

**Quality Measures Workgroup
Draft Transcript
September 10, 2010**

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good afternoon, everybody, and welcome to the Quality Measures Workgroup. This is a federal advisory committee workgroup, so there will be opportunity at the close of the meeting for the public to make comment, and just a reminder for workgroup members to please identify yourself.

Let me do a quick roll call. David Blumenthal?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Lansky?

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

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Paul Tang? Neil Calman? Eva Powell?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marc Overhage? Carol Diamond? Peter Basch is not available today. Bob Kocher? Jacob Reider?

Jacob Reider – Allscripts – Chief Medical Informatics Officer

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Karen Kmetik?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jesse Singer? Timothy Ferris? Hardeep Sing is on for Laura Peterson.

Hardeep Singh – Baylor College of Medicine – Assistant Professor of Medicine

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Walker?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Cary Sennett? Paul Wallace will be joining late. Kalahn Taylor-Clark?

Kalahn Taylor-Clark – Brookings Institute – Research Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Helen Burstin?

Helen Burstin – NQF – Senior VP, Performance Measures

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Kendrick? Patrick Gordon? Sarah Scholle?

Sarah Scholle – NCQA – Assistant Vice President, Research

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Russ Branzell will be joining late. Tripp Bradd?

Tripp Bradd – Skyline Family Practice – Physician

Present.

Judy Sparrow – Office of the National Coordinator – Executive Director

Charles Kennedy? Terry Cullen? John White?

John White

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Patricia Santora is on for Wes Clark. Kate Goodrich?

Kate Goodrich – ASPE – CMO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Dan Green? Steve Fong?

Steve Fong – HRSA/OHITQ – Medical Officer

Here.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

Wes Clark is on for Wes Clark too.

Judy Sparrow – Office of the National Coordinator – Executive Director

Steve Solomon? Tom Sang? Did I leave anybody off?

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

Paul Tang is here.

Farzad Mostashari – Dy ONC

Farzad.

Tom Sang – ONC

Tom is also here.

Josh

And Josh.

Judy Sparrow – Office of the National Coordinator – Executive Director

Great. Thank you all very much, and I'll turn it over now to Dr. Blumenthal.

W

Actually. Can I interrupt for one moment? Please, everyone, as a reminder for the workgroup members, please mute or turn down your computer speakers. There is an echo that we are hearing right now from that. When you are not speaking, please mute your lines to help with the audio quality. Thank you.

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

Everyone, thanks for being here late on at eastern time, it's late on a Friday afternoon. We are continuing forward now with the ... of a very insightful and helpful scan by the National Quality Forum of the quality landscape. We're going to move forward to think about the development of quality metrics for the next stages of meaningful use. And as we get ready and watch the implementation of stage one of meaningful ... learn more about how this is going to unfold in the average practice of medicine around the country. I think the work that we are doing for the next stage of meaningful use assumes ever greater importance and relevance.

The quality metrics incorporated into stage one, the levels of decision support required for stage one are pretty basic. If our goal is really to move practice to a new level, we clearly are going to have to provide more guidance and more incentive to use electronic health records, as they are capable of being used. And the incentives linking the financial incentives to quality goals, measurable quality goals, means that for in addition of the HITECH Act, and critical part of meaningful use. I had a chance to visit with some daily practice groups early this week in Vermont. Both of them had electronic health systems that focused this enormous energy on getting them up and running. And I had the feeling that they were now—now I've got thinking; now I've got my records electronic. I can relax.

M

We can hear somebody typing. If you could put yourself on mute, please.

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

And it's true that we don't want to run people into the ground, but we do want to create a framework that lists their sites out of the record-keeping mode and into the practice improvement mode. And what we're doing, what you're doing in this group is the core infrastructure, the core framework for practice improvement, as it can be accomplished in the next stages of meaningful use, and after the meaningful use Did you hear me?

M

Yes. David, we can't hear you now, if you are still on.

M

Hope he didn't fall off his chair.

Operator

He is disconnected from the line. I believe he'll be calling right back.

M

Great.

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

We can wait a minute for him to rejoin us. I want to just do a check while we're waiting. Did everyone see a copy of the agenda for today, and should we do a quick review, Tom and Farzad, of what we have coming up?

W
Yes.

Farzad Mostashari – Dy ONC

Yes. So in terms of running through the agenda, David.

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

Yes. That's what I was thinking.

Farzad Mostashari – Dy ONC

Yes. So we're going to have David continue to give the context in terms of the framework for clinical quality measures and meaningful use. I'll talk a little bit about giving greater specificity to the measure attributes, the ideal measure attributes that we're interested in, and a little bit about what the outcome, the desired outcome for the process that we're going through here would be.

Turning over to you, David, for a discussion of the survey, which a lot of people didn't respond to, so if you're on the phone and you didn't respond, it's not too late. We do want your input on it, but the results we got back already, and talking about the tiger team on the next step, public comment, and then adjourning.

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

Great.

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

I'm back, but you might as well go ahead. I didn't have a lot more to say except this is really foundational. Farzad, why don't you take it away?

Farzad Mostashari – Dy ONC

Sure. We have, as you saw in the Gretzky Report, there's just a whole lot of measures out there, and as we discussed last time, the goal is not to kind of further proliferation of additional measures necessarily, but rather to kind of identify the gaps in this process that are the highest priority to fill. Now there is something to make clear. There are two ways of thinking about this issue of filling in the gaps. One approach to that has been and I think is ongoing, a very broad based approach that says are there particular conditions? Are there particular specialties for whom we need measures? There is a lot of work going on in this already. I think the work of NQF and retooling. There's some total of almost 100 measures that are going to be retooled for electronic health record reporting hopefully by the end of this year, and there's additional specific programs and retoolings that CMS is continuing to do to address some of that.

The focus where we think that this work, this workgroup, and this initiative can add particular value is in thinking about measures that have certain attributes. One of those attributes that we think is very important is actually parsimonious self. In other words, measures that can cut across the broadest number of providers, the broadest number of care settings, different context. So this is one of the things that as we look at whether it's safety, whether it's care coordination, whether it's station focused outcomes or patient or population health, thinking about what are the measures that are in some ways as broad and cross-cutting and broadly applicable as possible and meaningful. This is one of the things that probably has not been—there's no one else really with that same focus out there, so it is something that we would be adding significant value to, I believe.

The other issue is around health IT sensitivity. I think it's worth thinking together about what that means. So a way we've been thinking about it here is measures for which the electronic health record broadly provides unique advantages, measures for which whether it's around clinical data and clinical outcomes like not just whether a screening was done, but whether levels of control, for example, for blood pressure

or clinical observations have improved, measures that are longitudinal where you can easily follow patient ... specific to the patient changes over time, improvements over time. The longitudinal patient view in some ways are uniquely provided by the system.

The other way in which you can think about health IT sensitivity is measures, as someone put it, it's like a reflex arc that tests, you know, when you tap someone on the knee. That's testing, you know, about six different parts of the nervous and muscular skeletal systems, so similarly measures that challenge ... draw upon ... of the electronic, of the appropriate implementation meaningful use of the electronic health record system. And finally, the other component of health IT sensitivity is the ability to do something about it, so the ability to not just measure, but actually improve care, the quality of care through the meaningful use of the electronic health records, whether it's the decision support tool, CPOE, patient reminders, and so forth.

So those are kind of the three kind of clusters, interrelated clusters of measures that may be uniquely and importantly the focus for us because, in a sense, nobody else is going to do it as well. Just to acknowledge with some humility that while these measures may end up being ideal for meaningful use, there's certainly not going to be the only measures that are going to be needed in order to fully capture whether it's the broad range of legislative programs, legislatively mandated performance programs for the federal government. They're not going to be the only measures that are going to be needed for all the different specialties and their desires for public reporting or accountability or performance-based payments and so forth. We think it's a very important part. We think that there are some unique advantages that this effort can provide that we hope will be broadly useful, but we're not expecting it to meet all the needs that we have out there.

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

Is it fair to say that we're seeking a set of quality measures that parsimoniously capture the impact and leverage the opportunity to get impact from HIT adoption and in a visible way that is manifested and proven to quality, but we're not necessarily trying to cover the broad swath of quality measurement domains or areas of interest. In other words, we're not trying to replace the quality measurement enterprise. We're trying to sort of focus it and supplement it in areas where HIT sensitivity is most manifest and in the most elegant and parsimonious way.

Farzad Mostashari – Dy ONC

That's a great way to put it.

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

...parsimony. I'm wondering. You know, obviously the Gretzky Report recommended we consider indicators by leading conditions, which inherently take this down to various potential subspecialty or areas of practice that are narrower than the broad swath that you suggested. How do you all think about the balance between parsimony in the sense of broadly crosscutting and applicable to many health professionals and ... versus using leading conditions to either tap otherwise untapped areas of practice or, you know, what's the balance between leading conditions and the goal of this elegant parsimony?

Farzad Mostashari – Dy ONC

Sorry, David. There's one other piece, if I may, and that may provide some useful context before we open it up, which is the NQF task 6.2 around measure prioritization that many of you have been a part of. They ran through an exercise, in a sense, voting for and ranking different domains, which have a great deal of overlap with the domains that we've been talking about and come out of the meaningful use and NPP frameworks, no surprise. And then within them, voting on some of the sub-domains.

One of the things that struck me is being part of that process was my fervent hope, and it ended up coming true was that it not identify three sub-domains that have the highest number of votes for one thing and then not address any in the other domain because what we're really trying to do with meaningful use is to cover the waterfront in terms of these domains. Indeed, when we look at the results of the voting

results in the sub-domain, there was, if you look at any one thing that had the highest scores, under care coordination and care management, communication and transitions of care and medication management were highlighted. Under health status, by far and away functional systems and quality of life was highlighted. Patient and family engagement, shared decision making was highlighted. Under population health, effective preventive services. Under resource use, overuse, appropriateness and efficiency. And under safety, prevention of adverse events and medication safety.

Another way to put it is that the ideal outcome of our process here would be to have, for each of those domains, a small set of parsimonious measures that best capture the essence of that. Now in some cases, that may ... functional status. It may be functional status

M

Farzad, can I just ask what document you're referring to?

Farzad Mostashari – Dy ONC

Sure. We can send this around. This is the results of the voting from the NQF 6.2 process, the prioritization.

M

But is that something we already have?

Farzad Mostashari – Dy ONC

No. We can send it around. For those of you who have been part of that have it, but we can, I think it's okay to

M

...just ask that the committee members do not share it outside.

Farzad Mostashari – Dy ONC

Outside, so it's still in draft form, I guess.

W

Farzad, I would also be curious about what this committee responded to as well.

Farzad Mostashari – Dy ONC

Sure, and we'll get into the results from the survey momentarily. Let me just—I promise I won't say anything more after this probably—that the leading conditions could help within this, so if we're looking for measures around effective preventive services, then maybe cardiovascular prevention in terms of public health and leading conditions, you might want to think about within effective preventive services what to prioritize. Or if it's functional status, then maybe, I don't know, if knee replacements are one of the most common things that are done procedurally, then maybe that's an area to have the focus for that. So there may be—it may not be, David, and either/or. It may be within the domains or sub-domains, there may be relevance of the leading clinical conditions.

Christine Bechtel – National Partnership for Women & Families – VP

I just want to say, so we filled out the evaluation form and sent it into you all. One of the things that I know I struggled with, as we talked about it internally here, was so within care coordination, for example, you know, what's the most important measure. Well, it was tough to assess because I think people define care coordination in different ways, and I wasn't sure what goals we were trying to achieve in care coordination other than more of it. So I almost wonder if it's worth overlaying the actual NPP goals themselves under each of the domains so that we get a little more specific about what we're trying to accomplish through measurement.

Under care coordination, for example, there's a goal about reducing 30-day readmission rates. There's a goal about continuously getting feedback from all patients and families about coordination of their care,

things like that. And that might help us better prioritize measures if we agree on those goals that were established by NPP.

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

This is a complicated process that we're involved in, and we are not going to be able to finish the process because there will be, for example, goals that the department will pursue in its quality strategy that may focus attention on some of the domain goals and lower the priority of others. So I think that what we should try to do is focus on HIT sensitivity, which is our expertise.

Christine Bechtel – National Partnership for Women & Families – VP

....

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

Pardon?

Christine Bechtel – National Partnership for Women & Families – VP

I was saying, yes, absolutely, but it's still hard to align even HIT sensitive measures if we're not sure where we're trying to go. But I think you raised a really important point, and I know that the national strategy, a draft of it was to come out sooner, or maybe it did yesterday. I'm not sure. Do you know if that's out or when it might be?

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

Farzad may know more than I, but I don't think we're anywhere near a draft, but I could be wrong.

Christine Bechtel – National Partnership for Women & Families – VP

It was supposed to be out, I think, today or maybe next week

Tom Sang – ONC

I think a draft is out for public comment. It's probably posted on the Web site, and I believe there is a request for comments from the department.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. That's right.

Tom Sang – ONC

But going back to, I think, what Farzad and everyone is talking about, it's really to give you all an understanding of how we're coordinating our activities here in relationship to the external work, as well as the departmental world. There is an abundant of activities going on within the department on trying to harmonize a lot of the measure work, not necessarily e-measures, but measures in general.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

Tom Sang – ONC

There's a lot of work that NQF and other external groups are doing. The Brookings is working on ACO measures, so there's tons of work outside. And we're trying to keep that work and the work of others within our radar screen so that, and this is what the Gretzky Group, the report is about is also doing an environmental scan of all those other measure work and seeing if we can come up with a short list at least that full under three buckets. So for the purposes of this discussion, we just wanted to give everyone a short synopsis of the context of what the environmental scan is about and what others are doing and how we fit in, in that picture. Farzad? So I think we can move on if there are no further discussion

Farzad Mostashari – Dy ONC

Unless there are any other comments about the measure attributes and what is it that we're—if there's clarity in terms of what we hope to achieve from this process.

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

Maybe I'll mention some of the thought behind the original meaningful use matrix with respect to quality measures because I think it addresses some of what David Lansky was raising. We used a term at that point of exemplars, and I think what we meant were actually the same three attributes. That is, and exemplar quality measure would be one where you know that EHRs, primarily through things like clinical decision support, would be the way that you both measure and improve in some health outcome measure.

Obviously through the clinical decision support that allows you to achieve improvement, that means it's actionable, and the whole concept of exemplar versus the 500 measures was the parsimony part. So I think this was, if you could reach, could measure and improve something of a high priority condition, then you likely have a toolset that can help you do things in other areas. And it seemed like that was the best way to, one, make sure you had a capable certified EHR, as well as the tools to do things that meet your local priorities, which is another thing that I think the program wants to do, not prescribe all the priorities for all pockets of the nation, but have the toolset that you could deal with your local priorities. Is that consistent also with the way you articulated the attributes?

Tom Sang – ONC

I think it is. Yes.

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

I think that also raises a question, Paul and others, of the link between the meaningful use functional criteria and how they may evolve and how they are evaluated and the quality measures per se. As you described it, Paul, which I agree with, we have understood that there's a set of metrics, which assess whether the functional capabilities are in place for improved care, which is a somewhat different criterion than demonstrating an improvement in outcomes, often in this case a complex outcome, that's mediated by a lot of other activity. I guess I want us to make sure the whole committee has a common understanding of, in this quality measurement domain in particular, our criteria and how it's distinct from the assessment of the functional capabilities that are going to be required as well.

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

Maybe that's where the meaningful use workgroup interdigitates with this. In some sense, it's the high priority clinical conditions or health conditions that we want to move the nation on that sort of this group, being sensitive to how would an EHR facilitate that through its health information storage, through its health information exchange, and through its clinical decision support. How would you measure and improve the quality with regard to this high priority condition? Then it's the meaningful use workgroup's intent to make sure that through its criteria and its discussion with HIT standards that the certification criteria would be such that the EHRs that are being developed and sold and adopted would be able to measure and improve these quality measures that come out of this group. It seems like that's how they all tie together.

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

Yes, I agree. Let me just ask the group as a whole for other comments given Farzad's review of some of these key attributes or criteria we're using. Any further reaction or comments or embrace of the criteria that we've talked about?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

I appreciate the criteria. I think I understand it. It makes sense. I did want to follow up on Christine's comment though. I think it would be very helpful to layer on top of that a clear statement of the goal we're trying to achieve in each of these priority areas. It just helps you all know the endgame. And I recognize what you're saying that the measures for meaningful use are not going to be all the measures that are needed to get to that endgame. Others are going to have measures. We're going to focus on these three

criteria. But if we don't state that endgame, I think it's going to be hard for those using the measures to understand where is this headed.

Farzad Mostashari – Dy ONC

For example, under safety it would be reduce average drug events by X percent. Is that the kind of goals you're talking about?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Yes, because then that just helps us all refocus. Okay. That's the goal, so then I can think of all the measures out there to do that. Which are the ones that take advantage of unique data in the EHR? I'm just repeating your criteria, Farzad. I just think it helps. I used the example recently of disparities. There's a lot of things ... what is it that we really want? We really want to eliminate them. We want to eliminate disparities in clinical care and outcomes based on these variables. So how do you get there leveraging what's in an EHR?

Christine Bechtel – National Partnership for Women & Families – VP

I'd even settle for just reduced adverse drug events. I know we went through this discussion in the meaningful use context on the policy committee around choosing some numeric goals, and David Blumenthal is, of course, right. It intersects with federal strategies. But we have chosen domains here based on the NPP framework. So even sort of the broad statement of reduce adverse drug events would be helpful.

Farzad Mostashari – Dy ONC

I think, partly that was the question was, what are the sub-domains? What are the concepts that you think are the priorities to accentuate. So under safety, what do we focus on? Is it adverse drug events in total? Is it adverse drug events among the elderly? Is it hospital-acquired infections? Is it central line infections or venous thromboses? So partly, I think, what you're asking is what we were asking from you was to prioritize the measure concepts that you think are the measures that matter in this case.

M

Well, but I think what David Blumenthal said was our value add is not in setting the nation's health priorities but is demonstrating that this is a tool that can help us achieve them. So probably the top priority of the attribution listed would be the HIT sensitivity, and that is what we're uniquely, both constituted and qualified to help render an opinion upon.

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

Yes. I agree with that, and I think I would be comfortable with us setting an aggressive parsimony goal that says within each of the buckets we end up agreeing to, we really look for just a small number of very powerful and understandable indicators, going back to David's original comment about the Vermont practices. Can we find a couple of things on the one? Someone just mentioned, Karen or others, about safety as a good example where it's unarguable. It's crosscutting. We can find a couple of indicators within that category of the medication safety, for example, for reducing adverse events that are relatively easy to capture and hard to dispute. And I would be happy if we had a small number of items of that power.

M

Yes.

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

That sample from each of the buckets we want to sample, and not try to boil the ocean, especially given we want to have an impact in the next two and four years of whether we have the discipline to really pick elegantly in that way would be the challenge. And then I guess I might test with the group whether an aggressive parsimony standard is one what we would want to pursue versus a more kind of pluralistic library of measures that tap a wider variety of concerns.

David Kendrick – Greater Tulsa Health Access Network – Principle Investigator

I would agree with an aggressive parsimony standard for sure because I think that there's so much uncharted ground just in that area that an 80/20 split at least would feel good. This is just a second question I have about the framework that may be considered under ... sensitivity, but it strikes me that the work of this group will have the capability of moving the marketplace. That is, having vendors alter their systems and having implementers implement in different ways based upon the measures that we'd use and should we not consider that explicitly, as we consider measures.

For example, in the HIE space, since we're committed to the existence of health information exchanges, is there opportunity to have sustainability assisted by, you know, the pursuit of sustainability assisted by the measures we choose. Just in the baseline measures we submitted for Beacon last week, what we saw was that within specific EHRs and organizations, the duplicate test rate was very low. But when we looked across the whole community, the duplicate test rate was shockingly high. And so I wonder if we should explicitly consider those opportunities to help out the entire agenda in this conversation.

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

I think HIT sensitivity is one of the key variables, but I think Karen's comment about impact has to be constantly on our minds. So we need to subject ourselves to the discipline of saying if we pick a measure, how will it affect an individual or population health goal and be sure that in our mind we can justify it because, if we can't, it'll get dropped out for lack of, you know, later in the process because it may be HIT sensitive, but it's not relevant to a critical public health or individual health goal.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I'd like to follow that. In the criteria, if you look at the buckets, and you look at individual measures that have been suggested, it seems like something like remediable burden of illness is an implicit criterion informing lots of the buckets and lots of the specific measures, but not all of them. I'm wondering if something like that should be an explicit attribute or, if not, I think it makes sense to sort of say why.

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

The other argument for being explicit, I think, is ultimately we're going to need providers and everyone working with us on achieving these goals to understand the relevance to them in the real world. While we're all having these conversations, and we get that as part of our conversations, ultimately whatever we come up with, the people who will be using them won't be privy to all of that, and oftentimes that's what happens, based on the ground, is a lot of good and thoughtful work is misunderstood because there's not enough context. I think, being explicit about some of these things will be extremely important for buy in and understanding of what, kind of like what Karen had said. What are we really trying to do here?

Farzad Mostashari – NYC DH&MHH – Assistant Commissioner

Great. So I think it was actually in the Gretzky Group set, and we had made it, I think, implicit, but I'm fine with making it explicit that the potential preventable burden or the potential impact of health IT for improving that quality measure, we can make that explicitly one of our measure attributes along the lines of measures that matter.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think something specific like remediable burden of illness would have the virtue of being in some cases actually quantifiable and at least given appropriate research quantifiable so that, granted the need for parsimony, which is real, we could both be confident ourselves, and also communicate effectively to all of the audiences that are relevant, how this parsimonious set was chosen and what the policy and processes will be for selecting additional sets, as that becomes relevant.

Farzad Mostashari – NYC DH&MHH – Assistant Commissioner

Great. Again, a reminder that what we are seeking at this stage from you is not so much this is the measure, but rather, in this domain, these are the gaps. These are the holes. This is where work needs to be done to be able to have the ideal exemplar measures in this domain. So when it comes to safety—and we'll talk about this more towards the end in terms of our next steps—having a small group of you who are passionately interested and experienced around this issue think about what are the gaps

between what we have today and where we need to be in terms of having the ideal exemplar measures when it comes to patient safety.

Helen Burstin – NQF – Senior VP, Performance Measures

I would hope we would also keep our lens a little broader, not just where there are holes where measure development is needed, but also where there are truly prioritized areas within these domains in which there actually are measures out there that would be helpful for us to embrace and potentially bring through the process. So as we saw from the environmental scan, there is really a remarkable amount of innovation out there that we shouldn't discount either.

Farzad Mostashari – NYC DH&MHH – Assistant Commissioner

No. Exactly. The goal of the identification of the gap is then for us to do the RFI and identify really in a much broader environmental scan than we have now what is available that we may not know about.

M

Helen, one question though about the innovation and the measure development. As you look across the spectrum, as we've discussed, and I think the Gretzky Report outlined to some degree, the measures that have been developed historically were developed in a retrospective manner without thinking about EHRs or EHR readiness. I think one of the powerful things about the Gretzky report is that you identify measures that are very likely to be EHR ready and are there opportunities to create new measures that are more forward thinking and better, you know, better, stronger, faster that might provide much less work to implement from either the measure developer perspective or from the EHR implementer perspective so that we could have great value without so much effort.

Helen Burstin – NQF – Senior VP, Performance Measures

Absolutely. The only response I would have to that, as well as one of the reasons we chose to go to the leading edge systems who have HIT in place is in fact many of their measures were developed in a fully electronic environment prospectively, thinking about what do we need. What can we do in our very broad, fully interoperable health system? We didn't start with those who didn't have it yet. We went to the ones who are way ahead. In fact, many of them have been able to kind of go to the place I think we're trying to go to and already have measures in practice, which, as many of the measure developers on the phone know, it's often difficult to take a measure that's not really been put through its paces in the real world and have it work quickly.

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

Could I ask Farzad and David to comment on the other attributes we haven't yet discussed, including the longitudinal dimension and the outcomes focused dimension, and how much? I guess I imagine that we are thinking of those as among the desirable features, but not as a requirement.

Farzad Mostashari – Dy ONC

That's right.

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

But talk a little bit about how the group should look at our inventory and whether, beyond favoring some of those, if those are both areas where we know there's probably less than the library than we'd like, and maybe more development work needed in those areas, should we give special attention to the questions, including methodological questions around the longitudinal and outcomes measure sets and take on some of the challenges? For example, one thing I'm thinking of in the case of longitudinal measures is they imply some mechanism for capturing multiple data points over time, which could be a registry, could be a longitudinal health record housed by somebody somewhere. On the outcome side, of course, we've got the issues of patient reported measures and risk adjustment and so on. So what's your collective guidance about how much emphasis we've put on those more challenging categories?

Farzad Mostashari – Dy ONC

I think, similar to the way the Gretzky Group Report had it, what we want to also identify is gaps not only in particular concept areas or domains, but as you're pointing out, methodologic issues that can be

crosscutting, whether it's longitudinal, kind of delta measures, whether it's risk adjustment, whether it's patient observations, as a part of electronic health record data, and we are working with AHRQ actually to then take the next step on those methodologic challenges and to kind of have some focused work on best practices around those methodologic issues that could be disseminated and incorporated into a variety of quality measures to be developed. So those kinds of more fundamental measurement challenges or opportunities are absolutely something that we want this group to surface.

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

Let me ask this group as a whole again about any last thoughts or reactions about supporting the criteria that we've just quickly re-reviewed and Gretzky summarized in their report.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

The outcomes-based is clearly a critically important attribute. They are limited in the sense that many care delivery organizations will be small enough that for many important problems, healthcare problems, their population will be too small for outcomes based measures to be accurate enough to be actionable. And in those situations process-based measures where the measure is genuinely validated to be connected to outcomes are going to be important. And this is most important for small practices and small hospitals obviously.

Tripp Bradd – Skyline Family Practice – Physician

I'm the quiet guy that is impressed with all the intelligence around me, I might add, but I'd like to sort of second the idea of the IT sensitivity from the perspective of the social aspects of physicians trying to implement and piggybacking off of what Jim said. These guys and gals who are really wrestling with implementing EMRs, as you mentioned, David, the first thing that we've noticed with Practice Partner Research Network that we've been doing since '95 was just clean data getting it to outcome correctly. I think that's the gap, that's the big gap. These other measures, we can add on, I would think, in a graded manner, but I think just getting the information exchanges and all the other aspects of providing the information will be probably one of the most important parts of referrals, etc.

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

Other comments about these criteria?

Bob Kocher – McKinsey & Company – Associate Principal

I think, for this criteria, I think we should, above all else, think about the criteria. Prioritize the ones that are going to be most consistent with things like payment reform and accountable care organizations and the delivery system changes. There's a real ... metrics that allow us to understand chronic disease ... management, attribution, and over/under use ... aspects that I think ... the metrics won't satisfy all these ... and there are more criteria than there are sort of ability of ... metrics ... so I would just flag that we should be very forward ... in picking measures that are most ... of where we're heading around policy.

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

Bob, is it more important to demonstrate for a given domain? Not demonstrate. I guess, assess whether, let's say, an ACO enabled by technology is more capable of improving an indicator of interest and picking one, let's say? I guess I'm trying to get at the criticality of the HIT implementation to achieving the public policy goals of the ACO strategy, which we might be able to do with a very small number of measures that demonstrate the leverage of the IT infrastructure in effect to reduce, say, adverse events or to increase care coordination across the ACO structure, or perhaps if an ACO is not strongly enough integrated to demonstrate the weakness of a certain ACO model to achieve better care coordination or reduce adverse events. By finding a couple of elegant indicators of that kind, we might help support the policy objective you describe of helping to support reform, but do less well, so to speak, of getting a broad set of quality measures across various subspecialties or eligible professionals in the program. Do you see what I mean?

Bob Kocher – McKinsey & Company – Associate Principal

Yes. I mean, my bias is I do think there's an inherent intension and tradeoff is that fewer metrics generally, although not excluding sort of specialty majors, I mean, I think we have to have all types of

physicians, and certainly the most common ... be able to be evaluated. Parsimony, though, probably is better and changing them over time, as opposed to having comprehensive sets that are, you know, inherently would have to be more stable.

Farzad Mostashari – Dy ONC

Bob, in terms of the suitability for payment reform and accountable care organizations and so forth, we've had a lot of discussions around that, and there's a couple ways to think about that. I think ... granting absolutely that one of the very important goals and outcomes for this work would be if these measures could be useful in supporting payment reform more broadly, acknowledging that 100%, is that the kinds of measures that would be useful. One, it appears, is just better measures of quality would clearly be useful in payment reform to make sure that as people are reducing cost, they're not decreasing quality of care for its measures that matter, that the patient experience with care is not worse, that the quality of preventive care is not worse, and so forth. I think, in some ways, what we're doing already will be useful in those.

One issue that we would—and this is maybe a methodologic issue that we would need to address, however—is moving beyond the—and this is what, I think, was referred to earlier—we would need to be thinking about methodologically whether all the information that's needed is contained, is likely to be contained within the small office EHR. And whether if we're thinking about measures that look at group accountability, joint accountability within a patient centered medical home, within an accountable care organization, whether there are any methodologic implications for having group level reporting or shared accountability, measures that rely on information exchanges or rely on local data warehouses for quality measurement. So that's one reaction is moving the ... from the provider to something larger than an individual provider.

M

Yes. Farzad, I think that's likely essential to be able to aggregate across multiple data sources and incorporate claims and multiple sources to do a metric on a patient level....

Farzad Mostashari – Dy ONC

The other implication of this, of the ACO one specifically is that you may want to make sure that we have quality measures that, A, provide an assurance that the cost savings achieved are plausible rather than statistical so that it's also accompanied with things that are associated with saving money, whether it's reduced admissions for avoidable conditions or a generic substitution or whatever. But looking at cost saving measures. Finally, measures that look, that are aimed specifically not at overuse, but at under use to make sure that the cost savings don't come at the expense of ... of care. So that would be maybe another kind of potential implication of what you're saying. I'd love to hear the group react to whether those are domains that we should be turning our attention to as well.

Tripp Bradd – Skyline Family Practice – Physician

Immunizations are a great example of what you just mentioned in terms of underuse. I think every doctor that I've ever talked to before they went into the research network thought they performed great with immunizations until they had it measured. It's amazing how the behavior changed and the appropriate use for at least reaching benchmarks really improved. Really that's what I think I'm here for is to help change behaviors of physicians and healthcare providers and improving care. Immunizations are not a good example of a crosscutting kind of measure, as you just mentioned.

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

Any other comments on the criteria? I don't know, Tom? Maybe you'll be able to ... this and refine it. I think we should also come back to the point that Christine suggested that we consider how our outer range of domains, and Karen said this as well. How do we specify them beyond having the short tag that we have now? Do we add a descriptive element to each, or do we borrow from the NPP subcategories, and do we assign kind of an aspirational metric to each one within which the measures we want to talk about are considered to be instrumental towards the aspirational metric?

I know I think it would be beneficial for us to drill a little bit into the domains. I know we're going to walk through that the next little bit of our time. But are there further comments after some of the initial ones we've had about the structure of our high level domains and how we set them up for the rest of our more detailed work that we're going to start diving into?

Farzad Mostashari – Dy ONC

If the suggestion, David, is that we take a look at what is already out there in terms of policy guidance, whether it's the national quality strategy, whether it's some of the other work that's been done, consensus work that's been done, as well as the responses to the surveys, and come up with some, like a straw man or a draft of what those sub-domain goals would look like. Is that the request/suggestion?

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

If people feel that way. I guess, as I look through the version we were working with from the Gretzky Report, it seems like it's been sort of evolving in response to a variety of inputs, and it's beginning to lose its sort of coherence. It's getting longer and more diverse. I hope we can get it back to something, especially if it ties to one of the national models that everybody—or I guess it does tie to the national model, but it's going to proliferate a little bit. I don't know. Maybe, Helen, you can comment on how the additional subcategories have been evolving and what the impulses have been that you all felt you had to respond to and what is the best way to do what Farzad said and connect the dots to the other key frameworks that are floating around.

Farzad Mostashari – Dy ONC

I think we can do that. We can have kind of a staff level. We can take the domains and based on, again, the work of the Gretzky Group, NQF prioritization group, the National Quality Strategy, as well as the comments received, identify some potential priority areas within each of those domains for people to react to.

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

Okay.

W

All right. Just in terms of the Gretzky Group ... David, we did specifically begin with the concept of the National Priority Partners goals specifically and then added in some that had come from high priority, some other high priority areas identified by some folks like ONC for example. But again, I think if you really bring that whole first part of the report back to basics, it is truly the NPP goals.

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

Yes. Everybody feel fine with Farzad's suggestion of having a staff rework of these leading priority areas, as we go forward? Hearing no objections, Tom or Helen, did we want to take a minute and go back to the summary of the voting on the 6.2?

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

Just one ... you had proposed and heard some seconds to the notion of "aggressive parsimony". Did you want to give sort of a target goal for the number you were thinking about to help staff with how to clump these?

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

Yes. I like the number one, but that's really aggressive.

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

Well, anyway, I mean, well, so the thought is a really small number.

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

Well, I would like to see big, visible success on a small number of well understood indicators, and I think that's partly a little bit of a PR desire to be able to say to the public and everybody else involved, we have

made a difference on something that we all understand is publicly important. So there are going to be many poles on the setting of the goal, but that's one. If we have, for example, three measures in each of the whatever we end up with, six or eight major headaches, so we end up with 20, let's say, HIT sensitive parsimonious, outcomes, longitudinal measures, I think that would be great. Other people's reaction, is that absurdly too low, or is it already too high?

Farzad Mostashari – Dy ONC

I think, at the measure concept level, that that's about right. But recognizing that something like blood pressure control may have many sub-measures in different groups, and if you have diabetes, you don't have diabetes, you have vascular disease and so forth. But at the measure concept level, it sounds right to me.

M

It seems a lot greater than one, but

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

I think we have to think about how many measures we will ultimately add to the meaningful use framework. Two hundred is too high, and 20 is too low. We're going to be retooling lots of measures that didn't get into the first time that were NQF approved that are specialty specific. So if we had, you know, 30 or 40 to add, I think that would be too many. So 20 seems like a reasonable goal to me, understanding that some of them may get reduced or put off just as a matter of out of concern about burden.

W

Might we split them into like a phase one and phase two?

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

...two, we could fit them into phase two and phase three.

W

That's what I mean. Yes. Sorry.

Farzad Mostashari – Dy ONC

I think the tendency will always be, as you get into the details of having more and more added, so starting with a low number and trying to guard against the inevitable creep is probably the right approach.

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

Any further comments on the scope of our assignment? All right. So, Farzad or Tom, did you still want to have any more discussion about that previous voting?

Tom Sang – ONC

No.

Farzad Mostashari – Dy ONC

No, unless folks would like to discuss their comments on the call. We can, again, we didn't get comments back from the majority of folks, so we would also, that'd be another reason to incorporate them into a staff produced document.

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

Okay. And the previous Gretzky, the 6.2 voting, do we need any further information on that?

Farzad Mostashari – Dy ONC

We would have to find out.

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

If they can share?

Farzad Mostashari – Dy ONC

Right, to what extent we can share the details of that and when. Helen, maybe we can follow up later.

Helen Burstin – NQF – Senior VP, Performance Measures

Yes. It really shouldn't be a problem. The draft report is going through a process, but at least these tables, the PowerPoint's for example that ... shared with you, I assume it's probably fine, but I'll confirm that.

Farzad Mostashari – Dy ONC

Thank you.

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

Are we at a point where we want to start going through each of the measure concepts and just beginning to get our priorities established and any ability to designate measures?

Farzad Mostashari – Dy ONC

Sure.

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

So until we do have a further workup from the staff, I guess we'll take the domains that were sent out to us in our sample questionnaire that everybody got, the measure concepts within each domain. We sent you a list of, I think, A through K, whatever that is, 11 or so domains. So the first on the list was patient and family engagement. Sorry, I guess that doesn't go in exactly the same sequence that we had in our Gretzky appendix A. It does. So we've got a high level domain of patient and family engagement. There were two sub-domains listed in the appendix from the Gretzky Report. One was the experience of care feedback, and the other was decision quality.

Farzad Mostashari – Dy ONC

And maybe I can just add in from the 6.2 work that the high vote getters on that was shared decision making and some discussion of whether palliative care and advanced directives could be subsumed under that item.

Tom Sang – ONC

I'll add that with the number of responses that I received, the incorporation of the CAPs measures was the most common and generally highest ranked measure, and somehow if we can incorporate that electronically.

Christine Bechtel – National Partnership for Women & Families – VP

ABIM has got a module that does CAPs electronically, and I think there's a lot actually that we can work with on that. I know that's definitely an area that if we can get that out ... NPP goals, that is the number one goal for NPP this year is to make patient experience surveys a routine part of every care process. I think there's also really good alignment with public reporting program vendors

Marc Overhage – Regenstrief – Director

I'm not as up on where we are with CAP as I should be, but we've seen a lot of problems trying to incorporate that at the level of individual providers versus organizations. And I know there's some work going on, on that, but I think it's still got a ways to go.

Christine Bechtel – National Partnership for Women & Families – VP

What problems do you mean, because we typically advocate for reporting at the individual level, which I know there's been pushback about, but we haven't seen the problem with administering at that level, so I'm not sure what problems you're referring to.

Marc Overhage – Regenstrief – Director

Just a lot of the questions, for example, are targeted at the last provider you saw.

Christine Bechtel – National Partnership for Women & Families – VP

I got you.

Marc Overhage – Regenstrief – Director

And that may or may not be the one that you think you're getting information about and things of that nature. I guess the question there is just is that sort of ready? Are the ... measure concepts ready for primetime for that kind of measurement?

Farzad Mostashari – Dy ONC

But I guess the three concept areas that we would want to investigate is around patient experience.

Marc Overhage – Regenstrief – Director

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Farzad Mostashari – Dy ONC

Decision-making, and potentially advanced directives.

Marc Overhage – Regenstrief – Director

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. Agree.

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

So what you're saying, Farzad, that CAPs in its current form may or may not be the right instrument.

Farzad Mostashari – ONC

Correct.

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

But those that don't measure domains, we care about

Farzad Mostashari – ONC

Correct.

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

So we can explore whether the CAPs process either historic or in play will satisfy our objectives ... that being our objectives.

Farzad Mostashari – ONC

Yes. Okay.

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

The decision quality row that's in the Gretzky Report, is that a proxy from the shared decision-making concept that we just mentioned? It's a reframing of the same domain?

Sarah Scholle – NCQA – Assistant Vice President, Research

I think they're different ideas. This is Sarah Scholle. And so the CAPs survey does have some items about the shared decision-making right now and will be field testing, working with the CAPs team to field test a new set of items related to shared decision-making and a medical home version of the CAPs survey.

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

Okay.

Sarah Scholle – NCQA – Assistant Vice President, Research

The decision quality is looking at – it's really more of an outcome measure of whether the decisions that people have made are consistent with their expressed values and preference. And so it's

M

And also whether their knowledge

Sarah Scholle – NCQA – Assistant Vice President, Research

Yes.

M

Regardless of whether they participated in a shared decision-making interaction of some kind.

Helen Burstin – NQF – Senior VP, Performance Measures

Right. And this is

Sarah Scholle – NCQA – Assistant Vice President, Research

The survey CAPs is more about the process than did they have an opportunity.

Helen Burstin – NQF – Senior VP, Performance Measures

Right. Much of the work on even the decision ... that second domain there is ongoing. In fact, it's actually less about really looking at the correlation of patient to provider, but more so, patient level of understanding of the process and patient's understanding of the major disease entities that they're facing and the major knowledge questions that they should face. So I think they're distinctly different than some of the items in CAP.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

How are we leveraging the EHR here?

M

Yes, that's

Karen Kmetik – AMA – Director Clinical Performance Evaluation

I'm losing the, like what gets in the EHR? Is it somehow we want the results?

M

Well actually, now I would actually point that to the PHR instead, so that's what I would read that red one, CAPs HIT supplement because I think that is true. I mean, we are already building a roadmap towards that in the MU stage one criteria. You'd love to, the end of the rainbow is really this information is acquired and used and displayed back to physicians to the PHR.

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Right.

Farzad Mostashari – ONC

So we had this discussion last time about whether patient entered observations through a PHR portal are inbound, in scope, or not, and we said it is in scope, and indeed it's part of, as Paul pointed out, the meaningful use roadmap.

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

Can someone update everybody on what the CAPs health IT supplement addresses?

Christine Bechtel – National Partnership for Women & Families – VP

It addresses— Sarah, you're there, right?

Sarah Scholle – NCQA – Assistant Vice President, Research

Yes. It has items about your ability to get into a patient portal to communicate with your doctor by e-mail, stuff like that.

Christine Bechtel – National Partnership for Women & Families – VP

A lot of it, David, is an assessment of is your provider offering you a particular functionality? Are they e-prescribing? Do they give you portal access? Is it user-friendly, things like? It's definitely something we should explore more. I mean, in my humble opinion, there are some great questions on there, and there are some questions that are just not mature enough, but there's some good stuff.

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

But was it intended that you would fill this out online?

Farzad Mostashari – ONC

It's a little Maybe we should make sure we can run through all of them. I think just being able to highlight at the level of patient experience, shared decision-making, either process or outcome, and end of life and advanced directives, I think, if we can get kind of our triplet for each of those seven or eight domains

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

Well, I guess, yes, that's fine. I guess what I'm asking here with this particular question on the IT supplement, what the domain appears to be is online service quality, online access and experience, which is a different domain than the one pretty much that we—unless you want to expand the concept of patient experience and have some sub-domains basically.

Farzad Mostashari – ONC

Yes.

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

So anything ... before we move off of patient and family engagement, just thinking very broadly about the heading, are we missing anything big in the ones Farzad just listed?

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

Well, did we answer Karen? I think it was Karen's question about how are we tying this to HIT.

Farzad Mostashari – ONC

PHRs, I think.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, Paul. You answered Karen's question.

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

No, I understand. Well, when we reviewed it, I didn't know that we made it a requirement of whatever tool we did, we advocated for.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It isn't clear to me how patient experience and shared decision-making are HIT sensitive.

Tripp Bradd – Skyline Family Practice – Physician

If I may offer, there's an excellent data point that is easily extractable and creates good discussion between the family and the physician or care clinician. It's an excellent point. I think that would be a good starting point there.

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

My answer to the question of HIT sensitive, I guess, Jim, is that the hypothesis is that a number of the features of HIT enablement, both clinical care and the patient's connectivity, will enhance the overall patient experience of the communication respect, care decision-making, technical quality, etc. that are part of the CAP's array. Similarly with shared decision-making, in theory, the patient by seeing their own lab results or being able to interact online with their doctors would have more, better-informed decision-making collaboration with their providers. Now maybe that's a false hypothesis.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I share your hypothesis, but I'm just concerned that it's at a little distance causally. So for instance, if we said patient access or patient communication or something that was more clearly HIT sensitive, I think the connection would be clearer.

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

One way I might propose, Jim, let's say by 2015 the measure read for advance directives is that it was not only accessible, but the patient could interactively update it online. What that gives you is clearly more contemporaneous expression of their wishes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Well, I think that advance directive is HIT sensitive by contrast with patient experience and shared decision.

M

Jim, what I'm hearing, just so we can kind of move on, I think you're asking us wisely to get one level deeper, as we specify and indicate what we think the instrumental device or metric would be that is HIT sensitive.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Right.

M

Not the ... concepts

Kalahn Taylor-Clark – Brookings Institute – Research Director

The way we've been thinking about it at Brookings is to think about what would be relevant to the provider at sort of an aggregated level like care experience, process, and satisfaction versus what would be relevant to the provider at the individual level, including functional status or patient preferences, which would include shared decision-making.

M

I'm not advocating any particular measure, but HIT has the ability to engage some of these patient-directed quality functions in a way that the paper world makes very difficult. Just to give you an example, when I was practicing at Partners, I had an icon that I could push to send a shared decision-making video to my patient. All I had to do was push the icon, and it was sent automatically, and with the return envelope. So I think the idea of putting it in an envelope myself or having my receptionist do it is a lot more intimidating, and harder to get me to do it. But I think you can automate file share decision-making using HIT in a way that you could never do in the paper world.

Timothy Ferris – Massachusetts General – Medical Director

David Blumenthal preempted me, but that put that measure in place at Partners. And we measure that on all our doctors, and it's pretty effective and pretty easy to measure.

Christine Bechtel – National Partnership for Women & Families – VP

And I would make the same exact analogy to patient experience that IT enables the data collection and display and use in a way that paper just doesn't.

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

Let me again just make a move on any last big missing big holes in this domain of patient and family engagement that you all want us to give more attention to?

Cheryl Danberg

Two things occur to me in listening to this discussion. One is I didn't hear anything about chronic care management and really working to take information coming out of the health IT system to help engage the patient in self management of illness, and I think that's a big gap area and a place where health IT can sort of empower that. Some of that can come through even in the near term sharing test results back with patients in a more immediate fashion, similar to what, say, Kaiser is doing.

W

Cheryl, the measures that are in CAPs that are under what we call shared decision-making, some organizations are using to call chronic care management. It just turns out that they're using the same measures.

W

And I was going to

Cheryl Danberg

Right, but I'm not thinking of them as asking the patient whether or not that happens, but I'm thinking of measuring whether any physician's EHR system is engaging in direct communication with patients about kind of management of their chronic conditions.

Christine Bechtel – National Partnership for Women & Families – VP

But, Cheryl, a lot of those are already requirements of meaningful use at the core. Right? So they're either a core or a menu set item, you know, patient education resources, access to lab test results. Those are already part of stage one.

Cheryl Danberg

Okay. So how do we pick up to the extent that the patient is really being engaged, because it's not clear to me that the current CAP set really fully captures that? I know in California, we've been testing a chronic care model, you know, that's an add-on to CAPs that really kind of gets more explicit about some of this. So I'm sort of seeing that as a gap area within the current CAPs context.

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

Let's note it for now, and we won't try to resolve it today, but a fair question that we'll make sure that whatever tools we embrace address the issue. Any other big domains that are missing from patient and family engagement?

Jacob Reider – Allscripts – Chief Medical Informatics Officer

I would vote or verbalize my vote that I think Tom has for the behavior change component, which I think is potentially quite powerful, under-leveraged. I'll give a tangible example in the context of David's example, which is, if I could gauge in some way or have a score of the patient's readiness for change, for example, the patients who are ready to quit smoking, or the patients who are ready to start exercising or enhance their quality of their diet, I might be able to then act on that to facilitate that any actions that would be a byproduct of that. As all of those of us who are primary care docs know, we spend a lot of time encouraging behavior change in the context of patients who are not ready. If we could focus that effort on patients who are ready, that would be wonderful. So assessing that readiness and then perhaps expressing it in the EHR

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

So this gets at a theme we haven't talked much about, but I think it's great to introduce it. Whether patient supplied data, clinical data, not just ratings or outcomes, is an opportunity here. For example, HRAs are a place where there will continue to be a lot of attention, and how do you capture health risk data from the patient and bring it into the clinical setting and the other setting?

Farzad Mostashari – ONC

That is, I think, a methodologic tiger team issue.

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

Yes. But as a concept for our matrix here, Farzad, it seems worth having at least a placeholder for now. Patient and family engagement includes capturing information from the family home patient into the care process.

Christine Bechtel – National Partnership for Women & Families – VP

And I think what was just suggested is actually that there's a gap around patient activation measures specifically. So we have patient experience, end of life care. The question is, do we add patient activation, which I like.

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

Let's hold that. I'm sure we will revisit this at some point. Let's go on to the population health category, which is ... public health in the way it's tabulated for us. I don't know, Farzad or Tom, do you have any background summaries from what the previous voting has focused on?

M

...population health.

Farzad Mostashari – ONC

Yes. I think the biggest discussion has been around effective preventive services, and particularly if you think about the ... secondary, tertiary prevention and thinking about measures that matter and the biggest burden and so forth. The cardiovascular stuff comes, you know, ABC, aspirin, blood pressure, cholesterol, smoking comes to the top, although certainly others have talked about immunizations and cancer screening as being other kind of usual suspects in this domain.

Tom Sang – ONC

The responses that I received from all of you focus on similarly preventive services and screening, as well as child development in terms of some of the, I guess, well child visits and looking at child development scores.

Farzad Mostashari – ONC

And then from the 6.2, the other thing that was highlighted there was not just bad behaviors, but healthy lifestyle behaviors as a measure concept.

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

Can someone comment? I know down on the list from the Gretzky appendix is the prevention index. A portion of 24 services is provided appropriately. That sounds like a nice way to summarize an awful lot of activity. What's the feeling from people who have looked at that as to whether there's a composite prevention measure that would get us ... easy ... given the applicability of different services to different populations? Is there a solution to that that we should be thinking about?

Farzad Mostashari – ONC

Is that one measure or 24 measures?

Helen Burstin – NQF – Senior VP, Performance Measures

That's actually one measure. We basically just looked around to see if there were any composite measures out there that might satisfy those needs. That was one that was put forward by one of the health systems, but there are other examples as well, so we can share that, the information on where there are composites of preventive services as well.

Farzad Mostashari – ONC

My point was that in terms of the burden of data collection and information needs to be in the system, information that the vendor burden for calculating it and so forth is an interesting issue about whether composite measures can be counted as being a substitute for parsimony on the measure concepts because that is an alternative approach certainly, but in some ways it really is 24. You'd have to be able to calculate 24 measures to be able to create the composite.

M

Exactly.

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

Well, if you go back to both parsimony, high impact, and HIT evidence, flu vaccination wins pretty big. It's an annual occurrence. It's an annual savings. It's an annual savings of lives. It mutates, as we all know, every year, and yet the same principles can be applied in every age group. Literally this does go obviously from infancy through old age. So that's a pretty decent kind of a thing. We also don't do extremely well.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I think, burden of illness, clearly childhood vaccination, I think childhood vaccinations would be the ones that we would not want to miss.

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

On the subject of whether a composite would substitute for parsimony, if the particular elements of the composite measure were fully HIT enabled, why would that add any burden? Couldn't the system automatically calculate everything as one measure?

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

Well, it's the numerators and denominators for each one of those different services. It's just harder in some cases.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Well, I would think, Paul, instead of doing it cross-sectionally, isn't the premise, and Helen maybe knows, to say for person X who is a male age 47. There's a set of preventive services that are preventative taskforce indicated how many of them were received or not rather than doing 24 cross-sectional measures and adding them up.

Helen Burstin – NQF – Senior VP, Performance Measures

Right. Yes, in my mind, that's

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It's the same thing. It's the same thing. You need the same data.

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

Right, but there comes a question. I guess the computational burden to the vendor.

M

The computation is trivial.

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

Right.

M

It's getting the data that's hard.

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

Yes.

M
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
...have 24 different numerators and denominators, it gets pretty tough.

Timothy Ferris – Massachusetts General – Medical Director

We have a 12-item composite of preventive services and are expanding it regularly, and we find that it is a very useful way to create parsimony with parsimony conceptual and measurement parsimony for the physicians without—it's not the same incremental IT work to add those because once you have the systems necessary to capture one of them, the incremental work to capture and report more than one is really quite small.

M
I would take exception to that. It depends on how you're doing it because if one preventive care measure is flu shots, capturing flu shot data is very different than capturing mammogram data is very different than capturing, I mean—

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

M
Yes.

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

M
So I'm not sure. I mean, I guess if you're thinking about it from the standpoint of, okay, if the doctor ... one thing, it's no harder to set it up to have them enter the second one.

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

Again, let's pause on sorting that one out for now, and think about conceptually are people wanting to pursue the concept of a preventive services composite?

Marc Overhage – Regenstrief – Director

I would be opposed to that for two reasons. One is that it's hard enough when you have to deal with them individually in terms of people understanding them and interpreting and acting on them. When you composite them, it adds another layer of complexity that I think a lot of providers have trouble dealing with, and it also means that you have 12 reasons or 24 reasons or however many in the composite to fail the measure, and that makes the work for a provider of figuring out what's happening a lot greater.

M
Marc, is your preference to identify whether it's flu vaccine or whatever number of two, three, or four individual measures that are reported?

Marc Overhage – Regenstrief – Director
Yes.

M
Also ... from a statistical perspective, you're going to have to factor in between and within measure variance on every one of those.

M
Absolutely.

M

Reliability gets shot.

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

I want to second what Marc suggested.

M

I want to third it.

Tripp Bradd – Skyline Family Practice – Physician

I'd only say that as a practicing physician full time, if you had a matrix to deal with, the carbon elements kind of get overloaded, as you mentioned. And starting with success with a few measures can lead to success with more, as people get experience.

Marc Overhage – Regenstrief – Director

And you may rotate them over time.

Farzad Mostashari - ONC

The one where perhaps many of those objections don't apply though is things like a childhood vaccination bundle where if you have systems in place for capturing immunizations, the composite measure of, you know, is the kid up to date on their immunizations is meaningful and can be intervenable as a bundle.

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

Right. I would agree with that. I think there's huge value in a composite measure if you're looking at it from the patient perspective. If you're talking about a preventive services bundle, that's really more of a provider centric perspective because presumably and, of course, depending on what goes into the bundle, there's no one person for whom all of those preventive services would apply. But if you're talking about something like what was just mentioned where it's a number of different things that should be done for the individual person, that's, in my mind, a great way to make use of the composite measure that does lead us to a patient centered measurement of quality, but also a potential parsimony on the measurement end.

Sarah Scholle – NCQA – Assistant Vice President, Research

We've developed a measure of that sort of well childcare, and we've actually had a lot of positive responses for people thinking about by age two not only are children's immunizations up to date, but are they up to date on all other recommended services for children of that age group, and we selected five ages that kind of represent different developmental stages for children and had a lot of positive feedback for those. But I do agree that it's not just one measure. It's five measures times six to eight indicators, so it is conceptually a lot of work. But I think that I agree with Eva that it's patient centered, and it allows you to say how we do an overall.

M

So just so I understand it better, Eva, and both of you, the construct of interest potentially is a patient centered view has how many of your patients have attained the right set of services, the desired set of services in terms of looking at the matrix. Instead of looking down the column of individual screening and prevention services, you're looking across the rows at each of the number of patients who have ... their needs meet. Is that the difference?

W

Yes, I think so, and there may be, and ... me not having looked into specifically what might be a good positive measure to try this with. But again, the patient centered view is what I think is valuable in the sense of can you really say you've provided top quality care if you've provided what that patient needed in four out of five cases. I'm not sure you can answer that question yes.

So if there are certain populations, I think Sarah's example of childhood immunizations and well childcare is a great one in the sense that every child should be getting all of that care, and I'm speaking broadly,

obviously, without specifics of any particular child. But I think that's a good way to look at the overall quality of care as opposed to this narrow, siloed view that we've got today, and move beyond that into the future that could really be enabled by HIT that should be easily calculated by an EHR. Again, it's an patient perspective, and the EHR can take a look at what's in that patient's record, what's appropriate care for that patient, and was it provided or not, all or none.

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

Aren't we talking about sort of a time horizon? I think we all agree on the goals, and I think some of us are expressing the emergence or lack of complete maturity of either the measures, the measurement system, or the workflow. All of those impact this, and aren't we basically saying it's just going to take a little bit longer than 2013 or potentially even 2015? I think that's all we're saying.

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

But I think, Paul, if that's the case, then if we can agree today or soon on the constructs of interest and whether or not we attain them by 2013 or 2015, we'll find out later.

W

Right.

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

But do we agree? What I've heard is that there's a child preventive services construct, which may end up being a set of individual measures or a composite. There's an adult preventative services construct, which we've debated a little bit whether it's a composite or a set of individual indicators. And we haven't talked yet about the cardiovascular proposal ... matrix.

Farzad Mostashari – ONC

Right. The one gap that would highlight there is the ability to assess and just get somewhat into risk adjustment, risk stratification, the ability to fine-tune the recommendations, whether it's for lipid control, blood pressure control, and so forth, by cardiac risk. I think that's ... gap, but being able to identify the appropriate level of preventive care based on the individual's tenure cardiac risk.

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

Right. I guess I'd go back to the time horizon and some of the challenges that Marc Overhage knows so well. It's the kind of data, and when you get into the qualitative data that's required by some of these calculations or determining the numerator and denominator in some of these measures.

Farzad Mostashari – ONC

There's some. There are risk calculators that don't require family history, for example. I think it's four data elements that are pretty readily captured in the set that we already have, but point taken that we have to be incremental.

M

Farzad, I'm not just totally with you. Taking the example of lipid control, and I know the comments in the chart talk about whether it needs to be risk stratified. Was your notion that in a perfect world, maybe later?

Farzad Mostashari – ONC

Yes. I mean, there are people here who I'm sure I know Tim or others who can speak more to this. But for example, the level of your LDL that you want control for depends on the level of risk.

M

Right.

Farzad Mostashari – ONC

And the level of risk can be calculated based on, I think, it's age, presence of diabetes, comorbid, and maybe one other data element, so if you look at the clinical guidelines, they are always expressed in terms of that, but we haven't carried that through to our quality measures.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Just agreeing with Paul that this is basically a time horizon issue. I think it's worth emphasizing the childhood immunizations are all the same kind of measure. It'd be much simpler. Of all of these, they are probably the earliest and might even be feasible for 2013 and probably represent the highest impact on preventable burden of illness.

Farzad Mostashari – ONC

Cardiovascular, in terms of preventing deaths, there's no question that aspirin, blood pressure, cholesterol, and lipids, smoking, any one of those four is in terms of years of life lost and so forth, and the U.S. is at the top.

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

Again, we have to go back to HIT sensitivity. What's your own criteria? What can it do? What can it do accurately and get the appropriate actions?

M

That's a good point. HIT makes childhood immunizations not quite easy, but almost, whereas before they were very, very difficult to time and get right.

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

Can we stay on the cardiovascular category for a minute and ask? I know that they were rated ... all four of the ones that Farzad highlighted. I guess we're going to contemplate some additional measures ... next year. It seems like making this risk stratification on elements of our work to enable us to do the cardiovascular risk models sensitive to the individual characteristics of the patient would be a big win if we thought it was a worthwhile result.

Helen Burstin – NQF – Senior VP, Performance Measures

I think part of the thinking here also is many of the measures you're talking about are already on the 2011 list, like childhood immunizations, blood pressure controls, some of the cardiovascular individual items. So the question was, well, what could be the next sort of major step up, so that was the idea of them saying, well, if you've already got most of the major preventive services, for example, on the 2011 list, is the next iteration of this bringing them to a patient centered composite? Or if you already have many of the cardiovascular risk ones, what's the next level up where HIT can really be brought to bear for significant improvement?

Timothy Ferris – Massachusetts General – Medical Director

Just to build on that a little bit because you used the work risk model, and I don't want to leave people with the impression that in order to do this, there's some sort of statistical modeling. This is about whether or not your HIT system has decision support that notifies you that some threshold has been tripped, either age or smoking category or lipid level, that puts a patient into a category where a change in the care is indicated. That's sort of the definition of clinical decision support from my perspective. Therefore, doing or measuring cardiovascular preventive service delivery, so secondary preventive service delivery according to risk stratification is exquisitely HIT sensitive because those are precisely the kinds of things that a busy clinician like me might skip over in the process of caring for patients.

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

Yes. Great point. Let me ask. Let's go back to buckets again. We've got something on child prevention, adult prevention, the cardiovascular bundle. We also have a broad phrase in here, public health. We have one or two elements in here about obesity, for example. How do people feel about whether we've got these buckets right at this point with three fairly well defined buckets with some debate yet to be had? What would you all want to do with other public health or obesity or nutrition or some other domains that are not explicitly in this first hierarchy? Or are you all happy if we just hit these three?

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

...development, prevention, and one of these cardiovascular?

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

I didn't put development on. I put childhood preventative services. We could come back to childhood development, which were some of the survey base measures. I think child prevention dealt ... cardiovascular, but feel free to

Sarah Scholle – NCQA – Assistant Vice President, Research

You could put the development as part of the child preventive services.

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

Let's take a minute and talk about that. How do people feel about putting the childhood development indicators on our priority list?

Sarah Scholle – NCQA – Assistant Vice President, Research

I guess I just want to be clear that the child preventive services could include the development domain.

Tripp Bradd – Skyline Family Practice – Physician

Can I ask how that would be measured and then extracted?

Sarah Scholle – NCQA – Assistant Vice President, Research

Well, there are two ways to measure it. One would be to look for parent reported information, you know, in the use of a standardized tool that's documented in the electronic record so that the parent is filling that in. The other way is to look to see whether the result of a parent reported tool is used, is documented, so one is the parent actually filled it in. The other is that it is captured. So it's not actually

Tripp Bradd – Skyline Family Practice – Physician

It's just whether it was done or not, right.

Sarah Scholle – NCQA – Assistant Vice President, Research

Right. I mean, you could have done or not, or you could have the results. And it's different from the development. Is the child at a developmental goal, which is really more of an outcome? I've put in sort of that bucket of functional status as opposed to here where we're looking at population health and seeing whether key preventive services and screening have been done.

Tom Sang – ONC

Sarah, but you can also built it into the template that's part of your workflow that pediatricians go through.

Sarah Scholle – NCQA – Assistant Vice President, Research

That's right, so that they could be asking those questions and documenting or it could be entered through a PHR. Is that what you mean?

Tom Sang – ONC

Well, during their well child visits, they can ask it during the workflow.

M

Well, actually, another workflow is Web based questionnaires prior to the visit, which is what we use from time-to-time.

Sarah Scholle – NCQA – Assistant Vice President, Research

Right. I was thinking more of having the family report directly through a PHR, Web based, or something like that rather than having a staff person ask questions. You could do that.

Carol Diamond – Markle Foundation – Managing Director Healthcare Program

I just wanted to jump in here and say that I'm struggling a little bit with some of the questions that were being asked and some of the discussion around would people prefer this or that or this measure to be added or, you know. My difficulty with this is that I feel like what we're going to end up with is a laundry list in each of these categories, and then they'll be refined based on current EHR capabilities or envisioned EHR capabilities. And going back to the sort of charge that I heard Farzad give us at the beginning of the call, it would be great if we could establish, in parallel to this discussion about measures, a set of criteria that speak to the impacts of the measure.

I like where Farzad was going in terms of if our goal is to reduce deaths, and there are four things that do that more than anything else, so to speak to the impact, that speak to their ability to address multiple pieces of the reflect arch that he spoke about. So sometimes measure may be or an area may be more highly ranked because it can address multiple objectives in the way that it's measured. I guess I'm just struggling with the arbitrary nature of preferences around some of these areas and would love to see us maybe out of this call, souse out some concrete criteria by which we can objectively look at them.

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

I think that was a theme we talked about early on in the call in terms of taking the – going back to the NPP original framework and some of the indicators that were proposed there as high level population level indicators of success in achieving better health outcomes and using them as litmus tests for whether the ones we're proposing operationally are instrumental to getting those population level goals met. So ... the example you and Farzad have used with the cardiovascular, reduction in cardiovascular related deaths is a great gross outcome indicators and whether we can use four, so it's the subsidiary indicators that we're talking about here as markers of progress is where we want to get. But obviously, unfortunately, we haven't made explicit yet what those broader sort of gross outcomes are that we're aiming at where the cart is a little bit in front of the horse here.

Carol Diamond – Markle Foundation – Managing Director Healthcare Program

Yes, I see, because it would also be good, in addition to just impact on health, it would also be good to have some criteria in this discussion around how much or how deep the measure or the area relies on the meaningful use of the EHR eliminating some of the sort of operational criteria that people tend to get into when they start to talk about the IT capabilities versus what the measure requires in order to be, you know, calculated.

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

Right. I definitely, from our conversation, even say I can hear us calibrating and oscillating between the mechanics of data capture and data management and the health outcome we're trying to get. We're going to have to keep working together until we find the right level we think we should be at for this program. Other comments responding to Carol's observation? No? Okay.

I know our time is going to start winding down, so where I was testing you all was the idea that we had child prevention, adult prevention, cardiovascular. Now we've raised the question of childhood development, perhaps measured by another mechanism. Any further comments on the priority for capturing that domain ... from the preventative services one whether they end up bundled or not?

Let me ask you again about the public health categories we haven't flagged in the last few minutes. There were some community health indicators, for example, that were on the master list in the report. We had ... category very broadly as an outcome measure, if you like.

Kalahn Taylor-Clark – Brookings Institute – Research Director

I thought that the community health measures were really important, but I wasn't sure if HIT was the way to go with those measures. I mean, I didn't think that we needed the HIT sensitivity was really there for those measures were necessary.

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

Anybody have a response to how we might achieve that, use the HIT sensitivity criterion to drive public health benefits?

Jacob Reider – Allscripts – Chief Medical Informatics Officer

I often will use and some on the call have probably heard me use or reference a framework that I've used for this, which is a formula. Priority equals value over work where value might be the public health impact that Carol was just describing, and work might be the HIT sensitivity or HIT readiness that we've brought up a couple of times. Obviously something of very high public impact, high value, but low work because it's HIT ready would be high priority, whereas on the flipside something of low impact, but infinite difficulty because we perhaps don't have the data or the HIT systems aren't yet ready for them would be lower priority. I found it to be a very useful concept and very simple because I'm so simple.

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

Where would that take you, that kind of analysis take us for purposes of the quality measurement gap analysis? Is that point ...?

Jacob Reider – Allscripts – Chief Medical Informatics Officer

What we might do is use a framework like that, and I don't mean to impose it so much as offer it. Take a model like that and say, okay. Let's look at the relative value, and perhaps use NPP as a guideline for that and say, okay, these are the priorities, a.k.a. values, and then we might look at the HIT readiness using something sort of like the Gretzky Report provided, so we might say this measure is HIT ready and, therefore, lower work. And that might allow us to create a fairly objective score for each of the quality measures that reflect a priority that contacts both how much impact it would have, but also how implementable it might be.

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

Do you think, when you talk about how much work will it be, I want to segregate. There's work to make a measure HIT ready, whatever that means, as NQF has been doing. The other and, I think, more important because it scales so broadly, aspect of the work is how hard is it to implement. How likely are you to be able to have the data and so on? So I just want to separate those two pieces of work, which are both important, but I admit that the making of HIT ready is the far less of those efforts.

W

I guess the point that I'm also trying to make is the importance of having that measure be incorporated in HIT readiness or sensitivity, incorporated in an EHR, for example.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I've been reading HIT sensitivity a little differently than that. While I agree with those points, there are some measures of quality that depend enormously on process redesign, on organizational commitment, buy in of the relevant actors, a whole set of things that have nothing to do with HIT. So some things—chlamydia screening comes to mind—are perhaps intrinsically not HIT sensitive at any stage of HIT development. I think that's at least part of what we're trying to get at is that there are some things that you just can't really expect the HIT to have very much impact on, whereas other things where some things are very hard for clinicians.

Patients maybe find them unpleasant. Maybe the evidence is controverted. For a whole set of reasons, putting in an HIT won't make very much difference. Others, everybody agrees that they're valuable. They're cheap. They're not objectionable to patients, and a reminder is likely to result in it happening like a flu shot or something. And I think that's at least one meaning of HIT sensitivity.

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

Well, our time is going to wind out here, so let's just see if we can get through two categories at least briefly. I'm hoping we can have a quick discussion on the domains for the patient safety domain and then also take a minute on the coordination of care.

On safety, we had in the Gretzky structure medication safety, healthcare acquired infection, BTE, and preventable hospital mortality, and then medication management and adherence. Let's just take the medication buckets first. Do people feel they want to retain those two domains of medication adherence

as one and medication avoidance and medication misuse as another? And toward our parsimony goal, where would you all put the highest priority in terms of medication safety?

Karen Kmetik – AMA – Director Clinical Performance Evaluation

Clearly medication adherence is an important issue in our country. I will say this is one area where I think we have to work with the tiger team pretty quickly or think about staging it. At least from my limited viewpoint here, part of this would be helpful as physicians are e-prescribing that they get data back on whether the prescription is actually dispensed. That could be the foundation for then working together with the patients on adherence. Jacob, you may have more information, of course, but from our anecdotal information, physicians are getting some of that, but they're not able to rely on it.

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

Right so

Jacob Reider – Allscripts – Chief Medical Informatics Officer

I would agree.

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

...some indicator of adherence based on dispense medications is desirable.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This would be an example where I would say that the ability to VTE prophylaxis, well designed order sets can make an enormous difference because that's typically the kind of thing the recipient says oh, my gosh. I almost forgot that. Thank you. And does it, and does it quickly, and is easy to do. Adherence strictly is enormously hard to change, and I'm not aware of any evidence as valuable as, you know, and as hard as we're working to get feedback on whether prescriptions had been filled into our EHR. I'm not aware of evidence, that knowledge of that has any significant impact on patient adherence to their medical regimen.

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

And partly it's because it's not presented well. The other piece is, it's still very spotty, including in California, that we get good, reliable adherence. So once you don't have good enough, then people won't even use it if they wanted to.

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

Again, let me ask the question for your domain prioritization ... details.

Tripp Bradd – Skyline Family Practice – Physician

If you can talk about rarely and absolutely inappropriate drugs in the elderly, I'm in an actual research process now with PPRNet on this. It's amazing the changes that have happened, the behaviors that have changed, and Darvocet is no longer, for instance, part of our discussion at all with our patients. In fact, that's helped us dramatically. I think, if we can get elderly people off of a lot of medications and then inappropriate medications, this would have a big impact. It's also HIT sensitive, as we found out, with PPRNet.

M

Right.

M

I agree, the appropriateness.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

With regard to the medication adherence, prescription drug abuse is a major issue for a wide range of age groups, and I think we need to keep that in mind. I notice it's not mentioned. And prescription opioid pain relievers, particularly as we have an aging population with people presenting for multiple pain

problems, you should be able to monitor that fairly effectively, particularly given their schedule and their tracked by a number of registries.

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

Going out one level of the hierarchy, other topics on safety that we've not at least flagged as a possibility for measurement? We've got the medications, the healthcare acquired infections, VTEs, and then we've got this broad category of preventable hospital mortality.

Tripp Bradd – Skyline Family Practice – Physician

How do you measure that in an outpatient EHR would be my question?

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

Well, we can segregate our work to both the hospital and the outpatient world.

Tripp Bradd – Skyline Family Practice – Physician

All right.

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

Any other big domains in safety generally that you all think we're missing? All right, so for the moment let's move on and check for a minute about care coordination. It's obviously one of the more challenging areas for us. The report gave us medication management and adherence, emergency department through care transitions and readmissions, and ER use.

Christine Bechtel – National Partnership for Women & Families – VP

Given the groundwork that stage one is already laying for medication reconciliation, I think we have to look closely at that domain.

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

Yes, and I would second that because that's truly something that's impossible without HIT. And while it's not easy with HIT, it just simply isn't possible without it.

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

I guess I would speak to that as well.

Tom Sang – ONC

I just want to point out to the group that we have five minutes left, so I don't know if you want to extend the conversation beyond 5:00.

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

Let's ask how many people have an additional 15 or 20 minutes to try to ...?

Christine Bechtel – National Partnership for Women & Families – VP

Do we need to do public comments though?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes. We can do that right at the very end for five minutes or so.

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

Anybody have a hard stop here in the next five minutes.

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

I do, but

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

I do.

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

Yes ... losing people.

Sarah Scholle – NCQA – Assistant Vice President, Research

I need to leave.

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

Yes. Because we have four or five categories still ahead of us, I assume we're not going to make, you know, we're not going to get done today, but I guess I'll be satisfied if we get the care coordination discussion done, then do our public comment, and then break and continue next time. Tom, can we live with that?

Tom Sang – ONC

Yes. I just want to point out to people that many of you have not returned your surveys back. So with this better and fuller discussion, maybe you can return some of your survey work, and I can put it in the matrix.

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

Great. Let's press on then. We had one comment about the care coordination sub-domains of interest on the reconciliation opportunity. Other priorities you all feel on the care coordination?

Steve Fong – HRSA/OHITQ – Medical Officer

Under the care coordination, the care transitions, perhaps we should flag or maybe be more explicit on one of the critical priorities that HRSA has been grappling with, and that is an effective measure for access to care or if there are any existing measures, effective measures that exist there for measuring access to primary care or specialty care. Now that may fall under the care transitions. However, I don't see any measures there. We haven't been very successful at finding good measures for that. We do feel that such a measure, if it does exist, would be HIT sensitive.

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

Can you say how you thought about so we all ...?

Steve Fong – HRSA/OHITQ – Medical Officer

Yes. Well, in some cases, in particular with the HIV and AIDS Bureau here at HRSA, they have an access measure, which looks at the time to a primary care visit after the diagnosis of HIV and AIDS. Now this becomes more complicated if you're just talking about primary care and when they enter the system. But perhaps even looking at the time a patient would enter even through their HIT and many EHRs or PHRs are allowing this where they can request an appointment, the time it takes to get that appointment, or even if we talk about care transitions, a patient who perhaps does not have a listed primary care provider or even a regular provider that is discharged from the ER when they receive their followup appointment with a PCP.

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

Other comments about the domain under care coordination that you all think we should try to capture?

M

How about identification of the patient centered home in the sense that even if you're a specialty doctor, you know who that person is, and the patient knows who they are? I'm putting that out for comment as much as anything else.

Christine Bechtel – National Partnership for Women & Families – VP

I guess I'd probably adapt that a little bit. One of the things, you know, there are a number of measures, some more meaningful than others that are in the matrix that we have from NQF already. But one of the things that came out of the care coordination hearing is the need to identify all of the members of a patient's care team broadly, not just who is the PCP, but figuring out really, who do we need to be

communicating with here. So I wonder. I know that that's not on the list, but I want to throw that out there also.

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

Kind of following onto that, the other thing that's not on here is a means of measuring both sending and receipt of information. I mean, a care transition really is dependent on at least two actors, if not more. It gets to the issue that Christine mentioned of identifying all of the members of the care team, even those in multiple facilities. It seems like that's critical, one, to really measure what we're after, but also it'll be critical when we get into things like accountable care organizations and holding groups of providers accountable for comprehensive care and coordinative care.

Timothy Ferris – Massachusetts General – Medical Director

I'd like to second that, and I think that it's particularly HIT sensitive in the way I think that term has been used to measure sending and receipt of information.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. Not to beat the dead horse but I think this is an area where we have to be really careful not to be constrained, as Carol talked about, about current capabilities of EHRs or information exchange. We were clearly in meaningful use stage one, but going forward, I think we need to think bigger in this area, which, you know, based on our research with patients is their number one pain point.

David Kendrick – Greater Tulsa Health Access Network – Principle Investigator

Yes. I was in Tulsa. This is a central tenant of our beacon approach and the major innovation we're applying.

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

All right, well

Sarah Scholle – NCQA – Assistant Vice President, Research

I want to echo that point about sending and receiving information is critical, and we've been at work at developing measures looking at the ambulatory side to look at that. But there's the next step is really can you tell whether there's some kind of agreement on an integrated care plan. We've been struggling with how to measure that, and I think that when we talk with the folks, that's a big issue. They want to know the information got back and forth, but then they want to know. Was there some sort of decision, meeting of the minds, that included the patient and the different providers that are involved?

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I agree with that completely, Sarah.

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

Given our time, I think what we should do is just pause the discussion here, and I wanted to give Tom a chance and Farzad to mention the tiger team opportunity so that people know what they're about to be invited to do, and then we'll go to the public comment. Tom, do you want to mention what we have in mind for this opportunity?

Tom Sang – ONC

Yes. I think what we'd like to do is have at least five tiger teams based on some of these domains that we talked about, and have perhaps four or five individuals volunteer, and you can send me, for all of you on the call, can send me which tiger team you'd like to volunteer for. I think some of the domains that we talked about: patient engagement, care coordination, safety, overuse, appropriate care. So we'd like to get started ASAP, probably over the next three to four weeks, and I'll send out more directions on this. On a separate, parallel process, AHRQ will be supporting ONC, and we'll work together on developing one or two tiger teams on a methodologic issues so such as the delta issues, the delta measures and longitudinal measures, and that we can invite other subject matter experts, not necessarily on the workgroup, but hopefully we'll get some more technical experts coming in, so that's the plan.

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

Dr. Blumenthal, if you're still on, do you have any other comments before we go to the public?

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

No. I've been following this closely. I think, as we dive down into the details, we'll wander around a little bit. We will have to come back to impact to talk about care coordination. I was thinking about that especially because there isn't sometimes a clear link ... coordination and outcome we care about. And ... measure the outcome, you may force the coordination, so that's just some random thoughts. But we appreciate your time and careful thought, and we'll have plenty of time to revisit

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

Good. Thanks, everybody. Judy, could you ask for the public comment?

Judy Sparrow – Office of the National Coordinator – Executive Director

Operator, could you open the line for the public if anybody cares to make a comment?

Operator

We have one for

Judy Sparrow – Office of the National Coordinator – Executive Director

Please identify your name and organization, please.

M

Yes. This is Adidia ... from Infinity Incorporated. My question is related to quality reporting. The quality measure, NQF 0038 is one of the alternate core measures. It has 12 numerators that need to be reported separately, as retooled by the quality firm. The 2009 PQR XML file format that HITECH requires where we generate has only room for one numerator per measure, so we cannot figure out how to use that file to generate a PQR XML file with all those 12 numerators, and we're not even sure if this is the right workgroup call I should be on to ask this question. I didn't get a response back from anyone else. If you could pass this information to any responsible entity, I'd greatly appreciate it. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you for your comment. Anybody else?

Operator

Yes, we have Shelly Spiro.

Shelly Spiro – ASCP – President

Good afternoon. My name is Shelly Spiro. I am the director of the pharmacy EHIT collaborative. It's a newly formed collaborative of nine national pharmacy associations. The collaborative is focused on insuring that technical standards are aligned with the nation's growing need for all-inclusive clinical services provided by pharmacists in all practice settings. The services provided by pharmacists, especially medication therapy management, are integral to the providers using the electronic health record in a meaningful way. Pharmacists play a key role in the prevention of adverse drug events and medication reconciliation to assure medication are safely used in all practice settings.

The pharmacy practitioner electronic health record has been developed through the standards organization and, in the near future, will be going through the certification process. Pharmacy practitioners have the ability to move past this record keeping aspect of prescription processing to providing a full integrated, clinical electronic health record. The pharmacy practitioner electronic health record will integrate with other providers' electronic health records and even the patient's personal health record to assure that the practice improvements provided by pharmacists related to safe medication use is achieved. The pharmacy EHIT collaborative is ready and willing to assist the quality measurements workgroup with the next stage in meaningful use and the quality metrics, especially as it relates to the prevention of adverse drug events and medication safety. I'd like to thank you for listening to my comments.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you for your comments. Any other comments?

Operator

There are no comments left.

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

Thank you, everybody, for making the time today and all your great suggestions and ideas. We'll try to document it and get back to you, and we'll talk to you again fairly soon.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you.

Public Comment Received During the Meeting

1. Several committee members have mention the Gretzky report, Is this something you can post a link to on the ONC website or can you include the ink in the meeting minutes...thank you.
2. The quality measure NQF 0038 has 12 numerators that need to be reported separately. The 2009 PQRI XML file format has room for only one numerator per measure. How is an EHR supposed to submit such measure calculations that have multiple numerators?
5. How about a roadmap or diagram of the proposed process?
6. Please post to the web site when the final version is available - NQF 6.2 voting. Thank you.
7. You guys have really been doing a remarkable job with keeping everyone informed and making these meetings so accessible - HUGE KUDOS!!!
9. Is the Gretzky report referenced in this meeting available for public review?
12. I would like the committee to take into consideration the documentation burden that the quality measures put on clinicians. The current hospital measures for Stroke and VTE for MU require a large burden for documenting "exclusions" due to snomed requirements. Snomed is not written in physician/clinical friendly terms and require a high level of specificity.