

**HIT Standards Clinical Quality Workgroup  
DRAFT Transcript  
January 27, 2010**

**Presentation**

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good morning, everybody, and welcome to the HIT Standards Committee's Clinical Quality Workgroup. Just a reminder that this call is being operated in public and there will be an opportunity at the close of the meeting for the public to make comments; and as far as ... if workgroup members could remember to identify themselves when speaking for attribution, and when you're not speaking if you could please mute your telephone lines.

Just to make sure that if there are any committee or workgroup members on the public line, you have in your e-mail an invitation the line that you should be dialed in on, which is open during the proceedings. Let me do a roll call and then I'll turn it over to the chair.

Janet Corrigan?

**Janet Corrigan – National Quality Forum – President & CEO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

John Derr? Doug Fridsma? Judy Murphy?

**Judy Murphy – Aurora Healthcare – Vice President of Applications**

Here, present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Marc Overhage?

**Marc Overhage – Regenstrief - Director**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Rick Stephens? James Walker? Floyd Eisenberg?

**Floyd Eisenberg – Siemens Medical Solution – Physical Consultant**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jack Corley? Walter Suarez?

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes, I'm here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Ken Gebhart?

**Ken Gebhart – National Institute of Standards & Technology**

I'm here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Did I leave anybody off that list? Okay, with that I'll turn it over to Janet Corrigan.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. Good morning, everybody, and thanks for joining the call. This is the first call of the workgroup for the new year. Our focus today really is on two things; we want to review the meaningful use measures that are in the NPRM and identify any potential comments that we would like to make on those. Those will be recommended to the standards committee. In addition to that, we want to take a look at the IFR standards requirements in light of the NPRM measures to see if the IFR standards are adequate to support the meaningful use measures that are included in the NPRM at this point.

In preparation for the call, Floyd Eisenberg was kind enough to prepare a grid measure retooling master list to grid, which you should all have, and Floyd's going to go through that. And what he's really done is to arrange the various measures that are currently in the NPRM and to do it in a way that we could see the extent to which those were consistent with the recommendations of the standards committee. What additional measures that have been added, so that we'll be able to then go through that grid and identify any potential concerns or comments or recommendations that we would like the standards committee to consider.

Are there any questions about the agenda? Okay. I should have said in our next committee meeting, we will begin to turn our attention to the 2013 and 2015 requirements, but in this call, we wanted to focus just specifically on the NPRM and the IFR requirement.

All right, why don't we turn to Floyd then? Floyd, if you could please take us through the grid.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Sure. Let me first give you a general overview of the grid.

**Chris Weaver - Altarum**

Dr. Eisenberg, I'm sorry, this is Chris with Altarum, we actually have the grid if you want to go through it. We have somebody who's going to share it on the screen so that everyone can see it if you want to, but you'll have to just kind of guide us through it and what you want done on it.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Sure, that would great if you can do that.

**Chris Weaver - Altarum**

Okay, just give them one second; it should appear for everybody in a few seconds here.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Okay. I'll explain the purpose of the grid originated with a set of measures that we at NQF for us to look as far as retooling. What I did was I sorted it by, actually if you can scroll all the way up to the top of the grid, it opens up in the middle. I'm sorry about that. You have to go to line two. There you go.

What I did was I added a column for those that this committee had suggested for meaningful use in earlier discussions and presented to the standards committee. So you'll see all the way to the left, the

column that says meaningful use and that was the recommendations from this subcommittee, if there's an "x" in that column. And it's sorted so that there were 17 measures recommended and they're the first 17 on the list.

If the measure was included in the NPRM, there's an "x" in the next column that the NQF reference number for the measure is listed. And next to that is the steward, the PQRI number if it is a PQRI measure, the title, and any comments about what would need to be modified or what needs to be done in a retooling effort.

As we look at these, you'll see there are two color codes here, yellow is, we've actually spoken with the measure steward and the measure steward does not intend to move forward with this measure. There are three of them in the list here that will not be continued by the measure steward, so that's what the yellow measure is. And there are two in pink and we'll show them for those unable to see the colors that you'll see there's some gray highlighting; but the pink ones are those that are not in the NPRM, but were requested or selected by this committee to meet the policy committee's recommendations.

If you remember back, looking through the recommendations started with the policy committee recommendations for a measurement based on priorities for healthcare and looking at those that's how the original 17 were selected, so this is providing that information. So of the first 17, there were two that are not in the NPRM and one is medication reconciliation, the other is use of the EHR for electronically receiving laboratory reports.

With respect to the laboratory reports, there is a reporting requirement in the NPRM, but not specifically this measure. There are 35 utilization reports, the NPRM suggests outside the table. All of the ones in this list, the ambulatory ones are in table 3 on page 123 of the NPRM. There are also utilization measures earlier in the "x" and lab reporting is included there, but not this specific measure, just to be clear.

I'll stop there and see if there are comments.

**Janet Corrigan – National Quality Forum – President & CEO**

In the medication reconciliation one that is not included, Floyd, can you tell us what is there instead?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

I was not able to see anything specific that was substituted.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. Are there any comments or issues about the two measures that weren't included? Okay.

Then we have the three measures that the measure stewards are not going to go forward with, so presumably those will likely fall off the list, so we may not want to spend too much time on that.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Right. What I can do is explain the rest of the list, as I've looked through the list in the NPRM, many of these seem to have been added and there are tests to that to address specialties. And if you go through the NPRM itself, there are a series of tables indicating which ones deal with approved specialties. And if that's the reason why there are many more in here, there are also some measures in here that were added in the NPRM to deal with Medicaid and different populations that were not in our original 17.

**Marc Overhage – Regenstrief - Director**

This is Marc Overhage, can I ask a question?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Yes.

**Marc Overhage – Regenstrief - Director**

Floyd, the three measures, and this is just ignorance on my part, the three measures where the steward doesn't want to continue, and I'm not sure how NQF approaches this, that clearly somebody thought these were important measures. Is there a process for rethinking or looking for an alternative steward for measures like that?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Well in those cases, the reasons they're not being continued is they're being rolled up into a new measure that will address a broader population or combining measures. Two or the ones that are further down in the list are about ABO compatibility and RH compatibility for pregnancy and they are being rolled up into a new measure to be submitted.

**Marc Overhage – Regenstrief - Director**

So this may just be a definitional question and I follow more the lumpers than the splitters of the world. So in some ways rather than saying these three won't be continued, it seems to me that there is a new and improved version of these three being developed or it's the evolution of these three. It's not the exact same measure, but it's the better version in some respects of these three measures. Am I understanding that correctly?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

You do. The challenges with the new version, it's not just the new version, there's more involved, so that needs review for endorsement as basically a new measure.

**Marc Overhage – Regenstrief - Director**

Right.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

As opposed to a new version that needs endorsement criteria to make sure evidence is there and testing is done that makes it work.

**Marc Overhage – Regenstrief - Director**

Yes.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

So it needs some work, but yes, it is evolution.

**John Derr – Golden Living LLC – Chief Technology Strategic Officer**

So my last point on that I guess is, so the trajectory we would like to see, it sounds like, is these three measures that were included initially will be replaced by, when they have been developed, endorsed, and tested, three alternative measures that get at basically the same concept, but in a slightly different way?

**Janet Corrigan – National Quality Forum – President & CEO**

I think that's correct. And so the main issue would just be whether that will happen in time for 2010.

**John Derr – Golden Living LLC – Chief Technology Strategic Officer**

That was my other question is what the timeframe for those things are? And this kind of gets back to, this is very analogous and we're going to talk about the IFR a little bit later. The standards development process and the timing and how we manage all of that as that becomes sort of, I don't know how to say it, not a, is it a hobby or is it a job?

**Janet Corrigan – National Quality Forum – President & CEO**

Yes.

**John Derr – Golden Living LLC – Chief Technology Strategic Officer**

And some of this is a little bit like a hobby and that sounds negative, it's not intended to be. People are trying to do this good work, but it's not, the timeframes and the drivers for it are not the same as when we've got to get something done by. So I guess the question there is, given that these are in the NPRM and so on, and these things take time to happen of course. Do we try to drive to, what do we need to get to the timeline we need as opposed to well when can get around to it? That may sound funny.

**Janet Corrigan – National Quality Forum – President & CEO**

Yes. No, I think it's a very good comment, and actually, John, in some ways, what you're commenting on is that our process for developing measures, endorsing, getting them into this pipeline, involves multiple entities. The key issue here is that really are relying on a variety of different stewards to get this work done and the resources are not flowing as of yet to those groups to modify existing measures or to do retooling. So I think until we can get contracts in place to get the work moving, the retooling work has not started yet.

**John Derr – Golden Living LLC – Chief Technology Strategic Officer**

Sure. And it's just more thinking out loud. This as you say a very complicated process and that's how you get the best folks doing the work. And I was just thinking out loud about how we think about that measure, stewardship, and development process, and I know that's what you do all day long. I'm just getting educated, thanks.

**Janet Corrigan – National Quality Forum – President & CEO**

Yes, I think that probably what you're alluding to I think would be very helpful, which is that maybe we really need to revisit the timeline again as to the absolute deadline for when the retooled measures have to be available. And back into that to see whether it's feasible for what is a new measure coming in the pipeline to actually make that deadline.

The other thing we don't know is how far along the development of those replacement measures is. That we really have to go back to the stewards and find out if these measures exist or they just decided they're going to begin the process of developing a new measure, for example, to replace these two blood ones that we have here.

**John Derr – Golden Living LLC – Chief Technology Strategic Officer**

And I have one more, that prompted one more question or thought for me and I'll shut up and let the group .... As we identify these measures, we have this NPRM, and this is where folks from the Federal Government may be able to help me understand this anyway. In the NPRM, we list very specific measures identified with very detailed labels and that's good in many ways. It always makes me nervous; it's kind of like policy and procedure. It seems like we maybe, and this maybe some feedback to the standards committee, I think we have to be a little careful about the level of granularity that we embed in the rules, because they're so hard to change and we can't be very nimble.

I guess the flipside of this concern about speed is, so now in three months one of the measure of stewards has a great, wonderful, much better measure. It's now a sort of "a new measure," not a version of the existing one, and presumably it would take rulemaking to incorporate that new better measure. And that could be good, and we don't want to move too quickly; but on the other hand I think you could worry a little bit if we got too specific in the rule. Does that begin to hinder our ability to incorporate the best knowledge and information? That might be the right tradeoff to make.

Does that make sense to people or am I jabbering?

**Janet Corrigan – National Quality Forum – President & CEO**

No, I think that's a critical question. Does somebody on the Federal side want to comment on that to help us understand a little bit better how tied in we are once we get to this very detailed or granular level in terms of specific measures? Okay.

My assumption is that we're fairly tied into at least measures that address the specific aspects of performance, so we can't replace the blood group measure with an imaging measure.

**John Derr – Golden Living LLC – Chief Technology Strategic Officer**

Exactly. CMS has identified in the NPRM what is important. But exactly, at what level can they get away with leaving a little more wiggle room so that NQF can evolve the measures as it needs to.

**Janet Corrigan – National Quality Forum – President & CEO**

Another issue there, which probably is a longer conversation that we really should give some thought to as we go forward is whether or not the requirement for certification should be the quality data set tied very much to the quality data types, which then gives us a great deal of flexibility in forming measures that run off of that underlying quality data set.

**John Derr – Golden Living LLC – Chief Technology Strategic Officer**

Yes, a great point.

**Janet Corrigan – National Quality Forum – President & CEO**

And that would probably afford us a good deal more flexibility going forward. And I'm assuming that that's really, I mean that's what determines, it's those quality data sets, data types in the elements that determine the HIT standards that have to be adhered to. And if indeed the EHRs are built to support that quality data set, then we have a good deal of flexibility in supporting many different measures.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Just to add to that, since the quality data set, for those who aren't familiar with it, it represents the context of use of information and the appropriate information, then the ability to use the information or report on it in that way indicates that EHR has at least utilized the information. And what makes it meaningful is which measures are chosen, but the standards using the quality data set and the context of the data will help allow potentially any measure for the future.

**Janet Corrigan – National Quality Forum – President & CEO**

Yes. Floyd and his team are constantly updating that quality of data set, so as the portfolio of performance measures expands, we're looking to make sure that the quality data set can support all of those measures. So that certainly would be an option, an alternative path that we could potentially recommend for 2013 and 2015 I assume.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Janet, this is Walter, I have a couple of comments.

**Janet Corrigan – National Quality Forum – President & CEO**

Sure.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes. The first one is more of trying to understand the sequence here. Because the way I see it, the IFR defines just the standards; and in the quality side, it just pretty much establishes what the codes, terminology, vocabulary, content format, etc. And for quality reporting these, it adopts the CMS/PQRI of the standard. So that's on the standard side.

On the certification side, the IFR basically, and looking at table 1 of the IFR, the IFR only, with respect to quality as a certification criteria establishes that the EHR, whether it's a complete or a module, should be capable of reporting quality, but it doesn't really get to the specifics. So on the IFR, things are very generic in terms of the general standards and the general certification criteria.

On the NPRM is where the details are described, but when you look at the actual text in the NPRM, the descriptions are the measure of descriptions really. And I don't think the NPRM side in the actual regulation language, the source of the measures per se, but actually the definition of the measures.

I think and I just wanted to ask, if that is the right sequence of things going from the IFR, the standard being set in the IFR, the certification, general certification criteria are being set in the IFR for quality? And then in the NPRM, the actual regulation text at the end of 500 plus pages really specifically defines the measures in terms of a description of the measure if you will and a definition of the measure how to calculate the measure if you will? Is that the right sequence just generally speaking?

**Janet Corrigan – National Quality Forum – President & CEO**

I think so, yes. The NPRM is also laying out the financial incentives that are associated with the various compliance with the various meaningful use measures.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes, in fact, all that part is of course part of the NPRM in itself, the actual incentives process.

This comment that I think was made about the degree to which detail information is written in today, regulation is always an issue with anything I suppose. I was on a conference call yesterday with the security and privacy workgroup of our committee and we were debating the exact same thing, to what extent the rules should be specific or more generic. The more specific you are of course, the more tied to specifics you are, the better it is for defining exactly what is expected, but the more you're tied to a specific measure that then has to be modified through rulemaking.

And then one of the things we argued was basically, you would have to almost go item by item to determining if the language in the rule itself, the actual language, was detailed enough or was too generic. I don't mean to probably go through that exercise here, but maybe as part of the overall assessment and the overall comment, we should state whether we believe or not that the description in the rule text is sufficiently clear to allow organizations to produce these measures. Or is too specific as to become a problem if measures are going to be updated in the future. So in my mind that's probably one area we definitely want to comment on.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. And do you have an opinion on that, Walter?

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

My view is, I mean, after reviewing the language actually more than the description and the preamble is that generally speaking I think we need that level of description, and maybe in some instances it is perhaps too narrow of a description. But I think when dealing with quality measures, one has to be as specific as necessary in order for an organization to be able to actually generate those quality measures.

Alternatively, one could argue that the rules should just refer out the actual definition of the measures to an outside body or to an outside agency like CMS or something like that. And then have the definition of the measure and the potential updates of the measure to be done outside of the rulemaking process, which always creates an opportunity to move faster with updating measures, but also a challenge for imposing new requirements without the rulemaking process.

I think generally speaking, my view is we need that level of specificity in the description of the measures.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. When CMS, these are the same measures essentially that CMS is using for their physician quality reporting program and their hospital program. The ones that you see on hospital compare, then the various public reporting and pay for performance or pay for reporting programs that Medicare has in place.

And I guess the other related question to that is maybe it makes sense in the future to just point to, I mean, CMS has a rulemaking process when it selects measures for those application purposes as well. It may well be that some further thought to just pointing to the other rulemaking process that as measures get identified and put in place under Medicare for public reporting or payment purposes. That then meaningful use will select from that pool of measures, that that would perhaps be one way to simplify it a little bit or completely bring it into alignment with the other Federal programs.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Exactly, yes.

**Janet Corrigan – National Quality Forum – President & CEO**

If that makes sense, okay.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Now one question I have about the medication reconciliation measure that was not included, that there is of course in the certification criteria and then also in the meaningful use, the expectation that the certified EHR technology will be capable of and will perform in fact medication reconciliations. What this issue of not including an actual measure is creating a question of how to ultimately measure that degree to which medication reconciliation is done, correct?

**Janet Corrigan – National Quality Forum – President & CEO**

Correct.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Right. That's right, that's measuring that it's occurred, right.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

And so in the absence of that measure, it wasn't clear in my mind from the NPRM how that particular aspect of both, but the certification process itself will go through specific certification criteria to be evaluated, but at the meaningful use level it didn't really give me any sense of how this will be in fact measured.

Aside from, I don't know, attestation, because it goes very specific to say 80%, whether for illegible hospitals at least 80% of the relevant encounters will go through medication reconciliation. How would one attest to that under the meaningful use rule is I think the question? And in the absence of a particular measure, outside of attestation what else there is?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Actually that this particular measure does deal with some attestation in the current version, but it does define it, the one that's not included. But it does define more clearly numerator/denominator. And I think what you're referring to on the 80% is, I think what I'm hearing you say is it's not defined as clearly as you like. I think for 2011, the reporting is by attestation.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Okay.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Actually part of work that we at NQF are doing now is we have an expert panel identifying element auto-electronic ..., which is not limited to EHR, but what could be captured to be used to create a log of information that could generate measures that don't require attestation. We have that panel working common elements, which can be captured that could lead to new measurement, that reporting out on those elements since they're not identified certainly are not in the IFR, that that's part of certification in this round, but we're looking to do that.

And then specific to call for measures using those elements to create standard output to identify things like med reconciliation, reporting labs, etc. So we're looking to move that enterprise forward to be able to generate those kinds of data directly, and that works going on, but for 2011, it won't be done.

**Marc Overhage – Regenstrief - Director**

Floyd, this is Mark Overhage. One point at least if I read the NPRM correctly that when people use the term attestation, at least those of us who aren't well steeped in this, sort of leap to the thought of it, it's just the doctor or hospital saying, "Yes, I have done this measure." As I read the NPRM though, it actually involves reporting numerator and denominator data for the measure as well as exclusions I believe, values for those.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Yes.

**Marc Overhage – Regenstrief - Director**

It's not through some electronic submission or whatever process. So in other words, the attestation is much more than just, I did it, it's I did it and here are the numbers.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Right.

**Marc Overhage – Regenstrief - Director**

Which that's just a point of confrontation for myself and I thought there might be a few others who had that same misconception going in.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Yes, that's how I read it as well, which leads me to believe it's attestation almost at every instance so that the numerator and denominator can be captured.

**Janet Corrigan – National Quality Forum – President & CEO**

And Marc, I think I recall at the standards meeting, I thought that it was indicated that there would be some kind of an auditing program in place as well to make sure that the numerator and denominator were actually generated from electronic data.

**Marc Overhage – Regenstrief - Director**

That's my understanding as well.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay, good. So really the road block here to having more granular information, more granular data submitted to HHS was, I assumed that HHS wasn't able to receive it in this timeframe, needed time to be able to setup a process for receiving that data, correct?

**Marc Overhage – Regenstrief - Director**

This is Marc, my understanding, that was a concern. The other concern identified in the NPRM was around the readiness of EMR vendors and others to have certified EMR components that were prepared to do the submission. So I think it was all of those together that led to the attestation at least proposed plan for 2011, with reporting in 2012.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. Is everybody comfortable with the attestation in 2011 as it is currently structured? Are there any comments we want to make about that? Is there any other information that should be submitted along with numerators, denominators, exclusions? Okay.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Just to reconfirm I guess the clarification that Marc mentioned about understanding the approach for attestation. It's not just a simple, "I hereby confirm that I am able to do this," nor is it just an attestation that, "I am indeed able to generate the numerator and denominator out of the ... of record, but it's actually generating the numerator and denominator and is it reporting that numerator and denominator? Where does attestation stop in that sense?

I can attest that I am able to do the measures, I can attest that I am able to generate the denominator and numerator and here are the numbers, I can attest and then attach if you will here is the report of the measure. What's the sense of the group of where that attestation is in terms of documenting and demonstrating?

**Janet Corrigan – National Quality Forum – President & CEO**

I think our understanding is that the attestation requirement would mean that a provider would have to submit the numerator, the denominator, and the specific exclusions from it, not just the final result on the performance measure, but actually those three or more different values for each performance measure. And in some cases for some of these measures, CMS receives measurement data through other sources already. So there is going to be some ability to look and see.

I mean, for many of these PQRI measures, the physician measures, at least for some providers, some clinicians, there is data flowing where they capture the relevant information by CPT code and tack it onto the billing, the claims form. So there will actually be in some instances another stream of data to compare what comes in under the meaningful use side too. But it seems like for 2011, it's just trying to get the ball rolling.

Did that answer your question, Walter?

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes, yes, I think, yes. There are soliciting comment specifically on whether deferring some or all of the clinical quality reporting until 2012 payment year is desirable, but I guess that's one of the areas we might want to comment on, right?

**Janet Corrigan – National Quality Forum – President & CEO**

As to whether or not the attestation is adequate for 2011?

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes, basically they're requesting or soliciting comment as I'm looking at specific sections of the NPRM on whether it may be more appropriate to defer some or all clinical quality reporting until 2012 payment year.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay, that's a good point. So rather than report on all of these measures or most in 2011, you would say we should think about a subset.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

A subset, exactly.

**Janet Corrigan – National Quality Forum – President & CEO**

How do others feel about that? Is this too much for 2011, given that it is attestation as well? Okay.

I had a question as to whether or not the full set here of measures, this is a lot of measures, and that we're adding on many, many more measures than what our group recommended or the standards committee recommended, and that corresponded to the policy committees grid. How do people feel about the full volume of measures here as it relates to meaningful use even in 2012?

**Marc Overhage – Regenstrief - Director**

This is Marc Overhage, as with so many of these things, there are multiple dimensions I think. One of which, and this applies somewhat to the overall NPRM, but to measures specifically I think as well, and it's a philosophical question is I think we do have to be careful if we set the bar too high particularly in the early years.

I think this currently reflects the bimodal distribution that we see in the country of where practices are and their ability to tackle these things. For large sophisticated physician groups that already have quality improvement efforts and measurement processes in place, this maybe an attainable goal.

Many hospitals, this is probably, especially academic medical centers or large urban centers, this is probably an attainable goal. For small hospitals in the 80% of small practices that have little or nothing in place, I do fear that this list of measures is so extensive and requires so much data capture that they will not believe they can achieve it, that if it's sort of self actualization of absent.

If you look at any of these models for physician behavior, their belief that they're able to implement the procedure or whatever is often one of the major barriers. And I think that we probably have setup a fairly high hurdle for that large portion of practices and that you have to wonder how many of them will even try to meet this goal, because they may not feel like they can achieve it.

I feel that tension between the large groups that you want to move down the road and make them sweat and the large fraction of folks that aren't even started. And so I think the answer may be different for those two groups and I do fear that the number of measures and other things in the NPRM are such a stretch that we're going to actually dis-incense people from making progress.

**Janet Corrigan – National Quality Forum – President & CEO**

So I guess there's a couple of options to address that issue and one is to have two different bars. One for the more rigorous requirements for larger entities that are farther down the road and a bit less demanding for smaller entities that are probably in an earlier stage of development. Or alternatively to bring the bar down and attempt to really motivate the lower end of the distribution and assume that the upper end of the distribution is going to be there no matter what.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes. This is Walter. I agree, I think the sheer number of measures is extensive. Part of the question, too, is whether practices will have to report all the measures or whether some of the measures are for specialty-type practices. And so only those that deal with those conditions will be required, expected to report those measures.

Once we look at the a hundred and plus measures, 150 or so measures or whatever number the total is, how many of those are truly specialty-level measures that only certain types of practices will be expected to report. I guess, my own brief review of it, it looked to me that some significant number, at least 50 of those measures are really not to be expected to be reported by a general practice if you will that doesn't deal with specialty-type patients.

I wanted to test that and see if that is the sense that people have also, that at the end, this 140/150 measures, a subset of it is really the total number that will be ultimately truly expected to be reported by the vast majority of providers, and then a subset of it is only specialty providers. Is that the sense that others have also?

**Janet Corrigan – National Quality Forum – President & CEO**

You're right, Walter. The NPRM on page 143, starting around there, there's a series of tables that show for different specialty areas the specific measures that apply to them. It looks like there really is maybe in some cases 8 or 10 measures at most, in other cases 6 or 7 that apply to specific areas, and then there is a core set, I don't recall how many were in the core set, Floyd, that apply to everybody. I think it's only about 3 or 4.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Three.

**Janet Corrigan – National Quality Forum – President & CEO**

Yes, 3 that are in the core set. So when it comes to practitioners, I guess you could potentially have upwards of maybe 10 in that range, some will have as few a number as 3, others will probably be somewhere in between. On the hospital side, it is a larger number, but they've been reporting for some time and are at a bit further stage.

Alright, so I guess we want to make some comment as the number of measures did increase, we clearly did move to greater burden, but recognizing that all measures don't apply to all clinicians. And maybe encouraging a close look at the hospital side, in particular too, for smaller hospitals, whether or not the bar is too much. And perhaps for the attestation piece; although, it doesn't seem like the burden is too much there. But maybe on the attestation side for the first year that that might have a more gradual slope taking them up to then full reporting on the measures that are here for 2012. Does that sound right?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Yes.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. Are there any specific comments, there's a fairly long list, we can't go through them individually here of new measures that got added in here that were not recommended, and are there particular ones that there were concerns about or issues that anybody wants to rate? About five pages of them here, probably not.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

This is looking at the tab that says added measures on the spreadsheet?

**Janet Corrigan – National Quality Forum – President & CEO**

If you go to the spreadsheet that Floyd prepared, the one that says measure retooling master list.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes.

**Janet Corrigan – National Quality Forum – President & CEO**

Then after, on the second page, you'll see that there are many measures where the first column is not checked and that means that our group, our work group in the standards committee did not recommend that measure. These are ones that were, appeared in NPRM that the government put on the list that we had not recommended, and they go on for several pages for about five and a half pages. And it's to all the new ones that were put on the list that we haven't talked about or weighed in on at all, and I didn't know if there were particular ones that individuals may have concerns about.

I will say these measures don't come as a surprise to those in the field doing quality measurement, because it essentially is the full gamete of measures that CMS is currently using in its public reporting and paper performance programs. The positive side here is that they've really gone to, made I think some important steps in making sure that the meaningful use work on measures has harmonized nicely with other requirements that Medicare imposes in particular on providers. And that's an important step forward and one that I think that we want to applaud, because it will really help in terms of burden and rationalizing this whole approach. But it is a long list of measures that have now been put on the table.

Are there particular ones that we think will be difficult to generate using in EHR or may not be applicable to the EHR environment or pose new issues in terms of HIT standards that we would not have considered, because they weren't on the table before? All right.

Well then I think we're ready to move onto the next agenda item, which is, are the IFR standards requirement adequate in light of this large number of measures? So are there particular IFR standards that perhaps that we don't have that we do need or ones that are there that need to be modified in order to be able to generate this, not only our original measures recommended, but the additional ones?

And Floyd, I think you had a couple of comments there.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Yes, and actually I don't need to single you out, Marc, but I know in discussions with you, there was some concerns. One is in the IFR, the discussion about vital signs, for instance blood pressure, which is required for calculating some of the measures that are in the NPRM, but a standard for representing blood pressure is not required in 2011 as one example.

Are you able to make a comment on that?

**Marc Overhage – Regenstrief - Director**

Well, I don't know that I have much more to say other than I think, if we were, I think this is true and I have not done this exercise. If we were to go through and look at the underlying data elements that are necessary for the measures that are identified in the NPRM, I do as you point out, Floyd, believe that there are gaps in the IFR in terms of having terminologies that are appropriate to represent all of those data elements.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Right.

**Marc Overhage – Regenstrief - Director**

And so the question then becomes what's the trajectory? And one answer is that we heard in the meeting is people can use their local internal terminologies, translate between presumably the measure specification would be in terms of the IFR standards. And then the folks would translate their local sets of codes or whatever to those for the period of time until there were adopted standards or of course they could guess what the standards would be and migrate there sooner. So I guess it's not a deal killer, it just seems a little inconsistent.

**Janet Corrigan – National Quality Forum – President & CEO**

Why are those gaps there, is it because of the new measures that were added to the list that we somehow didn't or were some of the recommendations coming out of Jamie's group, not reflected in the IFR?

**Marc Overhage – Regenstrief - Director**

This is Marc, I think some of it maybe labeling in the IFR, for example, saying laboratory as opposed to clinical observations or something like that may account for some of it. Some of it maybe in constructing the IFR that the folks involved in that may have been trying not to push too far too fast. But even there it seems like there was not a roadmap for those things clearly laid out.

I think it may be a little bit of lumping and just sort of a DTL between the two that didn't get sorted out in the process, given the very tight timeframes. And I said at the meeting and I'll say again, I think that these NPRM and IFR are phenomenally well aligned and constructed overall. There's a few little nits and gnats here and there, but overall it's incredibly consistent and supportive. But there are some things like this I think might have just not gotten, there might not have been the time and detail to think through.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

This is Walter again. I'm looking at the IFR and trying to see, and again, just looking at the actual regulatory language itself, not a preamble, and the description of the standards are so, they basically cover the realm of vocabulary and content standards.

I'm trying to understand a little bit more the gaps, because for example, the patient summary record, the IFR recommends for content exchange, the CDA and the CCR, for problem lists the SNOMED CT, procedures ... LOINC, medication list, RxNorm, so by defining it that way it defines the base terminology and vocabulary qualification systems. And so once you translate that into measures is the concern that some of the measures include descriptions in the denominator or numerator that might not be currently capturing SNOMED, the ICD9, RxNorm, etc., LOINC. Is that the concern that there are gaps in there?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Walter, maybe I can, this is Floyd, maybe I can help with answering some of that. In some of these, for instance med list and I think it's nicely worded in the IFR that any codes set by an RxNorm drug data source provider that is identified by the U.S. National Library of Medicine as being complete and integrated with RxNorm allows any local drug terminology that can be mapped to RxNorm. So if measures required there or state their medications in RxNorm as the terminology, this allows that there can be a direct mapping and that can be identified.

So in many cases and this is table 2A in the Federal Register IFR for those who want to know where these exist, it's on page 2033, so many of these do deal with that. There are certain things in measures, for instance if we're looking for a med allergies and there's no standard to identify the allergy, that the allergy is going to be specified based on a medication level code. And the concern is in stage 2, the codes look, that are recommended are at the medication component level, the UNII.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

And so that's not necessarily consistent, because it's not necessarily easy to map for medication to the component level, so that's one. I mean there are basically only two or three in this table.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Wherever, so I can see the point, that wherever there is no standard adopted at this time, so for medication allergy lists, for vital signs, or maybe even units of measures, during stage 1 there is standard adopted. Then when you translate that into the meaningful use rule and the calculation of measures, there could be inconsistencies in how vital signs as I think Marc was pointing out was one example.

**Janet Corrigan – National Quality Forum – President & CEO**

Exactly.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Okay, I see that clearly now. Thank you.

**Janet Corrigan – National Quality Forum – President & CEO**

I don't even know if, when going back to the issue of, that we can only really make changes to things that are already in the IFR. Where the IFR says, no standard adopted at this time, is that adequate reference that there is the possibility of being more specific in the final say pertaining—

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

No, I think, this is Walter, I think my understanding was if by recommendations, groups were to say, well vital signs you should adopt SNOMED or whatever, a particular one for stage 1, that would constitute probably a major change that would require some new public common process I suppose.

So that was at least my understanding of the somewhat limitations in terms of an IFR entering in final rule that adding levels of definitions to standards or basically adding a standard that has not been even embedded through the public common process would result in probably the rule having to go through another open common process.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. So maybe at a minimum though, it probably could be done is for if ONC wanted to give a stronger signal as to the direction in what requirement will be in 2013. So that as they start to build these, hopefully many will move immediately to the use of standardized vocabulary as opposed to some other intermediate step.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes, that's a good point, because as is noted in the table and in the actual IFR, and this is consistent probably with the statements made at the standards committee about changes that can be made on the IFR would be sort of "logical extensions" if you will of what have been stated already.

Yes. The candidate for stage 2 was presented on the IFR for vital signs for example as the CDA template. There could be arguments that call for that being, if they adopt that standard for stage 1, and that could result in a change in the IFR in my mind, that it's consistent with. Well, that's what we thought, I mean, we had already described it as a sensitive or candidate center for stage 2.

If people think that that's not only the right standard for stage 2, but it should be used as a standard for stage 1, that could be potentially considered as a logical extension if you will by change. And that could end up being a good suggestion if the group wanted to move in that direction I suppose in terms of recommendations.

**Janet Corrigan – National Quality Forum – President & CEO**

I mean, I think some of these, in fact quite a few measures, how do others feel about that? Where I think this is, basically if you're looking at table 2A on page 2033 of the IFR, there is a limited number here. So for medication allergy list, the candidate standard is UNII.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

UNII, yes, UNII.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. And for vital signs it's the CDA template, for the unit of measure it's UCUM, are there particular recommendations that the group would like to make on these?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

I guess one question I have on the CDA template that might indicate a chapter of where a vital sign would be, but is that the, to identified blood pressure specifically, would that be something we would look for the template or would we be looking at a different coding system? I believe the operations workgroup and please correct me if I'm wrong, because I don't remember exactly, I thought they recommended LOINC there.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

For vital signs? For what?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

For vital signs, but I might be wrong on that.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Clinical operations workgroups?

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

I don't remember.

**Janet Corrigan – National Quality Forum – President & CEO**

I mean, plus if we could do is to go through the list and flag the measures that are impacted by this that will not yield comparable results or interpretable results as a result of the inconsistencies and the use of different coding systems.

So maybe that would be helpful and urge the broader group to consider doing one of two things, if possible being more specific upfront. And I heard that from a couple of standards committee measures that their sense was that, "Gosh, people in the field would just kind of like to get specific direction so they aren't spinning their wheels and taking intermediate steps." If possible to move up and be more specific in stage 1 or alternatively to be clearer about what the requirement will be 2013, so that those that can be building for it aggressively and get to the right consistent system."

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

The other thing we can do I think is submit a request and just send an e-mail to Jamie and the clinical operations group to see what their perspective is with respect to moving forward with potentially recommending for stage 1 some of the standards. I know that some of them are not ready really to be out there by 2011, would be too aggressive, too difficult, and that might be the case for UNII and for UCUM.

I don't know about CDA template for vital signs or if they recommended LOINC, but that could be another thing that can be done is clearly the clinical operations group to see what their perspective was on this.

**Janet Corrigan – National Quality Forum – President & CEO**

And that's a great idea, we can certainly do that. And I think that goes back to John Glaser's earlier comment that we maybe on a more aggressive timeframe can be met if we lay it out and make it clear that we would like the standards to be ready in time and for EHR vendors to move towards them more aggressively.

Okay, we'll do that, we'll send an e-mail over to Jamie and we'll also craft some language about the general concern here and the number of measures that it impacts, and I think it's quite a few.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. Are there other issues related to the IFR? Okay.

Are there any other comments overall that the group thinks that we should be making on either the NPRM or the IFR and the overall direction this is going? I heard a positive one that these were really well put together, we want to applaud I think our colleagues at HHS, incredibly difficult work in a short time period.

It sounds like we've about covered it. Okay, Judy, when is our next conference call?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Yes, I was just looking for that, Janet. I don't know whether we set one for this group, at least not before the February 24<sup>th</sup> standards committee meeting.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. I think we're probably okay for the February 24<sup>th</sup> standards.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Right. Okay, then the next one after that, hold on here, I've got to read my chicken scratch. I think it's not until March 31<sup>st</sup>.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

So if you want, we could try to set one before that, but we can take that offline.

**Janet Corrigan – National Quality Forum – President & CEO**

Yes, and what we will want to do there is ... policy committee folks ... as we dive into 2013 and 2015, we will have to close the ... policy committee folks will be providing some additional guidance around the types of measures that they think will be important to have in meaningful use for 2013 and 2015.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Right.

**Janet Corrigan – National Quality Forum – President & CEO**

The end of March call may turn out to be good timing depending upon how quickly the policy committee is moving on their end, but if they're able to move more rapidly and we can move it up, that's great too.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

That's great, okay. Then I guess it's time for public comment if anybody in the public wants to make comment, are you ready for that, Janet?

**Janet Corrigan – National Quality Forum – President & CEO**

Yes, that will be fine.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Okay, operator, if you could just query members of the public on the line if anybody wants to make a comment.

**Moderator**

If anybody wants to make a comment, (Operator Instructions) and that's for anyone from the public that would like to make a comment, and if you guys want to make any wrap-up comments while we're waiting.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Janet?

**Janet Corrigan – National Quality Forum – President & CEO**

No, I think this has been a rich discussion and it is so nice to see the work that we've contributed too, and hundreds of others really starting to take shape. So I'm very excited about it and I think it's terrific.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

You got a lot accomplished.

**Janet Corrigan – National Quality Forum – President & CEO**

Yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

So Janet, this is Walter, would there be a summary of the areas we're commenting on?

**Janet Corrigan – National Quality Forum – President & CEO**

Yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

And the comments and then perhaps via e-mail we can exchange some feedback? Is that—

**Janet Corrigan – National Quality Forum – President & CEO**

Yes, yes, I think definitely so.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Because I think by February 24<sup>th</sup> we have to present, I guess each of the workgroups will be expected to present to the full committee their recommendations I think.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

That's right.

**Janet Corrigan – National Quality Forum – President & CEO**

Yes. So we will prepare a draft and some slides probably and circulate those to the workgroup for review and comment.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Right. And we'll probably need that, Janet, final draft like around the 19<sup>th</sup> of February.

**Janet Corrigan – National Quality Forum – President & CEO**

Okay. We'll do it before then while it's—

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Oh, yes.

**Janet Corrigan – National Quality Forum – President & CEO**

--fresh in everybody's mind, yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

So the due date of comments, oh, yes, because the 19<sup>th</sup>, but then the 24<sup>th</sup> of February is the committee meeting, right?

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Yes.

**Walter Suarez – Institute HIPAA/HIT Education & Research – President & CEO**

Yes, that's right.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Operator, any public comments?

**Moderator**

No, we do not have any public comments.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Okay. Janet?

**Janet Corrigan – National Quality Forum – President & CEO**

Yes, okay, wonderful.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Very good, thank you all.

**Janet Corrigan – National Quality Forum – President & CEO**

Thanks, everybody.

**Floyd Eisenberg – Siemens Medical Solutions – Physical Consultant**

Thank you.

**Janet Corrigan – National Quality Forum – President & CEO**

Goodbye.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Goodbye.