

**Clinical Quality Workgroup
Draft Transcript
March 31, 2010**

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to a call of the clinical quality workgroup, and this is a federal advisory committee, so there will be opportunity at the close of the call for the public to make comments. Let me do a quick roll call. Janet Corrigan?

Janet Corrigan – National Quality Forum – President & CEO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Floyd Eisenberg?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

John Derr?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Doug Fridsma? Judy Murphy?

Judy Murphy – Aurora Healthcare – Vice President of Applications

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marc Overhage? Jim Walker? Walter Suarez?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jodi Daniel? Chris Brancato? Mike Fitzmaurice? Jack Corley? Did I leave anyone off? Okay. I'll turn it over to Janet and Floyd.

Janet Corrigan – National Quality Forum – President & CEO

Great. Thank you very much, Judy. Appreciate it. Welcome, everybody. We have two agenda items we wanted to discuss today. The first was to kind of take stock of where we are in terms of value sets that are being produced as a byproduct of the retooling of measures. Just by way of background, efforts are underway to retool the approximately 110 measures, performance measures that were included for consideration in the proposed rule. We don't know which ones, of course, are going to end up being

selected for meaningful use, but efforts are underway to get virtually all of those retooled, the e-specifications developed. About 57 of those have been, for the most part the work is done, and we started to get the value sets produced in the course of doing that work.

The other thing we wanted to discuss a little bit was to start to dive more deeply into how we're going to approach getting more performance measures on the table for consideration for meaningful use in 2013 and 2015. Why don't we start with the first one on value sets? This is really in the context of the discussions at our most recent standards committee and the work that's also going on in the vocabulary taskforce that is a part of Jamie's group on clinical operations that really is trying to think through the approach to value sets that would support a variety of different secondary users, as well as the care delivery on the frontline, and the creation of some kind of a registry, presumably to store those value sets so that everyone can make use of them as appropriate.

We began to realize, as all of this retooling of measures was underway, that we were going to end up getting, in many ways, the first set of value sets that would be supportive of quality measurements. So we thought it might be good to take a few minutes to share with you the early results on the kinds of value sets that have been identified by the three major stewards or the two major stewards. NCQA and the AMA are the two large measure owners that are doing so much of this work on retooling. And, of course, some measures were also retooled as a part of the process of going through HITSP.

Floyd has done a comparison and a summary, rather, sort of a synthesis of the kinds of value sets that had been produced and tried to classify those. Floyd, do you want to kind of take us through that handout?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Sure.

Janet Corrigan – National Quality Forum – President & CEO

I think you should all have this handout. It came to you in advance, and there are two parts of the handout. First there's one entitled value sets completed for retooled measures sorted according to QDS data types, and then the second one is value sets by terminology/taxonomy type. Go ahead, Floyd.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Sure. What we did is, in the process of retooling the measures; we have a prototype-authoring environment. Into that environment, we took the value sets that were developed from the HITSP process where 16 measures were retooled in case any of those value sets were reusable, so they're in that tool. And that's where, on the spreadsheet, you'll see there were 16 measures, a total of 62 value sets created, mostly meds, patient identification issues, diagnoses or conditions, and some communication, so they're separated by the type of information, and the type is identified as a quality data type in the QDS.

The average there was 3.9 value sets per measure, which doesn't sound like a lot when you're considering 16 measures, but many of them, especially the meds, were reused from measure-to-measure. So the reason the average number is small is many of the conditions were reused. Understand those 16 were 3 conditions, actually 2. One was throughput through the emergency department, which really didn't have many value sets except locations. The other two were venous thromboembolism or stroke. So, in most cases, all venous thromboembolism condition types were the same for all of those measures, and all of the stroke definitions were the same. So there was a lot of reuse among the different categories, and that's why the number per measure is small. But the total number is actually 62 value sets.

In the other 2, the ones that have been retooled since from mostly NCQA or AMA measures, there are a total of 41 of those listed in here, and there are many more value sets. Part of the reason was this effort didn't only look for the idealized SNOMED. For instance, for conditions, but also because of other comments that came out in the IFR and in the standards committee also have an ICD-9 and for 2013 add in an ICD-10 value set for many of these conditions. And so there are, for each concept, there's more than one value set because of the current user versus the future anticipated use.

There is less reuse in these than there are in the HITSP ones, mostly because the measures that we're dealing with really are not just based on one or two conditions. They cross many conditions. There is some reuse in the measures performed by or retooled by NCQA in other NCQA measures. There's some in those produced by AMA in other AMA measures, but not necessarily direct crossover.

What we did find is that there is reuse when the conditions are the same. We did find that there can be reuse, but it doesn't necessarily cross measure stewards. They develop their own often, but we do also have quite a few value sets in-house, so we have 564 at this point in our authoring environment.

Janet Corrigan – National Quality Forum – President & CEO

Floyd, if I understand this right, to me that seems like a very large number of value sets. I was, frankly, really quiet surprised when you consider that this is a pretty limited number of measures. That's a lot. What we don't know here is, in part, this reflects the proliferation of value sets if there isn't a coordinated process that will facilitate reuse across measure stewards. Each one will go about its business developing its own value sets and not really coordinate. There's no reason ... they would if there's no structure set up. So 564 is undoubtedly a high number. If we had a coordinated process and a registry in place where people could reuse across stewards, then we would have somewhat less than that, but we're still probably talking about a very substantial number of value sets if you think about the retooling of the 600 or so measures, performance measures that are in our standardized database of performance measures. This is just scraping the surface.

Jack Corley – ATI – Senior VP-Chief Technical Officer

I've got a related question, Floyd. This is Jack. Did you see within a single measure steward, a lot of reuse of value sets or would that also be expected to be improved by central access to a set of value sets?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Within a single steward, there was generally reuse.

Jack Corley – ATI – Senior VP-Chief Technical Officer

There was? That's good.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes. The difference is between the ones done in HITSP and the others is HITSP basically was dealing with two conditions, so as you can imagine, the condition itself was defined once for many denominators, many different measures. There were many conditions dealt with in the more recent process, so you'd still see more, but they do reuse within the measure steward.

Janet Corrigan – National Quality Forum – President & CEO

Jack, part of that is probably because it's the same two or three people that are doing all of this work on the set of measures. It may be that unless there's a fairly coordinated process that may not be quite as much reuse within a steward, unless they have their own internal mechanisms to set up a registry because, over time, you'll have many different groups involved in the work. But right now it's all being

done by just a couple of people in each of these locations. I'm sorry. Was there somebody else who wanted to comment?

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Yes. This is Walter. Floyd, just a question: I'm looking at the table, the value set for the 57 measures, and I'm trying to understand the depiction of what issues where, and also the term value set just because I'm also surprised to see 564 value set uses. If you take, for example, the column that says HITSP 16 measures, and you go down and go to the communications and see SNOMED CT, and there's a 10 there, so that means that 10 of the 16 HITSP measures use SNOMED for communication?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

No. Actually, this was probably limited to about two or three measures that, at the time of discharge, these are all inpatient measures. And at the time of discharge, the patient needed to be educated on a certain number of elements. And so, among all of the 16 measures, there were 10 education elements that were required.

The other thing that you'll see the difference with why they are SNOMED, HITSP was consistent in making sure that only SNOMED was used because what had been agreed to in the care management health records and in many of the HITSP documents was that SNOMED would be the preferred terminology. For the near term, if everyone is not using SNOMED, and since ICD-9 is allowed, and ICD-10 is expected in 2013, in the newer retooled measures you'll see there are also ICD-9 options and ICD-10 options, and occasionally you'll hear some CPT options. The reason they're not all in SNOMED is because of what's available today, and that's what the more recent AMA and NCQA effort was addressing.

Janet Corrigan – National Quality Forum – President & CEO

Basically for these 16 measures, some of them included an assessment of the adequacy of communication between the clinician and the patient. There were ten communication concepts that then resulted in ten different value sets. In this case, they were all SNOMED terminology.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right.

Marc Overhage – Regenstrief – Director

This is Marc. Somebody expressed concern or surprise over the number of value sets, and I guess I wasn't surprised at all. This is a lot like clinical decision support rules where there's a whole bunch of basic stuff like age and things like that that are going to get reused. But then there's this huge tail of very specific stuff to each measure, so probably half the stuff in the measure is going to be common stuff, and the other half is going to be unique to that measure. I guess I wasn't too surprised, especially when you take into account—and Floyd is still trying to get me fully educated here—but especially when you take into account that a value set considers, if you will, a DVT, whether it's in the history or a current problem list or a suspected problem list, you know, those kinds of things as unique QDS, right?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes. There are situations where the same condition, if it's identified as a history versus a family history, actually may have a different value set. It's a different term dealing with, for instance, with SNOMED, what would be called a pre-coordinated term, so family history of diabetes would be a different code than active diabetes.

Marc Overhage – Regenstrief – Director

And medications ordered versus medications dispensed will be – even though it's the same medication, will have a different QDS.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

No. In most cases with medications, they were very specific to reuse them, whether it was dispensed or ordered.

Marc Overhage – Regenstrief – Director

Right.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

But....

Marc Overhage – Regenstrief – Director

...there's a distinction in some cases.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

That's correct....

Marc Overhage – Regenstrief – Director

So that multiples.

Jack Corley – ATI – Senior VP-Chief Technical Officer

Floyd, this is Jack again. In reading this table, I guess, can you clarify for me on the line 16, SNOMED CT under communication, under HITSP there are 10. Is that 10 measures that use a SNOMED CT value set for communication, or is that 10 different value sets that were used among the 16 measures?

Marc Overhage – Regenstrief – Director

The latter, so the example is to educate on management of weight and diet is one value set, and it was actually used in more than one measure. To communicate education on how to handle medications at discharge, that was also a value set used in more than one measure, but it's the number of communication types, not number of measures that equals ten.

One thing that's interesting is one of those value sets may very well be reused in a newly retooled measure for the one I mentioned about weight management. I haven't gotten confirmation, but we believe that'll be reused in one of the BMI measures, body mass index.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

This is Walter again. In light of that perspective, yes, I would agree with Marc. I don't think it would be that surprising to see the large number at the bottom of 564 because we're really looking so granularly to the type of activities that are being highlighted in each of these measures that need a value set. If we are equating value set to a specific activity such as a location on wheat diet, then I'm defining that in order to achieve that there is a value set that is needed, then yes, there will be, I would think, that level or that size, I guess, in terms of the number, the large number of value sets. And so the question I have is is that how granular we're going with value set definitions?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

At the moment, since there are no specific accepted ground rules as far as what's acceptable and what's not, if the measure developers are giving the value sets back that specifically say what I would call pre-coordinated terms meaning it's very granular, and a separate value set, we are accepting those. It would

be helpful to have some nationally accepted ground rules that might suggest that more of the concept level is recommended. For instance, not about a specific diet, but diet is recommended, diet advice is recommended, or a condition is identified, and where it's found or the context of its use is identified within the record rather than by the value set. If we could have standard rules around that, that could decrease the number of value sets and allow more reuse.

Marc Overhage – Regenstrief – Director

But if you do that, you're going to have to figure out some alternative way to express constraints on that broader value set in order to support electronic extraction. One way or the other, you've got to narrow it down to say we're talking about a wheat diet communication.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

First of all, let me just say maybe I misspoke. There's not something specific about a wheat diet. I'm not sure where that came from. It's diet management in general in that particular value set. Don't get me wrong on that one. It was all diet management. Something I said got interpreted as wheat. But, Jack, you're absolutely right that there needs to be a method to describe the context, and what I would put on the table is in the HITEP report, the HIT expert panel report that defines the quality data set, that does define the context. That data set, all of the data types were taken to HITSP. And in the HITSP quality data dictionary that's in a component called C154, all of those data types were mapped, except for a few that had some gaps, to a context ... in the EHR, so that context is provided in the table out of HITSP C154.

Janet Corrigan – National Quality Forum – President & CEO

I'm intrigued by a comment that you made earlier, Marc, about there being this is a logarithmic distribution with a long tail. I wonder if that does have implications for a lot of the thinking that Doug Fridsma and others are doing is to exactly what do we define as a value set for purposes of putting in a central registry. It may be that one approach would be to really only focus on those types of value sets that have a high reuse rate and, frankly, not put the rest of this into a central registry in terms of value sets, but it is something that is done on the fly for a particular application. I guess the other option on the other end of the spectrum is to have a very huge, central registry that includes all types of value sets, even if there are value sets that have a fairly low reuse rate.

Marc Overhage – Regenstrief – Director

I think the HITEP report, you know, the work of that group has really highlighted that, right? I mean, if you looked at the sort of perito analysis, you see that come through, and I think you raise an intriguing question of, is there a cutoff point where it's worth going through the energy to share and make sure that there's consensus, and everybody understands, and the rest of them are – there are going to be two people who create them, and they might be slightly different, and maybe we don't care, which is intriguing.

Janet Corrigan – National Quality Forum – President & CEO

Yes.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I think that's definitely worthy of some more thought.

Janet Corrigan – National Quality Forum – President & CEO

And it also has to do with how the within domain activities are organized because if indeed, for example, if most of the measures and decision support in cardiology is undertaken by the American College of Cardiology in concert with the PCPI, then maybe they can do the internal reuse. They can handle it

because the activity is all within one group or most of it. So there may be some reuse of value sets, but it's only reuse within that particular organizational structure that's really irrelevant, so you don't necessarily need to take it to a higher level into a national registry in order to get the benefits of reuse.

Marc Overhage – Regenstrief – Director

Although, let me argue with myself here a little bit, and that is, if for example you're the Diabetes Association, and you're writing a diabetes guideline, you're going to want to include an exclusion or inclusion criteria that's based on the patient's congestive heart failure, and you're not the expert in heart failure. You'd like to use the one perhaps that the cardiologists have developed. I think reuse, you know, people have their core knowledge set that a big chunk of stuff that get included.

I don't know what this looks like, Floyd. You might have it off the top of your head. You know, sort of all these QDS for a particular measure, how many of them are sort of domain expertise related to that measure versus outside or to that measure focus as opposed to how many of them are outside that area. That might argue for an opportunity to share and reuse them, but not necessarily detailed vetting and reconciliation. In other words, it'd be nice if the diabetes association could grab ... by the cardiologist, but not necessarily consensus based everywhere ... definition. Stick it into their guidelines knowing that at least it was better than they would probably do on their own.

Jack Corley – ATI – Senior VP-Chief Technical Officer

And building on that, one of the main thrusts is to support electronic extraction by various clinical providers. And it's there where the reuse of value sets and an ability to get at that value sets is most crucial. Over and over again, many different clinicians are going to be hopefully using the same value set regardless of whether it's developed by the cardiology, American College of Cardiology, or whatever. It's going to be reused over and over again, we hope.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim Walker. I agree. It seems to me that if we try to identify the tail by domain like cardiology or diabetes. It will be tricky. You could probably do it for ophthalmology, but for many of them, it's going to be a condition. There'll be some conditions treated by endocrinologists or cardiologists. Electrophysiology is probably not of very much interest to anybody else. But there'll be large parts of cardiology that intersect with almost everything.

Janet Corrigan – National Quality Forum – President & CEO

I guess the last argument too, another one for encouraging the centralized registry, even of those low reuse value sets would be to promote competition because if you do just give it to one group in a clinical area, and they kind of begin to own all the infrastructure, it's less likely that other creative or innovative approaches that came from outside that structured group would really be able to thrive.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right.

Janet Corrigan – National Quality Forum – President & CEO

Is there more discussion on this value set piece? We didn't really have an action item here so much as to try to understand a little bit better about what we would begin to see in terms of value sets, at least in the quality measurement area. We can summarize some of these points and make sure that we share them with the broader group, especially with Doug Fridsma, I think, since he is doing a lot of the thinking on this. It certainly does inform a broader strategy. Are there other issues or follow up work that we want to do on these? Guess not. Okay.

All right. Now we thought the next agenda item would be to talk a bit about the performance measures for 2013 and 2015. Floyd and I have been thinking a lot about this. As I said at the standards committee meeting, the last one, we're kind of concerned about 2013 in particular because if measures have to actually be developed and tested, that work really needs to happen very, very quickly for them to be ready for 2013 because it's a good 18-month process to be able to go from measure concepts to specifying the measure to getting it out in the field and testing it, and then really being able to have it considered for meaningful use and giving adequate notice to the field for 2013.

We have been trying to coordinate with the policy committee, and they're clearly moving along in their thinking about 2013, but we probably need to launch some efforts in parallel to try to make sure that we do have measures to select from for 2013. One of the ideas that's been proposed is that we do have leading health systems out there that have been wired for some time and are much more advanced in terms of their use of HIT and probably have developed some very good measures with these specifications, and some of those may well take advantage of the unique capabilities that HIT brings to really address aspects of care that we, frankly, couldn't address without it like care coordination and amongst team members and across settings.

We wondered if there might be some value to thinking about reaching out to those more advanced or leading health systems in this area, and perhaps starting with the ones that are represented on the standards committee, and some that are right on the call today to begin to understand better the collection of measures that they use for performance measurement and assessment, and see whether some of those might be very appropriate for addressing the gap areas that we noted when we took the standards committee list and tried to identify measures that applied to those. There were numerous areas where we didn't have any measures right now, and also obviously there are many other areas that weren't included on the standards committee's first framework. We thought maybe this would be a fertile way to bring in some measures fairly quickly and wanted to get some discussion on this with the group.

Marc Overhage – Regenstrief – Director

What I hear you kind of throwing out—this is Marc—always, these things are obviously always top down and bottom up at the same time. And, to some extent, this first round of 2011 measures were generated more by a top down approach where folks, we think these are worth thinking about, and then we did a little bit of paring, pruning with a bottom up sort of saying what do we have measures for, not have measures for, and so on.

What I kind of hear you suggesting is that for 2013, we think about a little bit more of a bottom up approach and sort of see what's feasible and then sort of align those with the top level policy and health outcomes goals that the country might have. I'm not sure, because I'm still not finished reading it, how the proposed legislation or the now law that was recently passed impacts this because there's a whole bunch of stuff that talks about the quality area. You probably know that far better than I the thing about a bottom up approach and then layering on, sort of applying the filter. Here's the 22 things that might be feasible in a sophisticated health system, now which of those do we want to focus on based on national priorities?

Janet Corrigan – National Quality Forum – President & CEO

That's exactly right, and the legislation, where the policy committee moved is exactly where the legislation is taking us in the country in terms of those national priorities. It essentially directs the Secretary to establish national priorities and goals and to do it in concert with a private sector, multi-stakeholder group, so we hope that that will build on the work of the national priorities partnership. Don't know for sure yet, but it's a likely thing to have happen. Hopefully there'll be some convergence here of direction, and we're moving in the right direction. But you're absolutely right. We're thinking about this in terms of getting

some bottoms up feedback here, and trying to make sure we don't reinvent the wheel because there are leading systems that are much further down this road and have had their HIT in place for a number of years.

Marc Overhage – Regenstrief – Director

It must be a stunningly good idea.

Janet Corrigan – National Quality Forum – President & CEO

In thinking about the groups that are represented just on the standards committee, we have Geisinger. We have your group, Marc. We have Kaiser Permanente. Who else have we got on there? Intermountain, we have Intermountain, and many of these groups, and I'm sure there are a couple others. I don't have the list in front of me, but—

W

We have Mayo.

Janet Corrigan – National Quality Forum – President & CEO

We have Mayo, okay.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

We have Aurora from Wisconsin.

W

Yes, Cleveland Clinic, Tenet Healthcare, Cerner, Aurora.

John Derr – Golden Living LLC – Chief Technology Strategic Officer

You do have Golden Living and post acute care.

W

Yes. Absolutely.

M

We do?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

And I'm trying to say if we go to 2013, when are we going to start including nursing homes and homecare?

W

You know, as we....

John Derr – Golden Living LLC – Chief Technology Strategic Officer

I keep quiet most of the time, but you know I....

Janet Corrigan – National Quality Forum – President & CEO

No, John. We appreciate your input, but even if it doesn't happen explicitly and, of course, we're all hoping that it does, as we move into those care coordination and outcome measures, they really affect patients regardless of where they are.

John Derr – Golden Living LLC – Chief Technology Strategic Officer

I know, and we're not – this sector of healthcare is not waiting to get included. We're doing different things already in quality measures and also in starter packages are toolkits and things because I personally don't think we'll ever get any money, so I try to work it so we can correct with the rest of you guys when you want us to. Anyway, that's just my two cents in.

Janet Corrigan – National Quality Forum – President & CEO

Is Jim Walker on the phone?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Janet Corrigan – National Quality Forum – President & CEO

Jim, you sent me an e-mail earlier this morning when you looked at the attachments with some important comments about this. Do you want to share those with the group?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I was just suggesting that the more specific we were with our question, the more likely we were to get useful and particularly comparable and aggregatable data back. So I was just suggesting that we talk about, when we ask people what measures they use or what data they use may be clearer to some of them to manage themselves and to make processes work, and to report to themselves and to other people on quality, that we specify things like asking them how much of an IT challenge it was to collect this measure. Some measures are so important that you'll spend a fortune in resource, being able to capture them. Others are really easy in the context of the tools that you have.

Then the other thing that I think is important, as we focus on the process aspect of this. Some of them might be trivial technologically to capture and report, but may be extraordinarily difficult in process terms. Beers criteria would be one of those. There's no problem identifying patients who are on a Beers criterion medicine. But in process terms, it's extraordinarily difficult. And it seemed to me that that might be something we want to learn from these organizations too. That's just a very rough preliminary sketch, but I think, if we can think carefully about what it is we'd like to know and then make that as standardized and fill in the blanks kind of tool as possible, I think we'll just get a lot more information.

The other thing that occurs to me as I'm talking is that a lot of the things that are being captured may not be obvious, at least to some of the organizations, as quality measures, things like black box warnings in order entry systems that aren't sort of what people think of as standard quality measures, but may be critically important to what we want to do down the road.

Janet Corrigan – National Quality Forum – President & CEO

That's helpful. Yes, and I guess the other challenge, I think it would be very helpful to have a structured sort of question. I wonder too whether we wouldn't want to set up a conference call and talk through with a group that we select to work on, not meant to be exclusive, but as sort of a starter group to kind of get the bugs out of this and to kind of walk them through what we're really interested in because, building on your last comment, Jim, there are a lot of things that may be important that we don't think of as standard quality measures. There may also be just a whole lot of quality measures, and we don't want to get volume here. If anything, I think we probably want the respondents to be thinking through what's really most important to measure and doing some filtering at the front end.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right.

Janet Corrigan – National Quality Forum – President & CEO

What do others think of this idea? I guess the next steps really would be then to perhaps fashion or maybe set up a call, a conference call, send out an e-mail to those on the standards committee that are from healthcare delivery systems. That would be ... they're from a healthcare delivery system. And to have an initial set of questions, which we could circulate to this group first for comments, and then perhaps talk it through on the call, and then see how best we could get some input from this group as to what some of those likely measures might be or really promising measures might be that we could then encourage to come forward for more formal evaluation, because I think if we just somehow don't reach out to them a bit more, I think we may be missing a real opportunity here to learn from what some of the leaders in the field really have done.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes, Janet. This is Judy Murphy from Aurora Healthcare. I actually think that's a great idea. I started talking before, by the way, and I was on mute. I think that's a great idea because we could involve then some of our quality people who have been probably germane to this whole issue of pulling indicators and get some real specific feedback from them.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Yes. This is Walter from Kaiser. I do agree too that this is a great idea. I think it could be positioned as a stepping stone towards maybe having a more expansive hearing or some sort of a meeting where we can hear various perspectives in an open forum on what directions can be taken towards the 2013 measures and then the 2015 measures. I think having this first call perhaps with the care delivery organizations could help us sketch out maybe a future potential hearing on this topic.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim Walker again. Someone mentioned Cerner in the list. It seems to me that there might well be at least vendors represented on the standards committee who have given some thought to this, and it seems to me it would be reasonable to at least discuss inviting them to join.

Janet Corrigan – National Quality Forum – President & CEO

Okay. All right. We can do that too. Okay. We can do that too.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd, just for a comment, in doing this outreach and this call we're talking about, would the committee be looking for a mix of structural process and outcome measures that they're doing, or is there a specific focus that you'd recommend?

Marc Overhage – Regenstrief – Director

Floyd, I think the other dimension that we have to think about that on is inpatient versus outpatient, given the way the legislation is structured.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

This is Walter again. Maybe the other, I guess, dimension to consider is the various areas that quality, national quality reports are based on the safety, effectiveness, efficiency, equity, patient centered areas to focus on. So you can have a multidimensional kind of approach with the inpatient, outpatient, with structured process outcome, and then with sort of this other dimension of where the measure really fits in terms of safety and efficiency and effectiveness and those other dimensions.

Judy Sparrow – Office of the National Coordinator – Executive Director

This is Judy. Just a reminder, Aneesh Chopra's implementation workgroup is doing a lot of work on setting up some resources and tools and talking about what's available now, and also the certification adoption workgroup or the policy group has been delving into HIT safety. So maybe you'd want to include Paul Egerman or somebody from that group.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Good.

Janet Corrigan – National Quality Forum – President & CEO

All right. I guess our next step there then will be to, Judy, we'll be working with you a little bit to get a first rough draft and circulate it to the smaller group, some questions or how we want to kind of structure the conference call, and then we will get a conference call in place with the representatives from provider organizations and some vendors as well to flush this out a bit further and see if we're on the right track, and then get some further thought to whether or not we actually want to have a hearing and get even broader input into the strategy.

Judy Sparrow – Office of the National Coordinator – Executive Director

Right. Perfect.

Janet Corrigan – National Quality Forum – President & CEO

We'll try to focus on both structure process outcome, inpatient versus outpatient, and using the ... names and the key priority areas, Steve and others to cast a fairly broad net here in terms of the types of measures that we need to be interested in considering. Of course, it goes without saying, we will continue to coordinate. We want to probably keep Paul Tang in the loop. I'm very much aware that we don't want to get out front on the policy committee. We need to moving in lock step with them. At the same time, having talked about this a little bit with Paul, we just both realize that we've got time constraints that we have to work in parallel, but we want to keep good communication and coordination in place. Judy, we'll be looking for you to help us with that.

Judy Sparrow – Office of the National Coordinator – Executive Director

Delighted. Thank you.

Janet Corrigan – National Quality Forum – President & CEO

I think that's what we had for today. Are there any other comments on this or other issues that workgroup members would like to raise? I guess not. Then I think we're all set.

Judy Sparrow – Office of the National Coordinator – Executive Director

Let's check and see if there's anybody from the public that wants to make a comment. Operator, can you ask, please?

Janet Corrigan – National Quality Forum – President & CEO

While we're waiting, Judy, do we have another meeting of this group on the books?

Judy Sparrow – Office of the National Coordinator – Executive Director

Let me see now. I'm sure we do, Janet.

Janet Corrigan – National Quality Forum – President & CEO

You've got these all lined up here. I think we can probably get comments on the draft set of questions by e-mail, but then we'll want to regroup a little further down the road.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes. The next meeting is on April 23rd, which is right between the policy committee meeting and the standards committee meeting. That's a Friday, April 23rd.

Janet Corrigan – National Quality Forum – President & CEO

Okay.

Alison Gary – Altarum Institute – Communication Technologies Coordinator

We do not have any comments from the public.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Alison. Thank you, Janet.

Janet Corrigan – National Quality Forum – President & CEO

All right. Sounds good. I think we're wrapped up, and we'll be sending you some further information by e-mail. Thanks, everybody.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Bye.

Walter Suarez – Institute HIPAA/HIT Education & Research – Pres. & CEO

Thank you, Janet. Bye.

Public Comment Received During the Meeting

1. I suggest you reach out to Puget Sound Health Alliance and/or the Oregon Healthcare Quality Corp. as they have done some interesting work on this front.