

**Meaningful Use eCQM Subgroup**  
**Draft Transcript**  
**November 29, 2011**

**Operator**

All lines are bridged Ms. Deering.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Thank you very much. Good morning. This is Mary Jo Deering of the Office of the National Coordinator for Health IT and this is a meeting of the HIT Policy Committee and specifically of the Meaningful Use Workgroup's CQM Subgroup. I will take the roll, but I will remind people that this is a public meeting, there will be an opportunity for public comment at the end and I would ask all speakers to identify themselves. So, now I will take the roll. Paul Tang?

**Paul Tang – Palo Alto Medical Foundation**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

George Hripcsak?

**George Hripcsak – Columbia University NYC**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Marty Fattig?

**Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

David Lansky?

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

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Christine Bechtel?

**Christine Bechtel – National Partnership for Women & Families**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Art Davidson?

**Arthur Davidson – Denver Public Health Department**

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Marc Overhage? Joe Francis? Okay those were the only ones who were officially on my list. Are there others who would please identify yourself? Josh Seidman?

**Josh Seidman – Office of the National Coordinator**

Yeah, I'm here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Allen Traylor?

**Allen Traylor – Office of the National Coordinator – Meaningful Use Policy Analyst**

Yeah, I'm here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Any other ONC staff? Okay, I'll hand it over to you Paul.

**Paul Tang – Palo Alto Medical Foundation**

Thank you very much Mary Jo and thank you everyone for attending this meeting. I think that our main agenda here is having, you know, had our last discussion and came up with some attributes of desirable clinical quality measures both in the strategic area and technical area that we would come up with recommendations that we would be making either to the Quality Measure Workgroup that David Lansky Chairs or the broader HIT Policy Committee unrelated to ONC and CMS. As you know, when we had our hearing the quality measures rose to the top as the most challenging criteria or qualification criteria for meeting Meaningful Use or qualifying for Meaningful Use, sorry. And so we established this small group to take in all of the feedback and see if we can't come up with a set of recommendations that would improve upon that for Stages 2 and 3.

So, what I did was took that list that we had and came up with just sort of example recommendations and these are just something that I did by myself and so they're merely there as examples that we can try to work on some or propose others, but by the end of the call would like to have a set of recommendations that we can go back to the Policy Committee and share that with them and get their feedback and then allocate it appropriately between the Quality Measure Workgroup and potentially going onto CMS and ONC as they prepare for the next round. Any questions about that or comments?

Okay. So maybe what we can do is sort of go through this. So, first of all does it make sense to sort of look at some of these draft example recommendations and comment upon them, throw them out? Edit them? Suggest others? Does that make sense?

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

Paul this is David. I have just a thought, which first answer is yes, I think it does, but when I started looking at the list and grouping them into some categories, which at least helped me think what was there and what was not there yet, and also cross-walking back your proposal, which I liked a lot, to the attributes detail you developed earlier, when we talked about the call. So, just off the top of my head, but this also needs some thinking, I thought there were at least four categories of bullet points if you like or recommendations that you mentioned. One was I just called them attributes of individual measures, many which are in the technical attributes list you had shared earlier.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

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

Secondly where measure selection criteria, which has now become almost a term of art that NQF and others were using and the MAPs are using and maybe it's worth it. We think about measure selection

criteria, which addresses the first recommendation you made, and also addresses...set or what the bundle of measures would look like for a given type of participant and program, and with that, if we do that...you may want to cross-reference with some other established measure selection criteria like those used by NQF in their recent MAP work.

The third bucket I had was what I would call utility of measures or reporting of measures and there are some features you have on your list and then some that are implied by the previous list like use of feedback, stewards and so on. And then the fourth category I had was certification and technology requirements, which is sort of implications to vendors or future of the measures as it pertains to implementation through vendor products. So, maybe that's not the right list but then I took those four buckets and put your proposals into those, as well as some of the attributes to kind of flush out the set a little bit.

**Paul Tang – Palo Alto Medical Foundation**

So do you have the list of examples and/or do you want to go ahead and clump them or cluster them so we can talk about them that way?

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

Well, I haven't worked out the clumping specifically so I'd have to do that on the fly. But maybe look to see if people want to pursue this clustering of recommendations. I can imagine if we do go down this path we could have the recommendation letter say we have recommendations in four or whatever number of areas and here's exactly a mention of those four areas generally and then obviously the details that we want to bring to it.

**Paul Tang – Palo Alto Medical Foundation**

Okay. What do other people think?

**Christine Bechtel – National Partnership for Women & Families**

Paul, it's Christine Bechtel, I hate to ask like a really basic comment but since this is my first call I'm digging for like material that would lay out the criteria that David is talking about. Did I miss them?

**Paul Tang – Palo Alto Medical Foundation**

That's what we were talking about earlier. Let's see. Yeah, actually, so the list of example recommendations that Mary Jo sent out last night also has, below what we call the attributes both strategic and technical attributes and that's what we're referring to.

**Christine Bechtel – National Partnership for Women & Families**

All right. I'm going to look again and see if I have them.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Christine, just scroll down through the message that I sent at 11:44 yesterday and it's basically below, it's another message that preceded it.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, I don't have anything from you, so if you have a sec just forward me. I don't want to take up everybody's time, but I don't have an e-mail from you for some reason.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Yeah, that's interesting.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Just, if you wouldn't mind sending it to her again, Mary Jo.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Sure will.

**Paul Tang – Palo Alto Medical Foundation**

Anyone else have comments on the four categories that David talked about? So one way to do it perhaps is do it on the fly as you mentioned, David, so we can go through some of these recommendations, obviously come up with others along the way and sort of be triaging them amongst the categories. Does that make sense?

**Arthur Davidson – Denver Public Health Department**

So, Paul, this is Art. David could you just run them by one more time?

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

Yeah, my groupings were, the first one was attributes of individual measures. The second was measure selection criteria, meaning incentive measures. Third was utility and reporting of measures. And the fourth was certification and technology requirements.

**Arthur Davidson – Denver Public Health Department**

Okay, thanks.

**Paul Tang – Palo Alto Medical Foundation**

Okay, so just to get us started why don't we just look at the first example recommendation and that really is to endorse what the Quality Measure Workgroup recommended to CMS, a number of months ago now, and that is that there is some core, you might remember the diagram that had a circle and then an outer ring of six different domains. So there is some sort of core measure, you know, that's sort of the model we've had in the past. And then there's a menu option that you must take one or more from each of those following six domains. And I've listed those for you. And this is basically saying, hmm that on looking at after getting the feedback, etcetera, this still seems like a good approach. Do you want to add anything to that, David?

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

Well, I think that since the Policy Committee has already endorsed this premise in a previous letter, I think, this as you just said, Paul, really after receiving the feedback from the initial experience in Stage 1, we still believe this is a workable framework.

**Paul Tang – Palo Alto Medical Foundation**

Right. And it's partly to address one that they're be some local flexibility, that there be flexibility, those kinds of things. So, there are a lot of things that came up during our hearing that re-enforcing this approach, this core plus menu approach and making sure that we cover the gamut is a good one. So, yeah, it wouldn't be a new recommendation but it would be useful feedback if we all agree that the feedback we had fits in the proposal we made.

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

And I agree with Paul, having, what you discussed as just sort of some of the rationale, but that the merits of this proposal in light of the feedback we've had included that it still provides for local flexibility and outcomes orientation and that sort of thing.

**Paul Tang – Palo Alto Medical Foundation**

Other people's thoughts? Does it seem to match up? Are we still absorbing that? Should I move on?

**M**

Yes, I think that sounds good, Paul. Thank you. Go ahead.

**Paul Tang – Palo Alto Medical Foundation**

Okay. The next one has to do with, so one of the underlying themes I think of the feedback was, gosh, the vendors under the time constraints seemed to try to hardwire some of these measure definitions into their systems. So, you can understand how that would be done under the pressure of time, you wanted to get certified...to be able to do that. Inadvertently that means that you are stuck with a measure and as the measure evolves well you've got to take another rev of the release of the entire system versus let's say just a new measure getting plugged in.

So, this may not be a good way of, you know, the best way to state this, but the goal was is there a way that we can create criteria that would have vendors create a platform for accepting these measure plug-ins, so that as measures change or you get new measures you can plug that into an existing platform or you can yourself localize some kind of, well I don't want to encourage that's a lot, but you may localize where the data element in that definition are drawn from. But to give it more flexibility and less need to upgrade an entire system just because a measure perhaps is not programmed correctly. So there's sort of a flexible platform unto which we can put plug-ins for measures to allow them to be flexible and allow them to evolve over time and to allow new measures to be inserted without telegraphing the whole system. Was that clear enough in terms of trying to explain what I was trying to get at?

**Arthur Davidson – Denver Public Health Department**

Paul, this is Art, I think this is clear. I'm just wondering do we have an example of vendors who have been able to achieve this?

**Paul Tang – Palo Alto Medical Foundation**

Well that's a good question. I don't know off the top of my head whether there has been any vendor that has achieved it, but I just don't know, it doesn't mean that it hasn't happened already. I think vendors would like to achieve this as well because it certainly has been a challenge for them as well.

**George Hripcsak – Columbia University NYC**

Well, this is George, in theory someone who uses something like Arden Syntax could design measures that put out reports. So, I mean it is feasible, whether this is for Stage 3 then they do have some time to implement it.

**Paul Tang – Palo Alto Medical Foundation**

Do people think this was, this kind of a requirement, this kind of a goal would address many of the new challenges that we heard about in the hearing? It's a reasonable technical approach and this has addressed a lot of the challenges we heard about?

**Arthur Davidson – Denver Public Health Department**

Well I think it addresses, this is Art again, I think it does address those issues and it would set a stage beyond Stage 3, a method beyond Stage 3 by which quality measures could continue to be implemented. I mean, we're not looking for the hard path down the road. And this seems to be an effort toward that.

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

I think it's an excellent proposal, Paul, and my only hesitation I guess is that maybe going through staff and maybe Judy or others we should do some validation of exactly how to state this in a way that the industry finds feasible. Then I think that we should try to put some pressure on the industry to go down this path and then obviously be cognitive of whatever the technical issues and requirements would be to do it.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Well that sounds like a fair idea. So you said two names, I couldn't understand you. I don't know whether other people were having the same problem, but your voice was a little bit muffled. I don't know whether there's a setting.

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

Yeah, sorry, I was thinking that really Judy and Charlene and obviously the staff could help us within the next few weeks to validate whether this is feasible or how to state it in a way that is most likely to be workable.

**Paul Tang – Palo Alto Medical Foundation**

Right. Okay, so feedback on it. So the concept we agree with, if we can find a way to word it so that it's understandable, I mean more clearly understood, that will be good. Other comments? Does this seem like the right direction?

**Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)**

Paul, this is Marty. I really think it is the right direction, if vendors can store the data needed for the numerator and denominator of these measures as individual data elements in say a sequel database, it's just a process of pulling those elements and performing the calculations. So, it's actually, you know, pulling those data elements out and it would be interesting to see if vendors can accomplish this.

**Paul Tang – Palo Alto Medical Foundation**

One of the things that they mentioned, the panelist mentioned is just the fact that vendors programmed the calculation a certain way and then people essentially had to change workflows to meet the way that the vendors decided to pull the data. And could vendors instead say let's talk about blood pressure and the organization decides "hmm which blood pressure data field did they use in their workflow" and plug that in instead of it be predefined, that's an example of some of the flexibility that seems like it would address a lot of those things that we heard about. So, I think that's where all the time and effort and consternation came from, as well as through the feedback.

**Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)**

Well, I hear you saying that, Paul and so that gets back to this local ability to search for a particular variable for a CQM, like you say in blood pressure. I was thinking more about this as a tool for which new CQM measures would be more easily implementable.

**Paul Tang – Palo Alto Medical Foundation**

That too. It's really both.

**Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

So, if there's a tool to essentially define the CQM then you can imagine how that each site can adjust the data elements that are used to satisfy the CQM definition based on their local work flow, and use that same tool to write new, let's say, quality improvement measures. These are things that they can create themselves. They don't have to use standards, it really addresses priorities in their local organization or market and that's separate from public reporting measures that are essentially defined, at least the definitions are constructed centrally. Where you pull the data from and can still be localized.

Okay, so it sounds like we're on the right track. We've got to find a way to word this clearly and also give feedback on, you know, what makes sense, how to encourage the development of a, sort of a CQM platform. Okay.

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

Paul, it raises two other questions for me that are may be related or imbedded. One is the Query Health work and whether this sort of opens the door to more of a federated query model and a little bit of what I think maybe Marty was suggesting that it's not necessarily the case that the EHR product itself does the calculation especially for the more complex measures and I don't think we have to address that specifically in this numbered recommendation, but as we get into this a little further it may raise kind of a distributed reporting architectural question that we may or may not decide to speak to. And the second implication of this one is the whole longitudinal multi-setting measures question and whether the capability of this recommendation prescribes for an individual EHR has some implication as you roll it out

to say a longitudinal measure, which we speak to later, and whether, you know, data point one and data point two are coming from the same technology platform. We probably are beyond Stage 3 but we just may want to speak to it at some point in these recommendations.

**Paul Tang – Palo Alto Medical Foundation**

Good point. I think this one is compatible with Query Health for example and also that's recommendation 8 which deals with the noncertified system. Your point about the longitudinal measure is a separate one that also is partly addressed in draft recommendation 7, but anyway, good point.

**Arthur Davidson – Denver Public Health Department**

So I think it may be compatible with Query Health but that's not our intended target at this point is it?

**Paul Tang – Palo Alto Medical Foundation**

No, no. It's just a matter whether, no, it's another option that's just compatible.

**Arthur Davidson – Denver Public Health Department**

Yeah, it would make it more complex to implement. What I'm trying to grapple with here is going back to George's comment, you know, if there were some sort of like Arden Syntax that were imbedded in the product how could it receive a CQM from NQF lets say and implement that with relatively little investment of time and effort from the local site, forgetting about Query Health. I think Query Health is a good thing; it's just that it's a big enough problem just to solve that first piece.

**Paul Tang – Palo Alto Medical Foundation**

So actually just to respond to your question, you could imagine, it's a combination of the definition provided by NQF and the filled out quality data model. So, the definition is basically text in some code sets, but just the whole notion of what standardized data elements in what work flow context, those are kinds of attributes that in theory are specified by this quality data model. So you imagine with the combination you could better achieve what you were suggesting, Art, which is, I think, something really plug and play into multiple EHR systems. But you need a lot more than just the text definition that's sort of the problem we're running into.

**Arthur Davidson – Denver Public Health Department**

Yeah, I mean you have to take that text and then convert it into some computable process.

**Paul Tang – Palo Alto Medical Foundation**

And that's the goal of what NQF's tool is. NQF is also developing, they're calling it an MAT Measure Authoring Tool. So that Measuring Authoring Tool uses some of the data elements that are specified in the QDM Quality Data Model and it's out some kind of, in theory, computable definition. Something that can be, again in theory, consumed by an EHR.

**Arthur Davidson – Denver Public Health Department**

So does the Measuring Authoring Tool provide you with some program that can run?

**Paul Tang – Palo Alto Medical Foundation**

It doesn't provide you the program but hopefully provides you the definition in the standard output.

**Arthur Davidson – Denver Public Health Department**

Okay. So still the vendor is going to have to figure out how to take that and operationalize it within their EHR.

**Paul Tang – Palo Alto Medical Foundation**

Correct, but if the output of that MAT was standardized at least vendors would have a fighting chance of saying "oh here's a measured definition in standard form using standard data set and data elements and standard value sets" they would have a much better chance of being able to consume that and calculate that in their own system.

**Arthur Davidson – Denver Public Health Department**

And are we thinking that the platform in the EHR would be to accept an MAT input?

**Paul Tang – Palo Alto Medical Foundation**

The output of the MAT? I mean, you know, that's one example of how that can be done.

**Arthur Davidson – Denver Public Health Department**

Okay. Thank you.

**Christine Bechtel – National Partnership for Women & Families**

Paul?

**Paul Tang – Palo Alto Medical Foundation**

Go ahead.

**Christine Bechtel – National Partnership for Women & Families**

I was going to build on this but also go in some other direction. So, did you want to finish your thought?

**Paul Tang – Palo Alto Medical Foundation**

It's just to have this recommendation stimulate that kind of discussion. So you can imagine, well if people all thought it was a good idea, if the provider organization thought that's the kind of thing I'd like, if the vendors say yes that would help us all as well, then perhaps ONC or CMS could convene, I'm just making this up, a meaning that would bring all the stakeholders together and say, hmm does this seem like a good idea and sort of design this architecture. One example of that is this whole NQF sort of effort.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, I agree with that approach and I was actually thinking, this is Christine, I was thinking a little bit about process which is, you know, sort of what happens to these recommendations because it seems to me that there is a lot of work that's been done, as you all know, and many of you have been involved and around sort of categories of measures and national priorities and measure types and things like that, but where the real, I feel like anyway, where the real gaps are, are in the sort of technical components. The first being exactly what you and Art and David are describing now, that kind of how do we get to like a plug and play thing where it just is easy for people to have a way for their EHR to calculate measures and update measures, and retire measures, and change the specs on measures, and everybody's got the same measures, you know, at least the, you know, specs. I think that's an area where we really need progress and the other area I think is what David was alluding to and Paul I think you said it was in part of recommendation 7 which is the ability to do longitudinal measurement across multiple settings of care where you have people feeding a data set.

And so I guess I have one comment and one question. The question first is really about our own process. So if we were to really hone in on a set of recommendations in those two areas for example would it make sense either for ONC to convene and really make some progress or if they can't do that would it make sense for this Workgroup to convene kind of in the way that the Privacy and Security Tiger Team really gets down into the weeds and kind of figures things out and makes pretty detailed recommendations about who needs to do what. I mean, I think this is such an area with acute need to move around the technical capability of information exchange and measurement that this is something that I would think would be smart to give some pretty thoughtful consideration to the process that's going to move those dimensions forward. So that's my question and then I'll hold my comment for a second.

**Paul Tang – Palo Alto Medical Foundation**

Well I think that's an excellent challenge, Christine. So we can perhaps work and Josh you might have an idea of who we could ask the question to, it may be Patrick Conway, saying how do we move in this direction? Because I just can't think of any stakeholder who wouldn't be interested in this kind of result and so what's the best, do we hand off this recommendation and then lets say HHS funds this convening, you know, convenes this meeting to jump start it or is it do we need to do a little bit more work as you suggested in the Tiger Team?

**Christine Bechtel – National Partnership for Women & Families**

Yeah or if HHS doesn't have the bandwidth or the capacity to fund it or to organize it, you know, at least sort of separately, you know, we have done lots of hearings and work sessions before in the Policy Committee, so I don't want to take that idea off the table just because something has to move here.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**Christine Bechtel – National Partnership for Women & Families**

So, yeah I agree.

**Paul Tang – Palo Alto Medical Foundation**

I like that.

**Christine Bechtel – National Partnership for Women & Families**

Yeah I think this is great.

**Paul Tang – Palo Alto Medical Foundation**

Yes, go ahead.

**Christine Bechtel – National Partnership for Women & Families**

Well I was going to go onto my comment. Is that okay?

**Paul Tang – Palo Alto Medical Foundation**

Go ahead. So it sounds like there's a lot of energy around this, let's figure out how to even be proactive and start the ball moving.

**Christine Bechtel – National Partnership for Women & Families**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

And what's the best way to do that.

**Christine Bechtel – National Partnership for Women & Families**

Right.

**Paul Tang – Palo Alto Medical Foundation**

So we can follow up on that.

**Christine Bechtel – National Partnership for Women & Families**

Great. So, I wasn't on the original e-mail train but I am now. So I have read through the example recommendations and I just wanted to suggest one thing which is that we distribute to folks the measure selection criteria that the MAP has used because I am a little bit, not that that's the end all/be all, but I'm just worried that we have MPP, we've got MAP, we've got us, we've got the larger Quality Measures Workgroup, we've got AQA and HQA, we've got so many people doing so much stuff in this area that the more alignment we can achieve the better. When I look under number one at the Quality Measure Workgroup 6 areas, which were done, you know, before the MAP, there's actually a really great degree, but not perfect, degree of alignment with the National Quality Strategy priorities. There's only one area that doesn't fit and so I wanted to give some thought of, if we distribute the MAP criteria a lot of them are very, very similar to what we are proposing here but the advantage is, I think of the work of this group and then the unique contribution, is the stuff around how do we get the technology to enable this kind of thing.

So there's a couple of things in the MAP measure criteria that I think are important. One is the addressing of the National Quality Strategy priorities. The other is addressing high impact conditions. There is another around alignment with program attributes and obviously for us that's Meaningful Use but

it's also ACOs and other things that we know are important and I think are reflected in some of the e-mail criteria. And then there's, you know, enabling measurement across an episode of care, there's the focus on health disparity to focus on parsimony. So, I mean, I think it might be worth circulating. I don't have the final version, but I know that we can easily get that, to see if we want to actually kind of use that as a starting point for some of these or just say look this is a given but then really what we need to do in terms of our example recommendations are to focus on the ones that are like so number two, number, where are we? Six, seven where there's a technical dimension to them, eight, things like that. So that we really focus where I think no one else is focusing.

**Paul Tang – Palo Alto Medical Foundation**

Well, I think those are great comments, Christine, and actually I think that's exactly what we intended with this. So it's almost by design and not accident that the quality measurements, the 6 domain areas overlaps substantially with the work of the NQF, whether it's the MPP or the MAP or the National Quality Forum, NQF came afterwards, but they're all quite closely aligned. So, that's by design and I think what we are trying to do is exactly what you said which is to focus in on the things of how can the HIT system contribute to the alignment and the less burdensome calculation of some of these.

**Christine Bechtel – National Partnership for Women & Families**

What I think I'm saying though is it's just like how the vendors and clinicians say, you know, look, when you give me a measure set it's the same measure topic but you've defined the specs slightly differently.

**Paul Tang – Palo Alto Medical Foundation**

Right.

**Christine Bechtel – National Partnership for Women & Families**

And that really throws a wrench in things and I feel like under our number one example recommendation we're doing the same thing. We either have to, you know, I think the National Quality Strategy which has nothing to do with the MAP, but did come after the Quality Measure Workgroup, it's kind of an important thing to align with like exactly not like close. So, I just want to suggest that there are a number of these recommendations that are probably less technically related unless I don't understand them, which is entirely possible since I am new to the call, but about, you know, measures that matter and things like that, that I think might be already present in like the architecture of the MAP recommendations. So, I just think it's worth circulating and so people could decide, oh, yeah let's just say that's a given and we are aligning with the quality strategy and we're going to take this and that and be consistent and then really separate out a very laser-like focus on the technical aspects that we need to enable because nobody else is. And then from there go to okay how can we really get the ball moving. Do we need to do hearings, do we need to convene a work session, blah, blah, blah. So that's my two cents.

**Paul Tang – Palo Alto Medical Foundation**

I think we're in agreement. David, any further comments from the perspective of the QM Workgroup?

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

No, I think appreciate the direction Christine is going in. I think this is very consistent.

**Paul Tang – Palo Alto Medical Foundation**

Yeah. Okay. Shall we move onto the other examples? Okay, so the number three, you know, came up in our discussions about how do we make sure that the measures that pop out are meaningful to consumers who are increasingly going to need some information in order to make their choices, whether it's about the health plans or providers, or hospitals measures that matter and are understandable by consumers. So that's just sort of an attribute but it's one that has not necessarily been a high priority or a focus for many of the people developing measures and that's something that has come up in our hearings and other advisory committee hearings like NCVHS. Do you think that's something we should include in part of our recommendations or sort of done elsewhere kind of thing? Comments?

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

Paul, I think it's really valuable. I'd certainly advocate for it. It seems to me it opens up other similar features that we should think about. This goes back to the issue of both in visual measures criteria and...criteria and how you have a set of measures that provides how you, in this case...as I've said before these goes a little bit out of our jurisdiction to take on all of broad issues of quality measurements and agencies and so to me it's a little different. It needs a little bit of thinking how to fold the stack on our particular...of leveraging EHRs and support quality. So I haven't got it clear in my head but that's the challenge I feel.

**Paul Tang – Palo Alto Medical Foundation**

So one of the areas that I was thinking about in sort of writing this in context of what we heard is that we might be one of the folks that are thinking about what are the other ways of gathering data and in our sphere, HIT, not only have we talked about the EHRs we've also talked about for example PHRs or patient portals and that opens up a new way of gathering information and displaying back the measures that matter to consumers back to them. Do you see what I'm saying? So it's not work that we would do and I agree with you it's out of scope, we don't develop measures. We don't even endorse measures. But from a technology point of view we can actually support new ways of gathering information, gathering data that feed into measures, you know, like functional status and ways to display it back.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, I agree, Paul, with that. I mean, it's like sort of hard to argue against something that says, you know, let's have measures that matter to consumers, but I agree with David that it is, and this was the tension that I was trying to point to because a lot of these seem like a mix of kind general measure attributes that lots of folks have tackled before and very, you know, more specific to EHRs. So, I think that where you're headed is a really good idea in that we should revise this one to say CQM should include measures that, and I don't know if it's the CQM or HIT should enable, right? So we need to have EHRs should be enabled to collect patient reported data for the purpose of quality measurement.

The other piece of this that I was thinking that relates to consumer facing stuff is being able to get a measure reported out of an EHR for public reporting, right? And I don't know, I guess my fundamental question is are these recommendations really designed to be about attributes that EHRs and information, you know, technology broadly like HIE need to have in order to support effective quality measurement or is it about what are the kinds of measures that should be in Meaningful Use, because those are two very different questions.

**Paul Tang – Palo Alto Medical Foundation**

...

**Christine Bechtel – National Partnership for Women & Families**

Go ahead.

**Paul Tang – Palo Alto Medical Foundation**

Different questions but one asks for the other. So, for example, by choosing a CQM that measures functional status as reported by a patient that is a CQM that CMS could choose.

**Christine Bechtel – National Partnership for Women & Families**

Yes.

**Paul Tang – Palo Alto Medical Foundation**

That would imply, well gosh I need to have a mechanism, it's probably going to be through a PHR that collects information that makes it visible both to patients and to providers. Do you see where I'm going? So that's what it's doing.

**Christine Bechtel – National Partnership for Women & Families**

Yeah. Oh absolutely. I just was trying to get an understanding of this Workgroups charge. Is it really about enabling the technology to deliver on these things whereas the Quality Measures Workgroup has already done some work of identifying categories of measures that could be in Stage 2? Are we trying to

replicate that or are we really trying to focus on how the technology needs to enable those things, in which case I would say yes, absolutely, you know, what you're talking about is right which is the recommendation is around patient reported measures, but I guess my question is it within this group's purview to be saying so therefore you should in Stage 2 or 3 or whatever include functional status as a measure, or are we trying to really prepare the groundwork for making sure that whatever measure types are recommended by whoever is doing the recommending, the technology supports their collection input and output.

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

Yeah, Christine, I'm with you on the second option. I like the idea that we speak to capabilities of the technology in an anticipatory way, in a sense we're saying we're hearing all around us a lot of interest and needs for patient recorded information suitable for quality measurement and there are three or four categories intact and we want to in a sense prototype or make sure that the technology we endorse for Meaningful Use in 2015 is enabled to do those things.

**Christine Bechtel – National Partnership for Women & Families**

Yeah. I agree.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So I'm going to take that feedback and say we actually included that as one of our, remember we talked about focus areas, this notion of gathering data from patients was one of the high priority focus areas. So we have that covered and maybe what you both are suggesting is the fact that we included, although it's not as clearly stated as those, these kinds of measures, functional status were included in the domain of patient and family engagement.

**Christine Bechtel – National Partnership for Women & Families**

Right.

**Paul Tang – Palo Alto Medical Foundation**

Remember that Christine. So it's just essential, but it's buried in there and it isn't called out as explicitly to say "oh there's a new functionality we have to be requiring in the HIT specifications. So, I think what I'll do is wrap this back into our priority area or focal areas and maybe find a way to call it out a little bit more explicitly as where we're headed is EHR certification that includes getting from data from patients.

**Christine Bechtel – National Partnership for Women & Families**

When you say focus areas, do you mean 1 through 6?

**Paul Tang – Palo Alto Medical Foundation**

No, this was under the Meaningful Use Workgroup, remember when we met, actually maybe you weren't at that meeting, we had identified three or four focal areas for where we wanted to concentrate our efforts in Stage 3, patient and family engagement was one of those focal areas.

**Christine Bechtel – National Partnership for Women & Families**

Right, but on patient reported measurement or patient reported data broadly.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**Christine Bechtel – National Partnership for Women & Families**

Was included there but this is a specific slice of it I think, which is patient reported data for the purpose of use in quality measurement.

**Paul Tang – Palo Alto Medical Foundation**

That's correct.

**Christine Bechtel – National Partnership for Women & Families**

So, I think it's appropriate to be an example, you know, recommendations.

**Paul Tang – Palo Alto Medical Foundation**

Okay, so you're arguing, that's why I put it here was to make it more explicit. I thought you were arguing for replacement.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, oh, no, no, no, I'm sorry. I've been agreeing with you the whole time, Paul.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**Christine Bechtel – National Partnership for Women & Families**

All was saying, the question that's raised for me was number 3, as it's written now that, you know, it's CQM should include measures that help consumer assess whether their providers are suitable for their health conditions, to me gets at a measure type which the Quality Measure Workgroup has already worked on versus a technical capability that we need in order to facilitate measurement. And then I asked the second question which is if our focus is technical capability, which I think it should be, then there are two technical capabilities. One is what you suggested, which is patient reported data for the purpose of measurement and the other is public reporting, right? Because if what we meant here was picking a provider suitable for their health condition, that's not just patient reported measurement, that's definitely public reporting and so making sure.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**Christine Bechtel – National Partnership for Women & Families**

You see what I'm saying? So I'm just...

**Paul Tang – Palo Alto Medical Foundation**

Yeah. Let me clarify that's out of our scope, you know, CMS...

**Christine Bechtel – National Partnership for Women & Families**

Okay, that's fine. Yeah that's fine.

**Paul Tang – Palo Alto Medical Foundation**

Great. So the goal of this is just to connect the dots between the CQM that was recommended by the QM Workgroup and the sort of the EHR for the HIT certification.

**Christine Bechtel – National Partnership for Women & Families**

Right.

**Paul Tang – Palo Alto Medical Foundation**

The HIT functionality requirement kind of thing. So let me rework on that and sort of make that point clear and maybe it appears somewhere else. So it sounds like there's interest in the area.

**Christine Bechtel – National Partnership for Women & Families**

Definitely.

**Arthur Davidson – Denver Public Health Department**

Paul, this is Art. I'm having a little difficulty in the way that this is worded. I'm not sure where the emphasis should be. I've reworded this and I'm just going to read it to you to see what you all think. CQM should include measures that encourage EPs and EHS to incorporate patient reported outcomes to evaluate quality.

**Paul Tang – Palo Alto Medical Foundation**

That's much better. Can you send that to me please?

**Christine Bechtel – National Partnership for Women & Families**

But, actually, Paul, I mean this is my fundamental question that I'm asking. Is our focus CQMs or is our focus EHRs should enable quality measurement that includes patient reported data.

**Paul Tang – Palo Alto Medical Foundation**

That's what I heard Art say, the later.

**Arthur Davidson – Denver Public Health Department**

Yeah, the later.

**Christine Bechtel – National Partnership for Women & Families**

Right, so but when we start all these sentences with CQMs we're talking about the measures and I think what we're talking about is, you know, like number two certification criteria should do this, EHRs should do that, I think that's where I'm falling off the wagon a little bit.

**Paul Tang – Palo Alto Medical Foundation**

So, I think Art's rewording is much clearer.

**Christine Bechtel – National Partnership for Women & Families**

I do, but I don't think it should start with CQM, that's my challenge.

**Paul Tang – Palo Alto Medical Foundation**

Okay, we'll make it not start that way.

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

Well, Christine, my reaction to your thought Christine is that it's okay to start with CQM because one of the things we are doing in the program is recommended CQMs, but we're recommending CQMs which test and demonstrate the capability of the technology. So it could be, just like in Art's language, say CQMs included in Stage 3 should include measures which utilize patient data captured by EHRs consisting with certification criteria.

**Christine Bechtel – National Partnership for Women & Families**

Okay. So I get that and I misunderstood the answer to my question. My earlier, and I'm sorry to be off on this, but my earlier question was is the focus of this Workgroup the measure set which if the sentences start with CQM it is or is it or maybe it's an and/or, the technical capabilities that are needed to support the measure set that the larger Quality Measure Workgroup has already recommended?

**Arthur Davidson – Denver Public Health Department**

You know, Christine, I think the primary focus is the first but I don't think that we're excluding the second here.

**Christine Bechtel – National Partnership for Women & Families**

So, I guess what I'm, and I'll be quiet now because I'm new to the group and I'm already feeling bad, but I feel like I'm not seeing the gaps in the work around figuring out what the measure set is given the work that's been done by the Quality Measurement Group already. Where I see the gap is how the technologies actually support all of that.

**Paul Tang – Palo Alto Medical Foundation**

Okay, we'll work on that gap and the wording. I think Art's rephrasing does a really good job with that, but we can work on it further. Okay, so let's move on because there's a lot of other really good ideas that came out of our hearing and our post hearing discussion. Number four talks about new kinds of measures and really the focus on delta means that each patient can change, you're not just measuring the risk adjusted population norm. The parenthetical phrase that I included there is to say, in order for a provider, so there's two ways to look at it, providers can get "credit" for improving each and every patient

and that sort of focuses attention on how can I, instead of looking at well gee how do I move my population average, how can I make a difference in every single patient? To me it's a couple of things. One, it's certainly more meaningful to patients but it also focuses tensions more on individuals as part of a population rather than population itself only. That seemed to be a main point that came out of the Quality Measurement Workgroup body of work.

And so again, so this is, so we're on the CQM subgroup and dealing with CQMs and that's why it does start out with CQM should. And this would be both providing recommendations to HHS that this kind of measure would be useful for the following reason. And the second point this issue makes is and its part of our recommendations that really we envision effecting certification that systems be able to calculate those kinds of measures. Comments, questions about that? You could drop it.

**Arthur Davidson – Denver Public Health Department**

I got distracted a little bit here, Paul, can you describe to me again what the incentivizing improvements directed to individuals means?

**Paul Tang – Palo Alto Medical Foundation**

It's an awkwardly phrased way of saying if providers are measured not just on risk adjusted population averages and rather get measured on what have I done for each individual patient that would incentivize and motivate a provider to make sure I'm doing something to have each of my patients improve not just my population average change.

**Arthur Davidson – Denver Public Health Department**

So incentivizing the provider?

**Paul Tang – Palo Alto Medical Foundation**

Correct.

**Arthur Davidson – Denver Public Health Department**

Right.

**Paul Tang – Palo Alto Medical Foundation**

And so if a provider scores really well on this, like I'm getting all of my patients, the majority of my patients to improve as a consumer I could say that's somebody who does work on each and every person. I had more information about it as a consumer than saying oh the population this provider takes care of has their risk adjusted average has changed. I don't know enough about how this person treats individuals. Is that any clearer?

**Arthur Davidson – Denver Public Health Department**

Yeah. I wasn't sure which individuals we're talking about and I think I got it now.

**Paul Tang – Palo Alto Medical Foundation**

The patients. Yeah.

**Arthur Davidson – Denver Public Health Department**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

Is this something worthwhile recommending?

**Christine Bechtel – National Partnership for Women & Families**

I think so because I think there are a lot of technical capabilities that need to be in place to facilitate that.

**Paul Tang – Palo Alto Medical Foundation**

Correct.

**Christine Bechtel – National Partnership for Women & Families**

So, I think absolutely it's critical.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**Christine Bechtel – National Partnership for Women & Families**

I also think that it's going to support more outcome measures and improvement strategies which I would expect would be key parts of things like ACOs and other reform strategies.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**Arthur Davidson – Denver Public Health Department**

So are we thinking that in Stage 3 possibly you would have to improve your blood pressure control rate are from 40% to 50% as a delta measure for instance?

**Paul Tang – Palo Alto Medical Foundation**

No. So the difference between going from 40 to 50 at a population level means that in addition, perhaps in addition, I'm not saying to exclude it. It's another either/or, so one way is to measure 1% of your population has their blood pressure under 140/90 and your goal, Art, might be going from 40 to 50%. The other way to measure is what percent of your patient panel has improved their blood pressure readings by 3 mmHg in the systolic or diastolic.

**Arthur Davidson – Denver Public Health Department**

Okay. Okay.

**Paul Tang – Palo Alto Medical Foundation**

That's different information and I think it causes different ways of looking at how do I improve as a provider and for a consumer different ways of looking, oh what does that score mean to me as an individual?

**Arthur Davidson – Denver Public Health Department**

Okay. Thank you.

**Paul Tang – Palo Alto Medical Foundation**

Yes. Okay. So let me get a little sense of the group, is this is something worth keeping as a recommendation, you know, it can be reworded.

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

Yes, I'm in favor.

**Arthur Davidson – Denver Public Health Department**

I think this is good, Paul, yes.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)**

This is Marty, yes.

**Paul Tang – Palo Alto Medical Foundation**

Good. Okay. And number five talks about a lot of the theme, and this, you know, came out in this hearing as well as other hearings related to quality measures is can I make more, I as a consumer, give me something that I can make more sense of and again, it goes back to the theme of, gosh if everything is a risk stratified population mean, I don't actually know how that applies to me as a brittle diabetic. If the

quality of reports are stratified by risk categories I would know as a brittle diabetic, or I would know as someone who does a really good job, how well does this organization deal with people like me. Again, that requires the technical capability of reporting that kind of thing out both to the public as well as to the providers so they can know how well they're doing with that.

**Christine Bechtel – National Partnership for Women & Families**

Yeah. I mean, I think this is kind of a no brainer to include in my view, in part because the groundwork was laid for this in Stage 1 through the collection of demographic data of race, ethnicity and gender.

**Paul Tang – Palo Alto Medical Foundation**

Correct.

**Christine Bechtel – National Partnership for Women & Families**

You know, it's hopefully the stratification is I think going to become part of Stage 2. And it's a huge, you know, not only is a benefit for using health disparities, but, you know, high-tech actually had a provision that required development of standards around these things so that you could do exactly that.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

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

I'm not sure...for Meaningful Use recommendations. I understand that, just as Christine said, there's a lot of pointers going in this direction that is very valuable and the ultimate quality reporting that CMS or anybody else does could choose to ask for the data to be stratified as reported to them, assuming that you continue to report numerators/denominators you could say report separate numerators and denominators for different populations where the, you know, the amplifies the end folds up. So is the implication for our program again kind of technical capability that the certification process should judge or is this just a recommendation to those who require measures to be reported to the public?

**Paul Tang – Palo Alto Medical Foundation**

I think it's both. So, we could have a Meaningful Use objective that certain kinds of CQMs are reported stratified by certain things. It could be looking at it from a disparity point of view or it could be looking at it from a clinical quality point of view, but that again that's exemplar. So there might be one or two measures that are required to be reported in a stratified way. One by demographics and two by clinical control of that particular health condition. And just as a exemplar so you know that the system can do this and you as an organization start learning how to use this as part of your provider dashboard to understand how to address priorities in your area. Does that make sense?

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

Yeah it does, especially now. I guess I'm thinking maybe it goes back to certification, that that capability be, because what we heard from the hearing there's a sense that whenever things get a little sketchy people revert to end work and work arounds.

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

...if there is one measure diabetes should be reported separately for people with BMI over 30 than other people or something.

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

And that would go get the clerk to pull some records from the computer instead of having the capability and the technology. So the more we're in the exemplar world the more it's an incentive to work around instead of engineering.

**Paul Tang – Palo Alto Medical Foundation**

That's a fair point. So, correct, I think it is targeting a certification criteria that this is easy to do and then maybe an exemplar sort of leading by example kind of thing on how this could be really important and useful to an organization.

**Arthur Davidson – Denver Public Health Department**

So, I like this Paul. I do think that e.g. should be expanded to say something more like based on the conversation, demographic and/or comorbid risk categories because I don't really know what risk we're talking about until we had this discussion, and I think...

**Paul Tang – Palo Alto Medical Foundation**

That's a good suggestion.

**Arthur Davidson – Denver Public Health Department**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

Good suggestion. Okay. Number 6 deals with the challenges we heard about, it's just really hard to calculate and a lot of the "hardness" is in getting these exclusion criteria. NQF already recognizes this and part of the endorsement criteria includes in theory, includes doing a sensitivity analysis about the inclusion of any one exclusion criteria or, you know, as part of a measure definition. So, that kind of challenge just continues on when you try to implement these measures and one possibility is to say, one to say NQF, you know, this was a really good idea to do a sensitivity analysis for each of the exclusion criteria and that as part of Meaningful Use of EHRs, we have a reason to want to have all of these exclusion criteria to be computable, to be computable using structured data. So that just ups the ante in terms of why, so the intra criteria says do a sensitivity analysis. Maybe our criteria for computable CQMs is that all data elements be drawn from structured data. So how would that work in the real world? CMS's list of CQMs would be all the CQMs on their list as part of Meaningful Use would have to be based on data elements that are structured data elements in the EHR. Am I being clear? Do people think this a good idea to pursue as part of Meaningful Use or is it just too high a bar?

**Christine Bechtel – National Partnership for Women & Families**

The sensitivity analysis?

**Paul Tang – Palo Alto Medical Foundation**

Well, actually, I'm more thinking about the use of CQMs which offer data elements or structured data elements in the EHR.

**Christine Bechtel – National Partnership for Women & Families**

Oh.

**Paul Tang – Palo Alto Medical Foundation**

So that would be a subset of all QMs. So there's quality measures. There are NQF endorsed quality measures that are a subset of all quality measures, and there's a smaller subset that says these are quality measures that you can truly compute out of structured data elements in an EHR and by making that the subset from which CMS draws this list of CQMs that must be reported as part of Meaningful Use we're moving people's attention to these kind of quality measures that can be gathered and gathered routinely and reported in real time, remember that was another suggestion people had from the hearing so that the burden is low and the use of these measures can be very high, the real time measures, like every day I can know how I'm doing.

**Christine Bechtel – National Partnership for Women & Families**

I mean, I think in theory that's a nice idea. What I worry about though is it gives us an incredibly limited set of measures, many of which are not particularly meaningful to consumers, purchasers, and others and I don't know enough about the technical process of IT enable quality measurement to know that that's the only way for us to have computable measures. So I am worried about this one.

**Paul Tang – Palo Alto Medical Foundation**

Well it's a fair worry.

**Christine Bechtel – National Partnership for Women & Families**

What?

**Paul Tang – Palo Alto Medical Foundation**

It's a fair worry.

**Christine Bechtel – National Partnership for Women & Families**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

It's sort of trying to lead the direction of saying this would answer the problems and issues raised by people who have to do this work, the providers, and it also would enable the other benefits side that they wanted. So one is remember it's the work of reporting this stuff and part of it is it's the work of reporting that causes them to be reported infrequently and then that prevents the results of that, that reporting to come back and influence the decisions made every day. So only when you can essentially automatically report on this stuff at will can we get the real-time reporting that people were asking for.

**Christine Bechtel – National Partnership for Women & Families**

Right, but I guess what I'm wondering is whether there's another approach, right? So instead of being limited to like a fixed set of existing measures, which means that it actually, I think knocks out a couple of our other criteria. I don't think there are patient reported measures that are defined that well. I think it knocks out the next piece around, you know, multi-provider input or longitudinal measurement or multi-setting measurement. I don't think those are in those measure sets. So it limits us to a set of measures that are not necessarily all the way what we want and many of which are not going to be that meaningful for our purposes and I just wonder if there is another approach that is more of, you know, can we write a piece, this is what I don't know, can we write a piece of software that says okay if you plug in the measure specs, we can, you know, pull the structured data out, as opposed to well we have to first define everything at a really micro-level, which is what we have in the measures you're referencing that are the subset of the subset, and only use those. Like is there a way to sort of re-jigger a technical process that gives us a lot more flexibility and adaptability and still, you know, can potentially lower burden on providers?

**Paul Tang – Palo Alto Medical Foundation**

I certainly hear the question, understand the question, and I don't know the answer. I think there's room for innovation on measures though. So there are some exclusions. So one of the challenges is you go look for how do you code exclusions. The reason for adding the sensitivity analysis is if you go through all the expense of trying to capture things for the exclusion it may not actually make that big a difference. And so if we stuck with the simple, easy to obtain already coded data elements, we actually might get a close enough approximation that lets us do the good work, that's the challenge. So I hear your question and I don't know the answer to that, but I'm imagining that there are ways to look at defining a measure that don't mean you have to ask everybody to code in excruciating detail.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, which I appreciate. I just wonder if before we make this as a recommendation, since we're not sure we totally get all the aspects of it, if it's one of the things that we might explore or however, if we, you know, in our follow up work, whether that's HHS or ONC doing convening or us doing some work. I'm not comfortable with this until we really understand better all of implications and how this field works.

**Paul Tang – Palo Alto Medical Foundation**

I totally appreciate that. Would it make sense, so this is just a feeling to see whether people agree with this, would it make sense to reword this in the notion of the recommendation is to either encourage or even use the word you used “explore” the use of CQMs that rely on coded information from the EHR? That might be as strong as appropriate with the data we have right now. Yes, in fact that would be something worthwhile to do, but let me ask everyone else where they think that would fall.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, I mean, I think that’s okay because we do want to explore it and we really want to understand it’s impact on the other recommendations that we have too because we’re talking about measures that I think do not fall and would not be part of the measures that that would be selected if we used this criterion. So, I think I’m okay with sort of exploring the implications of it.

**Paul Tang – Palo Alto Medical Foundation**

So let me hear others as well because I’m happy to drop this.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, that’s sort of my vote is drop it, but maybe others would want to keep it.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)**

Paul, this is Marty. I think we should aspire to have measures based on structured data, especially where there is widespread use of HIEs. We need to make sure that we are comparing apples and apples when we start putting data together and combining it in one location. Right now I am not sure we are at a place where the measures we really care about, many of the measures we really care about can come from structured data yet.

**Paul Tang – Palo Alto Medical Foundation**

Yes. Okay. So should we just drop this one? That’s number 6. Number 7 is...so some proportion, not all, of CQMs should involve the exchange of information that allows us both of course to aggregate but also to do the longitudinal measures.

**Christine Bechtel – National Partnership for Women & Families**

Yeah. I agree and I think this is also about it helps us facilitate measuring health outcomes; it helps us facilitate measurement across settings of care, so episodes of care. I think this is one that’s very important to include given where the environment is going. Like, in my view this isn’t just about Meaningful Use. This has to be about setting up technology in such a way that it facilitates ongoing improvements in the health system that we know are coming just from watching our environment.

**Paul Tang – Palo Alto Medical Foundation**

Other comments?

**Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)**

I agree strongly.

**Arthur Davidson – Denver Public Health Department**

Yeah, I agree also. Can I just go back to six? So in this process that you described when we were going through number two above, does the NQF QDM format address exclusions?

**Paul Tang – Palo Alto Medical Foundation**

It does in the sense that it tries to put what value sets you would use to characterize an exclusion and it relies on the endorsement criteria I mentioned say to the measure developers as you think of exclusions try to one, minimize them and two, have them in computable format. Nothing about that enforces it though.

**Arthur Davidson – Denver Public Health Department**

And do we have examples? Again, I guess I'm just going back to examples. Is it, I hear what Marty said it doesn't seem like the structured data are necessarily available and I think that's why we kind of passed on this, but is this something that people are making progress in?

**Paul Tang – Palo Alto Medical Foundation**

Well, so that was the motivation for putting it there. I don't know that people totally recognize how useful this could be.

**Arthur Davidson – Denver Public Health Department**

It could be very useful.

**Paul Tang – Palo Alto Medical Foundation**

Yeah and hence I don't think there's a lot of progress and ironically it prevents us from doing number 7. So it's just a lot. My question is it the appropriate time to start it?

**Christine Bechtel – National Partnership for Women & Families**

Paul, its Christine. I guess I also thought that once you design a measure, once you outline the measure specifications, how do you then make those specs become structured data? Are they one in the same or is there a process here? I just don't know enough.

**Paul Tang – Palo Alto Medical Foundation**

It's probably chicken and egg. You know, the problem is right now we're all stymied in what to improve, i.e., we don't know what we do now. And then two, as you've heard of rapid cycle improvement or lean etcetera, all those improvement processes depend on real-time data, because they're designed to be rapid and figure out change something and say yeah we're going in the right direction. Well if you have to hand calculate every one of them and it's the reason you have to hand calculate them is because you can't do the rough approximation, you have to get each and every one of these exclusions, it sort of gets stuck.

And so in a sense, this chicken and egg we're not going to get measures unless we understand how do we have measures that actually caused this rapid cycle improvement and you can't do that without...in the real time delay. So that's sort of the motivation behind it, understanding that, as everybody said, this is stuff we just don't have now. So we either try to kick start it with even one or some small number, some small proportion or wait until it happens on its own. So that's the dilemma.

**Christine Bechtel – National Partnership for Women & Families**

But I guess to me that comes back to what we said, in I guess two, which is EHRs should be able to consume e-measure specs to produce standardized quality reports.

**Paul Tang – Palo Alto Medical Foundation**

You're right. Everything sort of interrelates and depends, it really goes back to standards, which everything depends on having a standard way of representing things and capturing them.

**Christine Bechtel – National Partnership for Women & Families**

I guess what I heard was a little different. I think if we're saying that, you know, the exclusions need to be structured, that's one thing. What I think I heard prior was there's a subset, you know, that if we've got everything is super structured, exclusions aside, if all of our measures are uber structured then it kind of knocks off the table a whole of a lot of other measures in the areas that we've already agreed on one, I mean number 7 and, you know, number 3, new number 3 that we want.

**Paul Tang – Palo Alto Medical Foundation**

Well let me try to say it, I think I understand what you said and let me try to say it to you in a complementary way without having everything structured we basically can't do most of the stuff. Well, without a lot of effort. So the whole point is we're trying to avoid a lot of effort and the reason you want to

do that is one is the cost of it, but potentially more important is you can only repeat that so many times and when you're trying to understand how to improve things you need something in a nondemand way. And, so let's say, so you have a real good understanding of where you are and when you make changes, but you won't be completely accurate without an exclusion criteria and the cost of doing that, does that win you, you know, 1% more in accuracy, 5 or 10 and that's the whole sensitivity level.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, I mean, I get it. Here's what my gut instinct is. I think we are treading back into, you know, a holy war that has happened in MQS and in other forum for many years, particularly, you know, consumers and purchasers versus like providers where you get into these humongous fights about what measure is a meaningful one and what is appropriate because if you say everything is structured then the measures aren't meaningful to consumers and purchases and if you say they're not then the providers come back and say I can't collect all this stuff, it's too much burden. So, that's why I keep coming back to this fundamental question of what's the value contribution of this group, is it to, you know, go back into talking about what the quality measure should be? Delta measures and patient reported measures and longitudinal, which if you then have another criteria that says everything has to be structured, makes it, so there is no way in the next couple of years that we are getting any of those kinds of delta measures or longitudinal or patient reporting.

Do you weigh back into the war or do you say we need to have the technical capabilities to do all of these things and that's what we need to advance, regardless of whose choosing measures for Meaningful Use and what the content is, we've got to facilitate patient reported measures, we've got to facilitate longitudinal because that's the only way to get people out of, you know, the war they're already in.

**Arthur Davidson – Denver Public Health Department**

I think we should be pushing for that. That's our policy committee mission.

**Christine Bechtel – National Partnership for Women & Families**

Pushing for what, the focus of the technical side?

**Arthur Davidson – Denver Public Health Department**

I think we should be pushing for number, whatever that was, number 2, 3, and 7 and 6 means, and structured data is important to that, as you were saying, and I think 6 includes pieces of that as well. So let's talk specifically. For me when I look at the exclusions, a simple example of that would be again back to blood pressure is so the diabetic blood pressure is not 140/90 it's different. So are we going to put the diabetics into the 140/90 group or are we going to exclude them to make their CQM measure different than the typical one we might use for the general population that's hypertensive?

**Paul Tang – Palo Alto Medical Foundation**

Now but that's a good example where you can do that effortlessly.

**Arthur Davidson – Denver Public Health Department**

Right. That's what I'm saying. I don't think we should just drop this number 6.

**Paul Tang – Palo Alto Medical Foundation**

Yeah. We should encourage things that you can measure objectively quickly. Everybody is going to be better off. And I guess we ought to just either leave this or, the only ask here is look at what that would do. Can you pick one? Can you pick three? Whatever it is so that we can empower people with these things that you measure in real-time that is good enough to support your QI and even public supporting measures. That was the ask, but we probably should either try to drop this for good, at least for Stage 3, or not.

**Christine Bechtel – National Partnership for Women & Families**

Yeah. I get the importance of doing that and as Art and you have pointed out, there are measures where you can do this today, but there are measures that are patient reported, that our longitudinal, that are multi-setting, in other words, episodes of care that on the one hand we're saying are important to us and

on the other hand we're saying the technical capacity isn't there. So how can you make them part of Meaningful Use?

**Paul Tang – Palo Alto Medical Foundation**

So, remember I changed the wording to explore.

**Christine Bechtel – National Partnership for Women & Families**

No, no, it's not, my issue is not with number 6. I think, you know, my issue is not specific to exclusions. I'm saying we don't have patient reported measures necessarily, maybe the full suite or episode-based measures that have, you know, all the structured data that is needed to make exclusions and not, you know, included in that, but there's a larger problem that if you say only things with super structured data that make it easy for doctors to calculate should be included in Meaningful Use then I don't see how we're going to have any patient reported, any episode/longitudinal, you know, any sort of HIE enabled measures in Meaningful Use. Those are mutually exclusive to me unless I don't get something.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So we already agreed to drop it. So let's move on.

**Christine Bechtel – National Partnership for Women & Families**

I'm not.

**Paul Tang – Palo Alto Medical Foundation**

That's the only one that affects what you were just saying. Okay? We'll keep with that decision. Okay so number 8 had to do with the use of noncertified systems. So this was a quandary of many people were reporting on the quality measures using systems that, you know, they basically extract the data from their EHR and then we're doing it a lot of times in just their relational database, but that database itself was not certified and that actually doesn't follow the rules. So they had to go use the data as reported out of their EHR. So, the question is if subject to audit people could use whatever systems they were using to do population reporting and if that could qualify for Meaningful Use subject to audit, making sure that all of the data really came from the EHR. Is that something we feel comfortable with?

**Christine Bechtel – National Partnership for Women & Families**

Well, it's Christine. I'm comfortable with it unless somebody sees a downside that I don't, but I'm comfortable with it because I think this is such a new sort of area that this would probably do more to facilitate innovation and, you know, developments in the field at a faster speed, you know, if people don't have to go through the whole certification process for their add-on, you know, kind of quality generating report system versus their full EHR, you know, with these stipulations around the data being used to come from the HIT system that is certified, etcetera. So I like this one unless there is an issue that I'm not thinking of.

**Arthur Davidson – Denver Public Health Department**

I think this is an important one. The leaders in this field around quality in large systems, in particular that I know about have been trying to build dashboards and the opportunity for gaining intelligence from these multiple systems across health care organizations and making them have to go back to use a certified system when they're already in the lead in doing this sort of quality reporting and quality improvements seems unfair. So I am totally in favor of this.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Other folks?

**Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)**

Yeah, this is Marty. This just makes sense in the real world. As long as we have the ability to do this. I don't know what statutorily if it has to be a certified product or not, but it sure makes sense from a user perspective.

**Paul Tang – Palo Alto Medical Foundation**

I think the intent, I think it's under regulation, so I think it is changeable, but I think the intent was well-meaning. I think it just faced some complications and, you know, unintended side-effects. Anybody else want to comment on this one?

**Christine Bechtel – National Partnership for Women & Families**

Well, Paul this is Christine. I already commented, but what I don't completely understand is its relation to the next one, number 9, because if we're saying.

**Paul Tang – Palo Alto Medical Foundation**

Okay, yeah, let me explain that one. I don't think you were at the hearing. So this is where it turns out that vendors only had to produce results of the quality measure on I believe its 9 out of the 44 and so they were certified though to produce all the results and the certification test did not measure whether the actual output was accurate. So, they had to prove that they could do a calculation, but they actually didn't test whether they got the right results given the fixed data input.

**Christine Bechtel – National Partnership for Women & Families**

Okay that's makes sense.

**Paul Tang – Palo Alto Medical Foundation**

So those are things that people told us about. I don't know that many of us knew that was true, but that caused some problems. So then if you weren't using one of the 9 and it there was an error in that you got stuck having to wait for the vendor, you know, you had to point it out to the vendor, the vendor has to change it, that kind of thing.

**Christine Bechtel – National Partnership for Women & Families**

Oh, yeah.

**Paul Tang – Palo Alto Medical Foundation**

That hung up people.

**Christine Bechtel – National Partnership for Women & Families**

But the only question I have makes total sense. I mean, that's shockingly ridiculous, but the only question I had is really in the first part, certification of CQM reporting. So, we're saying on the one hand that people can use noncertified systems.

**Paul Tang – Palo Alto Medical Foundation**

Which one, are you talking about 8?

**Christine Bechtel – National Partnership for Women & Families**

Yeah. Yeah. So on one hand you can use a noncertified systems to generate reports, but on the other hand the next one is saying that EHR systems should be certified.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**Christine Bechtel – National Partnership for Women & Families**

That's what's confusing.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So if you wanted to use an EHR system to produce this then we were asking that the system be certified to produce each and every one of those measures and that the access is also certified.

**Christine Bechtel – National Partnership for Women & Families**

Okay, so maybe we could start it by saying for those HIT systems that are certified for CQM that it should include all possible CQMs and produce accuracy, absolutely, that makes a lot of sense to me.

**Paul Tang – Palo Alto Medical Foundation**

We should reward that. Okay. We'll clarify that one. Any other comments on these recommendations? So the only ones that dropped, there's many that we reworded, the only one we dropped was number 6 for good reason and 1 is more of, sort of a reconfirmation of the QM output. Anything else? Any other comments on just the other 8? And then any other suggestions? Okay. So what I'll do is I'll go reword then and then I may try to put them in David Lansky's categories or you might want to help see which ones fit and maybe reword some of his categories and see if we can't put together a cogent way of organizing these recommendations and also sort of talk a little bit about the implications since that's a question that came up here and pass that by everyone. Does that make sense?

**Christine Bechtel – National Partnership for Women & Families**

That sounds good to me.

**Arthur Davidson – Denver Public Health Department**

Yeah, that sounds good. So, Christine did bring up the idea about the National Quality Strategy priorities. Do we want to make any reference to that?

**Christine Bechtel – National Partnership for Women & Families**

Well I think what I had suggested was that Mary Jo circulate the MAP criteria which measures selection criteria which include the NQF, the National Quality Strategy priority areas. I mean, my instinct would be to make our priority areas the same as the National Quality Strategy like verbatim. They are, like I said 99% the same.

**Arthur Davidson – Denver Public Health Department**

Yeah.

**Christine Bechtel – National Partnership for Women & Families**

And to see if there is anything else in the, you know, measure selection criteria that is worth our noting.

**Paul Tang – Palo Alto Medical Foundation**

That certainly makes sense because one of the top asks from the people on the panel was alignment.

**Christine Bechtel – National Partnership for Women & Families**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

So we certainly want to follow that ourselves.

**Arthur Davidson – Denver Public Health Department**

Right.

**Paul Tang – Palo Alto Medical Foundation**

So I think this falls under David Lansky's measure selection criteria, category B and one way we can show that is by lining up with the MAP. So I think, and again, it goes back to one of Christine's comments, we're focusing less on, okay these are the CQMs we specifically recommend versus these are CQMs that we think EHRs should support. These are CQM types that EHRs should support.

**Christine Bechtel – National Partnership for Women & Families**

Or these are...

**Paul Tang – Palo Alto Medical Foundation**

HIT, sorry.

**Christine Bechtel – National Partnership for Women & Families**

Yeah, exactly, these are HIT or EHR capabilities that are needed to support the CQMs.

**Paul Tang – Palo Alto Medical Foundation**

Right. Okay. As I re-organize this and reword it I'll try to make that clear, make that distinction clear.

**Christine Bechtel – National Partnership for Women & Families**

Thank you, Paul.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Okay. Are you ready for public comment?

**Paul Tang – Palo Alto Medical Foundation**

Well, any other comments? Do we think we have a comprehensive step? Do we have one that's high impact for our recommendations? Our next Meaningful Use Workgroup call is, what December 15th, I believe?

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

December 15<sup>th</sup> that is correct.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So I'll put this together and run it by everybody here before that call.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Yeah, it's 10:00 to 12:00 on the 15<sup>th</sup> and as a reminder, the next Policy Committee meeting is on the 7<sup>th</sup> and the next one after that is January 10<sup>th</sup> and so what I'm hearing is that you would hope to be able to report out on January 10th, but you're not promising yet.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, no we're going to have to report this back to the Meaningful Use Workgroup and then if they agree then we will report out on the 10<sup>th</sup>.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Exactly.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So no other comments? Okay can we open to the public please?

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Operator, would you open the lines?

**Caitlin Collins – Altarum Institute**

Yes. If you are on the phone and would like to make a public comment please press \*1 at this time. If you are listening via your computer you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. We do not have any comments at this time.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Thank you, operator.

**Paul Tang – Palo Alto Medical Foundation**

Well thank you every one for a productive call and I'll try to incorporate all the comments and helpful suggestions into these draft recommendations and sort of categorize them and put them back out for your review. So let me know if there's other changes or additions that you think would be relevant.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

And I will, at the same time then, circulate what I heard was the National Quality Strategy measure selection criteria, is that correct?

**Paul Tang – Palo Alto Medical Foundation**

The MAP.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Okay the MAP.

**Paul Tang – Palo Alto Medical Foundation**

Yeah the MAP, Measure Application.

**M**

Measure Authoring Tool.

**Christine Bechtel – National Partnership for Women & Families**

Measure Applications Partnership.

**M**

Oh, you're talking about...

**Paul Tang – Palo Alto Medical Foundation**

Yeah, okay.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Okay. I'll find it.

**Paul Tang – Palo Alto Medical Foundation**

Good.

**Arthur Davidson – Denver Public Health Department**

Thank you, Paul.

**Paul Tang – Palo Alto Medical Foundation**

Thank you everyone. Take care now, have a good day.

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

Bye-bye.

**Arthur Davidson – Denver Public Health Department**

Bye-bye.

## **Public Comment Received During the Meeting**

1. Well, most CQMs have the same fields with the value within the field changing. They don't need to be able to receive a revised CQM so much as they need to receive a revised value within a field. For example, if the recommended age for a mammogram changes from 50 to 45, or the A1C value changes, the EHR doesn't need to understand new fields, just new values within the fields, right?