

Clinical Quality Workgroup
Draft Transcript
June 18, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you very much. Good afternoon, and welcome, everybody, to the Clinical Quality Workgroup. This is a federal advisory committee workgroup, and there will be opportunity at the end of the call for the public to make comment. Let me do a quick roll call. Janet Corrigan?

Janet Corrigan – National Quality Forum – President & CEO

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Gloria Eisenberg? John Derr?

John Derr – Golden Living LLC – Chief Technology Strategic Officer

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Judy Murphy is going to be on spottily. Marc Overhage? Rick Stevens? Jim Walker? Walter Suarez? Mike Fitzmaurice? Jack Corley?

Jack Corley – ATI – Senior VP-Chief Technical Officer

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Janet, I'll turn it over to you.

Janet Corrigan – National Quality Forum – President & CEO

I think Walter was on as well.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes. Did I not say Walter? I'm sorry, Walter.

Janet Corrigan – National Quality Forum – President & CEO

He didn't speak up, but I know he was talking before—

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, he's on.

Janet Corrigan – National Quality Forum – President & CEO

--you opened the lines. Great. All right. We just wanted to touch bases today for a few minutes just to share with you the results of the environmental scan. We had responses from, gosh, about eight or ten organizations so far, and Judy has a couple more that have just come in that aren't reflected on the summary survey results that we sent to you today.

What we tried to do here was to group the responses, and you'll see that we grouped them into the following categories: those that related to diabetes, which was the largest number, preventive services, obesity, hypertension, healthcare associated infections, safety events, medication management, patient experience, and staffing. And there was some overlap with the particular people, different people, more than one individual recommending the same type of measure. But by and large, I think it really surfaced a lot of good ideas.

Now you'll see on this little listing here, the summary results, that the middle column was the performance measure for each of those areas. Then on the right-hand side, you'll see the submitter. After the submitter's name, there will be either 2013 or 2015, and that means that they indicated that this was most appropriate during the 2013 or 2015. 2013 were the measures that we ... would be most HIT sensitive and defined HIT sensitive as measures that will not require a great deal of changes in care processes or patient behaviors, but where having HIT will likely translate pretty quickly into improvements in patient care, and we put those into the 2013 category.

Then the 2015 are the ones where HIT will be helpful, but also requires a pretty significant redesign of care processes. Quite a few more people identified 2013 measures and did not respond to the 2015 timeframe. I wanted to get some reactions from the group as to what you think of the measures that are here.

Jack Corley – ATI – Senior VP-Chief Technical Officer

I was thinking—this is Jack Corley—they do seem representative of the kinds of things we'd like to be seeing in 2013 and 2015.

Janet Corrigan – National Quality Forum – President & CEO

Yes. They do certainly cover the whole gamut of different areas. Now they will say, I know, Floyd, a little bit earlier, was pulling together whether the particular ones that are already reflected in the measures that are being retooled. I don't know if Floyd has joined us yet. No, probably hasn't. At NQF, we just completed retooling 42 measures that we were asked to work with measure stewards to retool about 110, 120 measures, and they were prioritized into batches. The first batch of 42 was just completed and delivered. The others will be delivered in the fall, late summer or early fall. And we did go through and identified ones on this list that are included in that initial batch, and so have, frankly, a pretty good likelihood of potentially being already in the 2011 measures.

Essentially, the measures under diabetes and the preventive service ones are pretty well covered in the potential 2011 measures. I know a final decision hasn't been made there, so I want to be careful how I say that. But certainly in the sets of 2011 measures that came out in the NPRM. In fact, the obesity and the hypertension prevention and diabetes measures are all included in the NPRM 2011 measures, which of course doesn't mean that they'll necessarily be in the final rule, but they were in that initial batch.

Then when you also take a look at the healthcare associated infections, many of those are reflected as well in the list of large number of measures that were in the NPRM. Now ones that were not there include the safety events, medication management, and patient experience. It may be that we end up, depending upon how things turn out for 2011, that frankly a lot of the measures that are on this list will already be incorporated into 2011.

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

Janet, this is Walter. I'm sorry I dropped, but I'm back. I have a couple comments. The first one, I think, is the list of measures is a very good. It cuts across several or most of the important areas, I suppose. But one question is really the variety of measures in the sense that some of them very clinically oriented,

some of them preventative, and some of them were more process measures and some of them, like patient experience where survey scores of age gaps. I'm not sure how they reflect the ability to use HIT to implement them or to use them. Do you have any comments around that since the idea was to try to identify some of these to be linked to HIT?

Janet Corrigan – National Quality Forum – President & CEO

That's a great question. I had some of the same questions when I took a look at the patient experience, as well as the nurse staffing. Now the patient experience survey, in my mind, I guess it depends in part on how it is administered. If it became part of a personal health record, then

(Audio interference.)

Janet Corrigan – National Quality Forum – President & CEO

The patient experience survey, I think if it was a part of the personal health record and somehow was captured there, and we wanted to encourage records to be built and the PHRs to have that capacity to gather this type of information and submit it, I don't know if that's sort of the thinking moving forward, but it seemed to me that that one really had more to do with PHRs than the EHR side.

The nurse staffing, the only thing I could really think of there is that we have not been able to gather information on nurse staffing measures because they need to be unit specific, and that hasn't been data that was readily available, and the burden was, frankly, quite high to be associated with capturing that kind of performance measure. It does capture important indicators of performance, but it does need to be unit specific within the hospital, as I understand it, so that was the only thing I could think of there is that maybe this does at least afford an opportunity to capture that kind of information if indeed the HIT and hospital settings enable the ability to capture it at the unit level. But I had many of the same questions as well, I think.

Jack Corley – ATI – Senior VP-Chief Technical Officer

And I think, building on that—this is Jack Corley again—one of the questions that I had, as I went back to the very first sets of slides that said in 2011, these are the kinds of things we want to accomplish and, in 2013, we want to accomplish advanced care processes. And I tried to look at what was 2013 versus the expected list of care processes, and we did check off several of them, patient outreach and reminders. I think that's good. Implicit the quality benchmarking and reporting in the context of like percent of patients with HBA1c. That could be looked at that way. But I didn't see anything in the context of use of evidence-based order sets or clinical decision support. Are those items that we might be able to inject in here?

Janet Corrigan – National Quality Forum – President & CEO

I think we'd love to see more of that, those kinds of items, yes. Yes, I was surprised we didn't get some of that coming in, in response to the survey. However, I mean, clearly decision support, if it wasn't there, you probably aren't going to do very well on these measures.

Jack Corley – ATI – Senior VP-Chief Technical Officer

Right.

Janet Corrigan – National Quality Forum – President & CEO

I mean, maybe that's the thinking from those who responded is that it would clearly stimulate the development of the clinical decision support side of it. Yes. Maybe that's where there's real opportunity in 2013 is to be much more explicit about what those CDS capabilities need to be.

Jack Corley – ATI – Senior VP-Chief Technical Officer

That's what I was wondering if we couldn't, for the CDS and also for evidence-based order sets, if we might not set that as an objective to identify something for 2013 that might validate those.

Janet Corrigan – National Quality Forum – President & CEO

Okay. All right. Yes, and there is an interesting mix here of process and very limited outcomes measures here. It's very much the process measures. I guess that is in compliance with the 2013 goal, with 2015 being more of outcome measures.

Jack Corley – ATI – Senior VP-Chief Technical Officer

Yes.

Janet Corrigan – National Quality Forum – President & CEO

Yes. The other thing that isn't here at all is any kind of patient engagement in decision-making, measures of whether patients that had a preference sensitive condition were provided with necessary information and understood it to be able to make a choice, and there isn't anything here that I can see really that relates to overuse, which would potentially be another area we'd want to think about unnecessary imaging or laboratory tests. We're trying very hard to identify. We have quite a few of those measures within NQF now that are looking at whether there was, for example, a particular imaging test ordered within a certain time period of one that was done before such that it really wasn't necessary to repeat the order. It seems to me that HIT has very real potential there to track those kinds of things and flag when it's not necessary to reorder a particular test.

Jack Corley – ATI – Senior VP-Chief Technical Officer

Perhaps I misinterpreted, but I thought the tobacco use in diabetic patients was one that might be checked off as a patient outreach and reminder and involvement in decision-making.

Janet Corrigan – National Quality Forum – President & CEO

Yes, you're right. That is a good one in that regard. It wasn't clear to me why the tobacco use measure though would be limited to diabetic patients.

Jack Corley – ATI – Senior VP-Chief Technical Officer

Me neither, but other than it gives the opportunity to verify that they can check their problem list or diagnoses.

Janet Corrigan – National Quality Forum – President & CEO

Yes.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd Eisenberg. I apologize for being late to join, but there are actually two or actually two measures in the current retool stat that do address tobacco use and tobacco cessation, but they are not specific to diabetes. The potential to stratify by condition or age is certainly something that could be done. But I don't know why it would just be specific to diabetics.

Janet Corrigan – National Quality Forum – President & CEO

Floyd, I briefly updated folks on the retooling. Do you want to provide a little more information on where we're at with that whole process?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Sure. I'm happy to. Again, apologize for being late here.

Janet Corrigan – National Quality Forum – President & CEO

That's okay.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

We have now with three measure stewards—AMA, the National Committee for Quality Assurance (NCQA), and Quality Insights of Pennsylvania—for process, for retooling, using the quality data set 42 measures and deliver them to Medicare. The rest of the measures are in progress. We have started into the next round, and we may have an additional two to CMS by the end of next week. And we're working with CMS on completion and timeline dates for the rest of the 68, but we're in progress. We have worked on processes so that things can come out as quickly as possible.

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

Floyd, this is Walter. So the total measures where the totals of the measures were 110 and then 42 have been completed and 68 are in progress?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

That's correct. Of the 42 that were delivered, they're all ambulatory.

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

Okay.

Janet Corrigan – National Quality Forum – President & CEO

But 12 have already been retooled. The hospital measures have been retooled elsewhere, correct?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes. There actually are 16 that were retooled in the HITSP process, and they are available on the HITSP Web site.

Janet Corrigan – National Quality Forum – President & CEO

But to our knowledge, there are 58 measures in total that are retooled out of that total list. Okay. I think we're actually making pretty good progress there and getting a lot to CMS. There's quite a bit to choose from for 2011. Yes. Okay. I also mentioned before you got on, Floyd, that the majority of these measures that are on our current suggested list from the survey results are in that batch of 42.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

That's correct. Ten of the ones that were in the suggested list are in the batch of 42 within some variation. In other words, instead, the one that's diabetic smoking cessation is a set of three different measures that are not specific to diabetes, but there's a relationship. And four of the measures are in the next round, and there are four listed there, one specifically patient experience and some of the nursing time percentages that are not in the retooled list.

Janet Corrigan – National Quality Forum – President & CEO

Floyd, do you know for things like patient experience, is the assumption that that would be captured in a PHR, perhaps even after the patient left the provider's office, or that there would be some mechanism for capturing this while the patient is in the office?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

There's actually an interesting discussion, and I know that's something that will likely come up in meetings and our HIT advisory committee. What was suggested and what came back to this committee

was to use the CAPS survey, and that is not something that is captured within an EHR or PHR. It's a separate, distinct survey. There is potential for, in the process of care, asking patients for advice on their experience on where they are, but I think that's currently – it's not in an existing measure, and it's not a standard practice.

Janet Corrigan – National Quality Forum – President & CEO

All right. This is essentially where we're at. This is the list that we got, and I think we're going to have to push a little bit harder. Jack, you had some good suggestions in terms of evidence-based order test sets and perhaps to define the clinical decision support that needs to go along with these. But if we're going to make a sizable step in 2013, it looks like most of these are going to be in 2011 or pretty good likelihood, maybe in 2013 if not just being able to capture the data and generate the measure, but to really demonstrate improvement on it, which we may want to be more specific about the clinical decision support that needs to accompany it. That ... perhaps be our next step.

Now there are a couple other sources or streams of information that are going to kind of flow into this thinking that we're aware of. The beacon communities are having some conference in the not too distant future, in the next few weeks, and they're going to spend some time talking about the measures they think would be particularly good for 2013 or 2015 meaningful use. There's also a small group that Dartmouth and NQF are convening on called the Gretzky Group that's a small group that's taking a look at some potential measures, especially ones that might be consistent with looking at longitudinal patient episodes and the kinds of measure sets that we think are needed for bundled payment and accountable care organizations, trying to kind of think about how this work nosedives with those other efforts that are going on in to sort of reform the payment and delivery system.

Hopefully there'll be some additional ideas that are flowing into this. Then, of course, the policy committee, ONC policy committee, it's our understanding from Paul Tang that they'll be talking. At their September meeting, they will be addressing their framework and suggestion measures for 2013. So we'll share a lot of this information with the policy committee just to help inform their decision making, but they, of course, will be the ones that then provide direction back to us, the quality workgroup, as to what measures they really want for 2013. So we're kind of working iteratively here simply because we're on a tight timeframe.

There's one effort I wanted you to be aware of, and it's that after quite lengthy discussions with Farzad Mostashari, we are, at NQF, doing a quick turnaround project for all of these kinds of measure concepts that get explored to take a look at – we have another list of measure concepts and ideas that came in as a result of the comments on the 2011 meaningful use measures in the NPRM. But basically going through all of those lists and trying to identify where we currently have NQF endorsed measures. If we don't, do we have a measure that's close and could be adapted within the timeframe? Or, third, would it require measure development de novo? That little effort is going to be going out over the next six weeks or eight weeks or so. Our goal really is by around August to have quite a bit of information on potential measure concepts, as well as a bit of a feasibility analysis as to whether they could be generated and prepared in time for 2013 so that all of that can inform the thinking and the decisions of the policy committee at the September meeting. Does that make sense?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes.

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

Yes. I was wondering if it would be helpful because I think what occurred, what happened, perhaps – what might have happened with the input that we receive is that, of course ... organizations that

completed the survey looked at the ... so it was ... variety of aspects that were being covered: diabetes, preventive services, obesity, hypertension. But we didn't give them, and it was probably appropriate to not give ... direction of consider – I mean, at this stage ... survey, consider including measures or chronic care related measures and acute care related measures and measures dealing with decision support tools and measures dealing with patient engagement. I wonder if now that we have this, and we see that there's gaps and gaps perhaps not because of ... measures, but because people didn't think of those.

If it would be advisable to begin to construct the categories of or dimensions, let's call it that way, of measures that would be important to consider in 2013, sort of creating a larger view of the categories of measures, and then as if there are measures around those or begin to collect information about whether there are measures around those. We identified a number of what I would call perhaps dimensions or categories or topic areas to see if measures exist. I wonder if that might be something that it would be worth doing. Then also do another survey perhaps or anything like that, but to create ... richer set of documentation to give to the policy committee so that they can consider, rather than individual measures, I don't think the policy committee would necessarily go down into that level of discussion, but more what are the higher level categories of measures or ... would want to concentrate on for 2013 clinical care areas or chronic conditions, certain chronic conditions, diabetes, cancer, or certain preventable services or things. I wonder if that will be helpful.

Janet Corrigan – National Quality Forum – President & CEO

I think that's an excellent idea. And I think there is a way that we can do that, Walter. This other small group that's been taking a look at the longitudinal measures, they've taken, really, we use at NQF a two dimensional framework for thinking about measures. One dimension are crosscutting measures, which really are the six national priority areas, so care coordination and overuse and safety and palliative care and there are crosscutting areas really that affect all different types of clinical conditions and settings, frankly. But then the second dimension really is the condition specific dimension, and we did just complete a project for Medicare, for CMS that prioritized the top 20 conditions that impact the Medicare population. We're doing a similar thing for the under 65 population.

What we could do, what we are trying to do is to identify where we have relevant measures in those categories, either the crosscutting areas, the national priorities, which is pretty much the framework that the policy committee used for the first round, but then also the leading conditions, the top five or ten. That is something, as we populate that a little bit, we could put out for comment and ask others to say, what do you think would be most appropriate in these various cells and in this matrix.

You begin to see pretty quickly where, frankly, we have a lot of measures for diabetes. We have a lot of measures for heart disease. When you get to many other conditions, there are far fewer. But certainly for the top conditions, there are plenty of good candidates, certainly process measures, and there are also some pretty good measures out there, some potential ones on care coordinations and handoffs, which I think might be really useful to push out of that. It's leaner when you get into the outcome measures, the actual functioning of health status measures. But that may be another very real area of opportunity to capture that information perhaps in 2015. I don't know if 2013 would be too early, but by 2015, we might be able to sort of be at that point where we'd actually be capturing those outcome measures, but I think that's a great idea. We can, on our next round, kind of pull together what we have from a variety of different sources, including this environmental scan we just completed, and share that with this group, and even just put it out and request them to comment on it.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

This is Jim Walker. Sorry I'm late. To follow up on that, I think the subtext of that, that everyone assumes that it would be useful to get explicit, and I've said this before, sorry, is to really focus, you know, to say to

people, the real question here is burden of illness and demonstrate an ability to decrease that burden with specific interventions. That's, you know, care coordination, transitions of care management, getting a food exam for a diabetic. It cuts across all of – I mean, the reason all of those things are important is because either they've been demonstrated or believed to decrease burden of illness in areas where the burden of illness is significant. Obviously if the burden of illness is significant, then the cost to Medicare is significant or whoever the payer is, is significant.

I think that's the level at which we could make a proposal to the policy committee, and it would be reasonable for them to say we're going to address these things based on best estimates of ability to decrease burden of illness in the population. One of the fortunate things is, the things we have lots of measures are, partly we have lots of measures on them because they have a huge burden of illness. I think that is a sort of policy level commitment that then could rationalize. Then any time anybody says we think X ought to be it, you know, so the organization of the oncologist comes and says this should be a quality measure. Then we have a transparent, discussable, it may not be a slam dunk, but a discussable set of criterion against which we build all of this stuff out over the next decade or so.

Janet Corrigan – National Quality Forum – President & CEO

Yes. That's a great point, and I think it's important to make it again and again, Jim. The frustration or I guess the challenge that I think we have would be the 20 conditions, measures that relate to the 20 conditions that NQF just went through this prioritization process under Medicare. We had very strong evidence there that's been pulled together on burden of illness of those conditions. They're really heavy hitter conditions that account for a huge amount of health burden, as well as cost. I think, in some areas, I'm not sure we have that kind of quantifiable data.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

But there again, that's a policy committee level kind of commitment. If they said this is the way we're going to organize our approach to this, and that means that we need ONC, HHS, or fill in the blank to commission studies that will be what are the – you know, you could take Beth McGlenn's 2003 article. What are the 20 most important conditions or interventions—it could run either way—for children, for adults, and for the Medicare population? What are the next 20 and the next 20 and the next 20?

One of the things we need to realize is that we're going to end up with hundreds of quality measures if we do this at all right over some number of years. That's the question. By the time we can transact all the big obvious ones, care coordination, transitions of care, diabetes, heart failure, asthma, and so forth, if policy committee can encourage HHS to develop the next layer of evidence, then by the time we get through the obvious stuff that we really, you know, everybody agrees big burden of illness, then we'd have sort of the next level, and we could attack the next group of things in a similarly sort of thoughtful, meaningful way that would be easy to explain to congressmen. It would be easy to, you know, that's the thing about that. That makes a lot of sense if we just would develop the data so that we could do it.

Jack Corley – ATI – Senior VP-Chief Technical Officer

Jim, this is Jack Corley. Building on what you've said about let's focus for a moment on care coordination, I think of how one might get reports that represented the fact that care coordination was indeed accomplished. One of the ways I think of is adherence to a widely accepted set of best practice guidelines. For example, in diabetes, it's not just that A1c is checked multiple times a year. It's also that a retinal exam is given once a year and the extremities are checked once a year and a couple of other things like that. Might we look for evidence of care coordination being the adherence to that best practice guideline, so list several characteristics? They did the A1c checks. They did the retinal exam all as one measure, or did I make a leap too far?

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Or as a set of measures, you know, I think part of the beauty of electronic systems is once that report is built, it doesn't really matter to the technology if there's 12 things in it or 5,000.

Jack Corley – ATI – Senior VP-Chief Technical Officer

Right.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

It's much more the difficulty of our specifying it.

Jack Corley – ATI – Senior VP-Chief Technical Officer

I'm just trying to think though how one would get evidence of care coordination.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Absolutely. That's the point, you know, we really, maybe we had talked about that, and I missed it before, Janet. I apologize, but our medical home and other medical homes, I mean, we could give you a whole set of measures that we use to assess ourselves. They're a combination of things like it started out particularly ordering hemoglobin A1c, but now it's much more about did the eye exam get followed up if there were abnormalities, kind of care coordination questions? I think we and others, and I know our people that do that would be very happy to share the measures that we use to judge ourselves. If we got that from a number of organizations, I don't think there's any question. But we could identify five or ten probably to start, something like that, that would be reasonably feasible, at least by 2015, if people sort of knew they were coming, maybe even by 2013, that would sort of meet the criteria of being heavy hitter issues that have pretty clear impact connected with them and are measurable in some systems, lending credence to the idea that they could be measurable in most or all.

Janet Corrigan – National Quality Forum – President & CEO

I think that's exactly what we're looking for, Jim, and I thought some of that was going to come in response to the environmental survey.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

You know, I'm sorry. That's just the way, you know, it hit my filter, and I didn't process it all the way through. I will ask those people right now and send you a list of sort of things that we measure to know how we're doing in medical home, and I think the other thing, my guess is, they're probably 2015 instead of 2013 because more of them depend more on care process rationalization rather than being highly dependent just on health information technology.

Jack Corley – ATI – Senior VP-Chief Technical Officer

But that's still a 2013 objective, the advanced care processes.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Yes. We can certainly look at them against that filter. I personally am in the camp that's real interested in this being feasible for organizations with modest resources, so we don't just blow them away at the beginning. But, yes, I wouldn't try to prejudge how it comes out. You're right.

Janet Corrigan – National Quality Forum – President & CEO

Great. Yes, please do send that in. We will then, as we just keep updating this list to include other submissions here, and as well as I think, before you came on, Jim, I said there were other groups underway that are doing similar things. We'll try to feed those into this list of potential measures.

We'll also go down this list here and identify for you the top 20 conditions that came out of the prioritization process, the ones that account for the greatest Medicare dollars and burden for Medicare at least. For each of the priority areas that were identified by the National Partners Partnership, including care coordination and palliative care and overuse and safety and a couple of others, those were areas where we were able to pull together a lot of evidence about potential interventions, as well as the payoff or the benefits associates with those. Those are pretty strong areas where there is a strong evidence base around sets of interventions. That may help to structure some of the thinking forward and fill out this list, so it's a bit more robust, as we move towards the end of the summer and keep this going as an ongoing process.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Great.

Janet Corrigan – National Quality Forum – President & CEO

Do we have any other comments today?

Judy Sparrow – Office of the National Coordinator – Executive Director

I think we just need to get the public, see if the public want to make any comments.

Janet Corrigan – National Quality Forum – President & CEO

Okay.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Janet, can I ask one question?

Janet Corrigan – National Quality Forum – President & CEO

Sure.

Jim Walker – Geisinger Health Systems – Chief Health Information Officer

Have you used the Beth McGLenn 2003 RAN study as one input into this? They had, what, 439 validated quality measures related to 20 diseases in kids and 20 in adults and 20 in Medicare population. I think that would be an important, high quality input into this.

Janet Corrigan – National Quality Forum – President & CEO

I think that's a great idea. Many of the RAN QI measures or similar ones that address similar areas have come in ... QF. We've got about 150 measures in the NQF database, but I haven't gone back in a long time and taken a look or cross-walked over to see what potentially was there that hasn't surfaced through the national standardization process. I think that's a good idea. We'll take a look at that and see if there are other gems that are in there that we should reach out and see if we can pull those measures in because they're very well validated and tested, so that's certainly has that advantage.

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

Janet, this is Walter. I wanted to just make a comment, and this is mainly for informational purposes. This week the NCVHS, the National Community on Vital Health Statistics, held its 60th anniversary celebration. We had a full committee meeting and had a number of discussions. One of the subcommittees of the national committee is the subcommittee on quality, and that subcommittee, incidentally, is chaired by Paul Tang and Justine Carr. Made a series of recommendations late last year to the secretary with respect to the need for a national coordinated quality and performance measurement framework, if you will. And the amount of recommendations that they made and some of you maybe

have seen the formal letter that was sent to the secretary. I will distribute that. I will send it to Judy, so she can distribute it.

But one of the core recommendations was to formally establish a national quality and performance measurement coordinator, sort of like the Office of the National Coordinator for health IT. There will be a national quality and performance measurement coordinator. It seems like this is moving ahead and there would be some of this being done. A lot of it is really going to rest upon AHRQ, Agency for Healthcare Research and Quality, which will probably have the primary responsibility on this, but ... that and make that informational comment. And, as I said, I will send back or send out a copy of the letter for distribution.

Janet Corrigan – National Quality Forum – President & CEO

That would be great. That would be great. Yes. I think more leadership and coordination on the federal side for this area would certainly be very, very helpful. Thank you for sharing that. We'd like to see that. Judy, I think we're ready for public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Great. Operator, can you see if anybody wishes to make a comment?

Operator

We have no comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Thank you, Janet and everybody.

Janet Corrigan – National Quality Forum – President & CEO

Great. When is our next call, Judy? Do you know by any chance?

Judy Sparrow – Office of the National Coordinator – Executive Director

I don't actually. I don't have my calendar right in front of me, but I will send a notice out. I will send it to you first to make sure it's agreeable. Then the meeting, of course, is on June 30th.

Janet Corrigan – National Quality Forum – President & CEO

Wonderful. All right. Good. Thanks, everybody. I appreciate it, and please send followup information, and we'll get that circulated to the group and reflected on our written survey results here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Great.

Janet Corrigan – National Quality Forum – President & CEO

Thank you very much.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Bye.

Janet Corrigan – National Quality Forum – President & CEO

Have a good weekend.