of Oregon – Prof. of Health Policy, Dept of Planning

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marty Rice, you're on for Lillie-Blanton?

Marty Rice – CMS – Nurse Consultant

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anybody off? Anybody else on the call?

Marsha Lillie-Blanton – Kaiser Family Foundation – VP, Health Policy

I am here.

Daniel Green – CMS – Medical Director

Dan Green, from CMS.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Karen Kmetik.

Shelly-Ann Sinclair – Public Policy Institute – Policy Research Analyst

Shelly Sinclair.

Eugene Nelson – Dartmouth Medical School – Prof. of Community & Family Med

Gene Nelson, Dartmouth.

Judy Sparrow – Office of the National Coordinator – Executive Director

Anyone else?

Pat Santora – SAMHSA/CSAT

Pat Santora, SAMHSA/CSAT

Judy Sparrow – Office of the National Coordinator – Executive Director

Anyone else? Dr. Blumenthal, are you on yet?

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He is not here yet, but he will be here momentarily.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay, great. Well, I'll turn it over to David Lansky then.

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

Thank you all for making time to get together today. We're going to pick up our work and as you saw from the materials that were sent out, we're going to get busy. I think all of you will have an opportunity to contribute enormously to what we're trying to do to support the meaningful use program and develop a set of quality measures for stage two and three that can drive our health priorities forward.

The staff has done really wonderful work in the last week or two since the feedback we had from our first call to try to give us a structure that reflects the input you've all provided both in writing and in the last call. As you've seen in the packet that I hope you all have today, besides the agenda, you've got a logic model that we'll talk about a little bit on this call, which tries to tie together the threads of what we're about and a timeline that we'll primarily talk about in the subsequent Tiger Team calls in a minute. I'll go over it briefly now just to see that we're all on the same page with the schedule we're going to try to adhere to and the deliverables that we're going to try to produce.

... sure everyone has the agenda, let me quickly review it until David gets on and gives us our charge.

David Blumenthal – Department of HHS – National Coordinator for Health IT

I'm here.

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

Oh, great, David. So do you want to just kick us off before we get into some of the details?

David Blumenthal – Department of HHS – National Coordinator for Health IT

Well, first hello and thank you all. I want to thank the staff and David who have put together a great set of background documents, Tom and Josh and others. I think that the main purpose of today's call is to move us from a kind of a committee of the whole into a set of working groups that can focus more on our goal and be put in the intense effort that's needed to achieve our goal of identifying the gaps in quality metrics that need to be filled in preparation for stage two of meaningful use.

I think the sense has been that exciting as the conversations have been when we've met as a committee of the whole that we don't have enough time on these meetings to get into each of the domains that are so essential. A lot of thought has been given to which domains we need to highlight, some ideas about who should serve on those working groups. Later on in the meeting, we will at 3 o'clock break into administrative sessions of those sub-groups to begin the work of producing that conceptual step. What are the measure concepts that we really need to fill in? What are the gaps that we need to fill in that are unique to build on the ability of health information technologies for delivering them.

I'm going to stop there, time is short and just step back and let you carry on, David.

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

Let me kind of again, review what we've got for today. We've got the logic model to talk about here for a minute. We had settled on a working set of domains, within which our work will be organized. I think most of the people on the call have volunteered or have been asked to serve on a particular Tiger Team—we're calling them focused workgroups—for a short period of time to try to really get into the

details in each domain. I will talk about the process we had in line for that today. Then at three, we will adjourn into those small groups and get to work.

I hope you've all received a copy of the spreadsheet, which is our working grid that we're going to gradually try to populate. I thought what I'll do for the next couple of minutes is just orient you with—hopefully Josh and Tom can help me—the logic model that we've represented here. Then talk about this grid and how we hope to populate it as we break up into our groups. Then of course, if we have any discussion from all of you about the process we have in mind.

If you have a copy of the logic model handout that was sent out with this week's material, you'll see it has four major headings: Input Goals, Output, and Short-term Outcomes and then Activity's nestled within that.

If you start over on the right with the short-term outcomes, what we're trying to achieve are measures that will allow us to drive improvements in health and healthcare through the programs that we're all collaborating on here. You see under both the short-term and the long-term outcomes an initial working sketch of some of the goals we have. Clearly what we're trying to do is improve health outcomes and use quality measures in a way, which drives improvement. Incidentally, tie the measurement of health outcomes to the introduction of health IT, which is obviously the challenge about the program as a whole. We want to identify HIT sensitive measures of clinical quality and of outcomes that can be used to create appropriate incentives across the program.

Our part in that work is to make recommendations under the output column to the Policy Committee as to what we think would be the measure concepts and ideally the measures, which could be deployed in stage two of the meaningful use program to help create the right incentives for people to implement the HIT in a way which produces improvements in health outcomes and quality of care. Our job is to make recommendations.

Working back to the left then we've identified some goals of our work immediately. One is to identify domains that are the areas of measurement. We'll talk about those today in some depth. Within those to identify measure concepts, things we think would be helpful to measure it to drive improvement. Identify any gaps, where we don't think the current measurement suite is adequate to document performance against those measure concepts.

We know that those are going to raise some methodological questions, so we had some parallel path work on methodologies that could be improved to take advantage of HIT enabled measures will permit us to capture them. Our job in the Tiger Teams will be to flesh out the domains and the sub-domains to identify measured concepts within each and to then identify measures within each. That's a hierarchical approach to our work I guess.

The inputs on the far left are really—the staff has done a great job and NQF has provided us with a lot of input through the Gretzky Group report to canvass the different frameworks for organizing all this complexity. As you see on the left side of this one page, there are nine or so frameworks that are in active consideration by a lot of important groups ... today. What we've tried to do for the purposes of this particular program through ONC is stay aligned with the dominant frameworks and paradigms that are floating around, but make sure it applies particularly to the challenge we have of identifying gaps in the quality measurement framework as is applied to the e-enabled environment.

As a result of taking these—I think there are nine—frameworks over here on the left, and reflecting of course that last year the Policy Committee endorsed essentially a subset of the original NPT framework, we've tried to stay consistent with that. So what we end up with as of today—and I guess we could still have another bit of discussion about this, but I think we want to try to lock this down and get moving with this today—are five categories of analysis that we're going to do together in these Tiger Teams. They're listed on the big grid.

They are Patient and Family Engagement, Care Coordination, Patient Safety, Population and Public Health, and a broad category we called Efficiency, which includes overuse and under use, but is meant to capture a variety of other resource use domains the sub-committee might think appropriate to try to address, and feasible to address. There are some other categories that are on the agenda page, like patient reported health status, disparity, quality of care, and then the large domain of leading conditions, which we don't have explicitly called out as a separate domain for measurement, but we believe all of those things should be folded into one or more of the other categories, and certainly won't be lost. We should all be challenged to make sure we don't lose track of those other categories as you do the work within your own Tiger Teams, but for the sake of our own organization and simplicity and so on we're going to try to pull everything into these five categories.

Now we've got a sixth group, which here is listed as a Methodology Team on longitudinal or delta measures. We used to have, you probably recalled, the idea of having two methodology committees, one on the challenge of capturing data from patients, and the second on longitudinal measures. We've decided at least for working purposes to group the methodology challenges around patient source data into the Patient and Family Engagement Team. That isn't to say that there aren't patient based measures useful in other teams, in other areas, but for the sake of consolidating some of the expertise that we're bringing together we thought we do it under that one heading. That Tiger Team will meeting obviously in the next hour and will have to wrestle with how to couple the methodology issues with the content issues in their discussion.

Let me pause there with the very crude overview of the logic model, the domains we ended up with. I guess to just wrap up the logic model down the middle of the picture you see the activities list, which has—now in this picture it has the previous version of the domains and now I've just summarize for you're the re-categorization a little bit different than box one on the logic model that you have. Essentially the same work still remains: to identify the domains, identify the sub-domains, identify the measure concepts, and then identify measure within those.

I'll come back in a minute to the procurement process if you like—solicitation process—to try to identify those measures. Before I do, why don't we have a little discussion about the model as a whole and the proposed five big domains? Let's see if people have any thoughts about that. Since no-one has objected yet, is there any acclimation that we should proceed down this path? People feel okay with it?

Bob Kocher – McKinsey & Company – Associate Principal

I think it's the right logic. I'm just curious—it would be helpful to have a sense of concretely what's the most helpful end product for us to arrive at? Is it a handful of defined metrics? Is it areas for future research? What do we need to accomplish?

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

Well I think that speaks to the timeline issue a little bit. That is I think we'll have a set of intermediate products. The ultimate product has to be a set of measures that can end up at a final rule for purposes of implementation. We don't of course have that job. Further downstream I think our job is to say—

Let's go back to the logic model picture at the very bottom. The first stage of our work over the next three or four months is to develop a super set of measures, which could work for stage two of meaningful use. During 2011 our belief is that we will try to identify a set of either individual measures, or measure developers who can refine measures to the point where they're ready for use during 2011 so they'll be available for stage two. During this next three or four months we have to get ready to support that ... for ONC to support that process over 2011. I think they want to be able to support that measurement development work during the next year.

To get them ready for that the best case is we could actually identify measures that are ready to be considered. One short of that would be to identify measure of concepts and some of the investigators or developers who could support that work over the next several months.

Let me see if Josh or Tom wants to clarify my understanding of that.

Josh Seidman – ONC

No, I think that's good.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Let me add a point here. I think it would be a very tall big lift for this group to come up with measures that are As impressive as our expertise is – there is a huge body of expertise that's not included on this, including the professional societies and many of the providers and so on. Also we need to make sure that if we have committed to an area of measurement—if we've decided that some conceptual indicator of care coordination is really the cat's meow—I think it would be better to make clear early that we need that measure rather than wait until we've come to agreement on what we think the precise measure is. Because it will need to be vetted at a technical level that we're not capable of and we're not staffed to do.

I think I might say we should produce measures where the measures are ready to be produced, but I don't think we should define our absolute end point as a set of measure because I think we would delay a process that may need to involve outside resources and a contracting process that needs to get started earlier rather than later. If we're going to have measures by a year from now, a lot of very, very fast technical work and specifications need to be written up because we can't include things in the NPRM until we know that they are capable of being e-specified. We don't have a lot of time to do that.

I think we should get quickly to the domains and the concepts and wherever measures are include them, but not break our necks over being very precise about what the numerator and denominator are going to be and what the exclusions are going to be and all the other things that go into measure specification.

Christine Bechtel – National Partnership for Women & Families – VP

We had a call earlier for some of the Tiger Team co-chairs. I think Tom gave us a helpful construct and I just want to make sure. I think it's consistent with what folks are saying. The construct was really measures or measure concepts in three areas. One is measures that are ready now, which we have this huge grid in the Gretzky Report and the meaningful use rule, etc.

The second is measure that need improvement, but they're already in the core of quality measures that have been vetted. Let's say for example, rely on administrative data that would be much better as HIT enabled with clinical data. Then the third is more of aspirational concepts or domains that measures would need to be developed in, but as you point out, David Blumenthal, we're not developing the measures those things might go in your RFI and RFP process later. Is that accurate?

David Blumenthal – Department of HHS – National Coordinator for Health IT

That's correct, Christine.

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

So, Bob does that get to your question?

Bob Kocher – McKinsey & Company – Associate Principal

Yes, thank you.

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

Other clarifications or endorsements or concerns?

Neil Calman – Institute for Family Health – President & Cofounder

Are you looking for us also to try to define some of these things as 2013 ready or 2015, or that would be a separate process?

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

Well, I think it's very helpful to clarify what—in Christine's taxonomy—what the state of development is today for those measure concepts. Obviously sooner is better in most of these areas, but we have to be realistic as David described the timeline.

Neil Calman – Institute for Family Health – President & Cofounder

Well the measure might be ready, but we might not be ready to want to measure it yet. I think those are two different things really.

Russ Branzell – Poudre Valley Health System – CIO

I absolutely agree with the concept that we're heading down. If I think the current metrics and measures are any indication, I think there is going to be an overall industry struggle regardless of what we define. The more we define overall criteria that meets multiple factors of readiness, not just whether we know exactly what the measures should be, but as it was stated, is HIT ready to support that? Or are organizations ready to support that? Can we get the outcomes we really need by forcing this measure to happen? The more we can define that overall readiness I think the easier this process will be or the less difficult this process will be.

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

There was a parallel to that point, Russ. There was a parallel discussion in the last meaningful use workgroup meeting, last week, about how we can be most helpful in sending a signal to vendors—the EHR vendors—that here's a measure concept that's in our pipeline that we think is realistic, but how do we give the signal early enough to the vendors given their software development and release program that they can incorporate it in time for either stage two or stage three. As a rule of thumb we were thinking that we needed to be about 18 months ahead of the curve with a pretty well defined set of technical requirements so the vendors can reasonably anticipate that.

That's just another reason, as well as Dr. Blumenthal's comments, that our timeline, and Neil's, we have to be very early in identifying any critical data requirements so it's toward these measures if we want to communicate those to the vendors in a timely way. The rule of thumb has been any signals have to be to the vendor community by next March, in other words in five or six months.

Russ Branzell – Poudre Valley Health System – CIO

I would highly encourage that. We're getting a lot of mixed signals from the vendor community right now in support of our applications that they may not support the metrics native to the EMR, the certified EMRs, but rather a secondary product, which kind of goes against our concepts all along.

Marc Overhage – Regenstrief – Director

Could you say a little bit more about that because I would have thought the modular approach to certification that the ONC has developed would support that?

Russ Branzell – Poudre Valley Health System – CIO

We were just on a call earlier and many of the CIOs that our original thoughts would be that the native EMRs and certified EMRs would—because that's where the data would be—would be able to support the metric reporting on this. What we're hearing from many of the vendors is they may need a secondary product or another module rather than being able to report natively out of the system. Again, the sooner we can get this data to them I think the easier it will be for them to not have to rely on secondary reporting tools or another module to be able to complete that task.

Jacob Reider – Allscripts – Chief Medical Informatics Officer

I feel like I'm being asked to comment here on behalf of the vendor community. I would say that in general many of our transactional systems—so the core EMR—you wouldn't want to do the reporting right off of that system. Many vendors, ourselves included, are using other systems to offload into data warehouses and whatnot so that we can do the quality measure reporting.

I would echo that the comments that others have said, that the soonest—and my vendor colleagues have all shared this with me ahead of today's meeting in fact—is that the sooner we can clearly define what it is

that this group will be looking for, the more likely it is that the systems will be prepared. In fact, I think the vendor community in general wants to step up and wants to meaningfully participate in driving outcomes toward significant improvements. In order to do that I think let's do what David described earlier, let's get this accelerated so that we can telegraph the path here.

Eugene Nelson – Dartmouth Medical School – Prof. of Community & Family Med

... clarification—stage two starts when?

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

Right now stage two would start in 2013. So I presume January first of 2013, a little earlier for hospitals. Anyway January first, so it's two years after the start of stage one.

Carol Diamond – Markle Foundation – Managing Director Healthcare Program

I guess I have a question about the charge to the Tiger Teams. I understand breaking out the different domains. Are there specific health goals that the teams are going to be asked to work towards or are you looking for the teams to develop those, or are those coming from ONC?

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

I would say, Carol, I know we've had this discussion and Christine's actually kind of led the charge on this the last time we talked. There has not been any commitment to specific health goals that are applied to each of these domains. It is obviously implicit in the choice we make of quality measures, but the short answer is no.

Tom Tsang – ONC

Carol, that's why we are using the nine different frameworks and specifically I'm referring to the National Quality Strategies. We're closely supporting the National Quality Strategy work that reports to Peter Lee and the Office of Healthcare Reforms and also Cal and Clancy at HR, too in that some of the work that you guys are doing and the recommendations that you're making would be informing the EQM task force, which also informs the larger set of quality workgroups. The four main principles in that strategy is patient centeredness, family engagement, addressing all ages in terms of coverage and access, eliminating disparities. In addition to that, we are also using the NPP framework and the six goals and priority areas.

Carol Diamond – Markle Foundation – Managing Director Healthcare Program

Yes, I think based on our previous discussions I think we all understand that and the different domains. My question was more about what specifically we should be looking to accomplish in each of those areas. What are the priority health goals in each of those areas? Then start the scan for those measures in HIT capability. My worry in this sequence is that, as David said, there will be some health goals implicit in the measures we find, they may not be the ones that are of greatest importance to population level or in terms of order in which they are sought out.

Christine Bechtel – National Partnership for Women & Families – VP

It might be helpful since of the nine frameworks—I think and I could be wrong—that the NPP framework is actually the only one that really has some specific health goals around hospital required infections and safety and adverse drug events and things like that. So perhaps the Tiger Teams leads and the rest of the workgroup could look at those specific health goals as they're going through their exercises. It might be worth circulating the NPP goals themselves to the workgroups for that purpose.

Tom Tsang – ONC

We exist within a larger governmental ecosystem. If we pick measures that support particular health goals and then the National Quality Strategy highlights other health goals, we won't be doing the field a service. So I think at this point what we ought to be doing is teeing up measures that are candidate measures, that we think are important and competitive. But I don't think we can be specifying that our goal is to reduce heart attacks and strokes and that's our primary goal against which we are measuring everything we've proposed. I think it would be just premature and I think we wouldn't be covering the full set of tasks that we need to take on at this point.

Our EQM task force cannot set the goals of the federal government for healthcare improvement. I think what we are doing is trying to find those measures that are now candidates for inclusion in quality measurement that are really central to the framework we're using and that are very fruitful to potentially include in the NPRM.

We're also not writing an NPRM. We're providing a resource for the Policy Committee and the Policy Committee will take what we propose and try to take it the next step including saying—if they do come up with goals and if they meet in light of the National Quality Strategy—these are the electronic healthcare data that's required in order to meet the quality measurement tasks for meaningful use that are implied by the Secretary and the President's healthcare goals.

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

I just had two other quick thoughts to this. One is we are encouraged to have measures, which apply to as many of the eligible professionals in hospitals as possible. Breadth or cross cutting character is a helpful characteristic with some of these measures we're going to talk about. The other is I think we are particularly in the workgroup being asked to address gaps. So the domains we have on our table here are particularly those where the current suite of quality measures has been judged to be less satisfactory like care coordination and patient engagement.

Part of what we have to do is balance what you all know very well about the current state of art and availability of measures with where really the very important domains that are not adequately addressed. We've got a number of simultaneous equations to solve for that we'll just sort of have to juggle within each of these work groups as we go forward.

Other comments people have about this framework or the process we have in mind so far?

Daniel Green – CMS – Medical Director

One thing I would suggest that we also consider when we're thinking about different measure topics or measures specifically is considering the high cost conditions and particularly where there are gaps. It fits somewhat in the framework of value-based purchasing, which Medicare is interested in, as well as some of the other projects in the Affordable Care Act like the Accountable Care Organizations. I think that might be something to consider while we're looking at the different measures.

I was just going to ask on that ... Dan, maybe Tom could just go back to the comment you made earlier, Tom. I'm not sure if everyone is aware of the EQM workgroup and what the other federal initiatives are and how do we fit into that. I get asked that pretty often. Can you just—or David—can you summarize how our work fits into this larger matrix of activity?

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

You mean the work that's going on elsewhere among our sister agencies for example, CMS?

Daniel Green – CMS – Medical Director

Well, like Tom just mentioned there is this federal quality committee and then there is the EQM Workgroup, I guess. They're doing e-quality measures germane to that larger charge.

David Blumenthal – Department of HHS – National Coordinator for Health IT

I wish I could fill in all these ... for you but I haven't been part of all these discussions. Farzad is better equipped to— Tom, do you want to step in?

Tom Tsang – ONC

So the total quality workgroup stems from legislation in the ... charging the Secretary to develop a national quality strategy so that's within the federal space. All the partners have put together—or all the federal agencies—have put together this national strategy that was actually put forth into the public domain and is available for public comment. I think that was put on the Website last week. The EQM task force is informing that workgroup in a concerted coordinated effort to let them know what are the

priority domains—what are the priority e-measures—that would be available to improve and how it would fit in the national quality initiative. That's the national quality strategy.

Now the HHS 6.2 task, that's essentially a contract with NQS that CMS and ASPE have in terms of prioritizing some of the domains and doing similar work, but not specifically related to e-measures, but measures as a whole. That's an ongoing activity that many of you are actually engaged in.

There are other groups that are actually coordinating with each other making sure that we're not duplicating efforts. For example, CMS and ONC are working very closely and making sure that we're not duplicating our efforts. That some of the work that they're doing is for leading conditions and for some of their other programs, Dan mentioned them, the value based purchasing program, the ACL, PQRI, There is ongoing measure development work that CMS is doing. We are in close contact to make sure that we are on parallel, but looking at separate domains.

I think that's basically a summary of some of the activities going on, David.

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

So you'll share with us whatever other areas when there is opportunity for us to take advantage of their work or us to contribute to theirs. It sounds like the staff will keep us integrated or at least aligned as necessary.

Tom Tsang – ONC

Yes.

Daniel Green – CMS – Medical Director

Tom, obviously you believe that this plan does not duplicate what's going on elsewhere.

Tom Tsang – ONC

Yes. That's the other reason why we have multiple federal members sitting in this workgroup so that there is a very high level of coordination going on.

Helen Burstin – NQF – Senior VP, Performance Measures

I'm still a little bit fuzzy in terms of the wording we've been using about HIT enabled and HIT sensitive. I think before we get into our workgroups, a little clarification might help. I guess HIT enabled, as David Blumenthal said, is HIT ready to support that? I think at least in some of those thinking around the Gretzky Group were, we were thinking more so that HIT sensitivity really reflected the ability to drive improvement using HIT by having that area measured. Can you give us a little more clarity of your thinking currently?

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

I'll be happy to tell you mine, hopefully David can tell his, too. I think HIT sensitive is a better framing. Although, we also want them to be HIT enabled where that's appropriate. I know in the patient engagement area we're not expecting a certified EHR to be capturing the patient's evaluation of their care, for example. That may be HIT sensitive, that is the patient may have a better or worse care experience because of the HIT enablement that's been included in the care system. It may not be HIT enabled, it's so important for us to measure. I'm sure there are other examples of that, so that's my take. I appreciate other's thoughts.

Josh Seidman – ONC

I think this is true that definitely both those concepts are important. Obviously if we're trying to understand whether providers are meaningful users the issue of HIT sensitivity is important. One of the purposes, of course, of the EQM task force is really to take advantage of new clinical electronic information infrastructure. In that sense, there are some things that are EHR enabled that are important.

Tom Tsang – ONC

I think Helen's question raises the fundamental issue of are we measuring for measuring sake or measuring for improvement? The answer is we are measuring for improvement. So there may be a public reporting and that's been tough, a public reporting component to encouraging improvements. I think that what's new here is as Josh said, we've got a richness of data that we didn't have before so we should look for measures that are improvable and that weren't possible to highlight in the absence of health information technology.

Christine Bechtel – National Partnership for Women & Families – VP

I would add too, I think we're also measuring meaningful use from a programmatic perspective. There are lots of quality measurement programs that are in play that measure improvement, but I think part of the—at least to me—the strategy here is choosing quality measures that were at least some of them demonstrate the clinician is using the right IT functionality effectively. That to me is how we get to some parsimony around you not having to require the use of every single feature and function of the technology if what you're really doing is requiring clinicians to look at the outcome of their care that can really only be done if you're using those features and functions in the right kind of way. For me I also think this is about measuring what the meaningful use is meaningful to patients and others.

Neil Calman – Institute for Family Health – President & Cofounder

I just want to throw in a recollection, which is that when we started to talk about measures before that were improved by HIT, but not measurable by HIT that it was pointed out to us that that requires extra work. That we were already asking people to implement electronic health records and use them meaningfully. We were trying to minimize the extent to which the reporting of that and the monitoring of that required additional work outside of just that implementation in meaningful use. I think when we start talking about things that are improved by HIT, but not measurable through HIT and that require additional types of measure or additional kinds of modules and things like that, we should be cautious. We're going to get a huge amount of pushback because we're already asking people to do a whole lot.

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

I think it would agree, certainly with the focus on the HIT sensitive and the way that it was defined. Fortunately most of it will overlap with HIT enabled and to the extent that they completely overlap, which is I think where Neil was headed, I think that's desirable.

I wanted to raise another source of data particularly on the patient engagement domain. We had talked about and heard hearings that covered the use of information that's generated by patients such as through PHRs. I would hope that that gives something, although we don't have a lot of data in terms of the sensitivity of the quality of measures to HIT as option, but I hope we can think in that direction while we include measures that are HIT sensitive.

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

I mentioned it maybe before you get off, Paul, that the patient engagement Tiger Team is also going to take up the methodology questions that are raised by your points of how do we best capture data from patients in this environment.

Eugene Nelson – Dartmouth Medical School – Prof. of Community & Family Med

Just to tag onto the point that was made, when we were able to look at some of the more progressive health systems and their use of HIT to improve care and outcomes, it turned out, as I think Paul Tang is suggesting, that they're using their EHRs. They're integrating that with PHR (Personal Health Record). They're integrating both of those with registry. HIT meaningful use in a lot of these progressive systems really does mean bringing together the EHR and the PHR and person level registries in order to improve care and to improve measured outcomes.

Kalahn Taylor-Clark – Brookings Institute – Research Director

I appreciate that comment but I am curious about the penetration of those, what you call progressive systems. My concern is—and I'm really very supportive of including these PHRs and the information from them into the EHR, in particular around patient engagement, but I am just curious about how

representative those are and whether that can be a realistic goal for let's say the Tiger Team to advance measures in that way?

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

I'm going to suspend this conversation because it's a very rich one and I'm sure we'll spend many hours on it in the other groups. But we only have about five minutes left before we have our public comment and then adjourn to our other discussions.

Let me just, if I could, suspend the conversation here—we'll resume it—and direct your attention to two other pieces of information for this call. One is the schedule, which we may go over again in your Tiger Team, but let me just make sure everyone is oriented to our overall schedule and then to this grid, this worksheet, that we're going to start working on today.

On the schedule front, today is on the Tiger Team model that we're introducing today this is the first call obviously. Our goal today is to identify the high priority sub-domains that the group wishes to focus its attention on. You're being given the domain. You get to choose and prioritize your sub-domains.

The next call in a little more than a week would be to look again at the sub-domains and then start looking in greater detail at the specific measure recommendations in the prioritized sub-domains. Now maybe we'll get into a little bit of that today in our calls, we'll see how quickly we come to agreement and how quickly we can get into some of the details, measure concepts, and measures.

We have a third call scheduled for October 13th of these small groups. Then we will, on October 20th, according to the draft schedule start getting ready to report out to the Quality Measures Workgroup—that is back to this whole full ... group. On October 28th, essentially a month from now we will bring back recommendations to this full group from each of the sub-groups. Really you have a month to get through the sub-domains, prioritization, concepts, and however far you can get into actual measures or candidates for measures. That's our aggressive timeline for the next month. Essentially it's three phone calls and reviewing a report probably offline.

The second thing is you got a grid today in your handout, which is a long form spreadsheet. It has the five major domains listed across groups of rows rather and then you'll see underneath it the sub-domains that have so far been suggested. One of your jobs today is to select, prioritize, perhaps add to those sub-domains.

Just to orient you to what's in the columns for the sake of guiding our discussion, but nothing more than that, we portrayed for you the current meaningful use stage one measures that seem to fit into that sub-domain or domain. Some of the information you've already seen from the Gretzky Group report that are the measures that could also be applied to that sub-domains that have been reviewed through other channels.

There were some appendices sent out to you in an earlier e-mail from other national and international projects so the column that says, "Third Party Measure Examples" are other good measures floating around the world that we may want to draw upon. Then you all, in our survey a couple of weeks ago, suggested some measures you were familiar with, so those are now in the column labeled "Measure examples from QM Workgroup." That shaded area is reference material if you like from other prior activity.

The blank columns on the far right are wide open for you to generate these concepts or measures that you think would really address that domain. So our goal—simple-mindedly—is to start populating those three columns on the right with ideas or measures that you think will advance the goal.

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

David, which document is that?

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

I don't know what its title is in the handout. The title on the page is Tiger Team Worksheet. Let me just check and see if Tom or Josh have anything else you want to say about the tool itself. Nope, you're good?

All right, then I think we're coming to the end of our time with the public call, except for public comments. Before we go to the public let me just see if anyone on the committee has any burning questions, clarifications, other challenges about the process? I guess we should leave the substance aside until the next call.

Tom Tsang – ONC

David, I just wanted to mention to everyone that there will be an ONC staff assigned to each Tiger Team for any questions.

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

Let me make a comment too, about the FACA process that I think you all know we're part of. Because this is our first chance to organize these Tiger Teams, the next call, this afternoon, will not be open for public comment. It's an administrative call. All calls subsequent to today will be public meeting. The public will have the opportunity to listen in and contribute their suggestions to the discussion. Do keep in mind that we are representing a public process for input to ONC.

John White

I have a health IT sensitivity question. I'm assuming that if we say that something is HIT sensitive that there is something backing that up. It's not just because somebody says so, which would lead me to assume that there is some sort of level of evidence associated with the given measure that says that it's health IT sensitive. Would that be fair?

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

Well, I think it's a legitimate comment. I'm a little personally I'm challenged to operationalize it, but maybe that's a fair discussion to put to the staff or others who've worked through that more than I have.

David Blumenthal – Department of HHS – National Coordinator for Health IT

I think if there is a good strong logical clinically based set of experiences in logic that suggest that a reminder system— For example, we know that reminders in general improve outcomes. If we think a reminder around a particular type of care is going to result in improvement, we may not need a controlled clinical trial of that demonstrating that improvement in order to go forward with the proposed measure.

Helen Burstin – NQF – Senior VP, Performance Measures

At least in the Gretzky Group report, we tried to at least build in the concept that low was relatively weak evidence although there is some logic that it could improve care. Medium was that with implementation of key HIT functions like reminders, as David had said, you would likely expect performance to improve and evidence is called emerging. High was really where there was clear strong evidence that implementation resulted in improved outcomes in performance. I had actually done a little two-pager for the ONC folks, which we'd be happy to share if that would be helpful.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

I heard clearly about that it's not our role to set specific goals. That that's premature and other places are playing that out. Would it be helpful in our Tiger Teams to at least think about beyond 2013? So what is it that we really want to achieve to really hit the ball out of the park on efficiency? To get there we might have to take step one in stage two and then the next step in stage three. Is that within bounds? Would that be helpful?

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

I think it's helpful. I think if we were to say explicitly that our goals are to reduce infant mortality, reduce obesity, cut heart disease, and improve and reduce the frequency of breast cancer, I would hate to see us focus just on those five healthcare goals. Then find that in fact, the department and the government were

going in different directions, then that work was not going to be used. I think that we ought to be clear that the measure's we're picking up are related to important healthcare goals.

Now we have domains in care coordination, population and public health, so staying in those domains is a first test of the end product that we're seeking. If we want to go to specific conditions—so we're not just improving population health, but we're reducing the prevalence of obesity—I think we should be cognizant of that as the end point of the measure, but I wouldn't say exclude measures that didn't contribute to that.

Christine Bechtel – National Partnership for Women & Families – VP

David, I have a process question, which is are we then going to go back to these quality measures and revise once the federal government—?

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

The Policy Committee can do that.

David Blumenthal – Department of HHS – National Coordinator for Health IT

We may have a super set of measures that we generate.

Christine Bechtel – National Partnership for Women & Families – VP

Right, I'm just thinking in selecting measures we are selecting health priorities, whether it's organized in focus or scatter shot, that's absolutely the case. I understand what you're saying that you don't believe this group is really invested in sort of picking our own health goals and I get that. It makes sense then that we would come back as a group—whether it's this group or the Policy Committee—to say, —“say the federal government has laid out 12 health improvement goals,” and we need to now re-align measures to those goals so that this investment gets focused. Is that essentially something in our future?

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

I think it's possible. I'm hoping that the measures that are suggested here will be robust enough that they will anticipate any likely healthcare priorities that are set by the government. Certainly the Policy Committee would have a chance to comment on an NPRM, for example. This committee could inform the comments of the Policy Committee. I think there will be other bites at the apple.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Looking at our time I think we should see if the operator is going to allow any comments from the public.

Judy Sparrow – Office of the National Coordinator – Executive Director

At this time we would like to invite public comment. Just a reminder we need your name and organization, and there is a three minute time limit.

Operator

Our first comment is from Charlene Underwood, with Siemens.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I just wanted to make a suggestion under the patient safety area. One of the key areas that I think is both HIT sensitive as well as where there has been a lot of measurement work done is in the area of safe medication practice. So I would want to try and influence that workgroup to make sure that subject matter experts—for instance, from the Institute of Safe Medication Practice, ... etc.—on those committees as well as I think there has been a lot of health systems that have been working with, for instance, the Robert Wood Johnson organization in terms of pursuing perfection. I would just suggest that we make sure that particular area is covered in the measurement space.

Operator

We do not have any more public comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

I'll turn it back over to Dr. Blumenthal.

David Blumenthal – Department of HHS – National Coordinator for Health IT

David, do you have any other comments?

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

No, I don't. Thank you, David.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Can I just ask maybe Tom or Josh, if you want to give us a little bit of advice about the next session in terms of who the lead people are for the Tiger Teams and so on. I think everyone understands they'll need to call back in. I hope you have that information and a specific pass code for each Tiger Team that you're affiliated with.

Tom or Josh, do you have any logistical advice?

Tom Tsang – ONC

No. I think just dialing back into those specific numbers that you should all have that and then the details for that call will be discussed at that time.

Josh Seidman – ONC

David, not a logistical issue, but just a comment going back on this HIT sensitivity thing because I don't want people to be fixated on is this measure sensitive, is this measure enabled, because the purpose of the by-product of all this is that we're going to put this in an RFI so we will be getting solicitations facilitating comments from the real measure developers and from outside organizations to see what are they using? Is it parallel to what you as a group have recommended?

If it's not being used out in the real world then we need to go out there and develop it.

David Blumenthal – Department of HHS – National Coordinator for Health IT

Okay, thanks. I guess we are set. Everyone gets to hang up and dial in again to the new code number and we'll talk to you all as a group again in a few weeks. Meanwhile, thanks for all your help with this and your very creative and insightful comments, and go forth.

Thanks everybody.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thanks, David.

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

Thanks, David.