NATIONAL QUALITY FORUM

Moderator: Kim Patterson
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10:30 am CT

Zabrina Gonzaga: Hello, this is Zabrina.

Ameera Chaudhry: Hi, Zabrina. This is Ameera at NQF. We're going to wait a couple more minutes to let people sign in and then we'll get started. Thanks.

Zabrina Gonzaga: Sounds great, thank you.

Man: (Unintelligible).

Ameera Chaudhry: Good morning, everyone. This is Ameera at NQF. We're going to go ahead and get started. Thank you for joining us for the EHR Data Quality TEP Web Meeting 2.

So very quickly we'll just go over the agenda, we'll start with a welcome, conduct the roll call and go over some objectives. We'll also be discussing scope and data quality, and also have a discussion of the environment scan. Towards the end we will open up the line for public and member comments and also go over some next steps.

So welcome again, I'm here with our project staff, our director, Chuck Amos, could not be here today, but you may have seen him in our emails. I'm also here with senior project manager, Katie Goodwin, alongside senior project manager, Jean-Luc Tilly who will actually also be serving as our timekeeper today. We also have myself, Ameera, the project analyst, and our NQF consultant, Chris Millet.

Christopher Millet: Good, hey.

Ameera Chaudhry: So before we get started, we'd like to do a quick roll call. So I will say your name and if you are on the line, please let us know. So to start, John Marc Alban? Zahid Butt? Cindy Cullen?

Cindy Cullen: I'm here.

Ameera Chaudhry: Welcome.

Cindy Cullen: Happy New Year.

Ameera Chaudhry: Hello, John Derr?

John Derr: I'm here. Happy New Year.

Ameera Chaudhry: Happy New Year. Karen Dorsey?

Karen Dorsey: I'm here.

Ameera Chaudhry: Zabrina Gonzaga?'

Zabrina Gonzaga: I'm present.

Ameera Chaudhry: Toby Heyn?

Toby Heyn: Here.

Ameera Chaudhry: Angela Kennedy?

Angela Kennedy: I'm on the line.

Ameera Chaudhry: Hello, Joe Kunisch?

Joseph Kunisch: Good morning, I'm on.

Ameera Chaudhry: James Langabeer?

James Langabeer: I'm here.

Jamie Lehner: Hello.

Ameera Chaudhry: Michael Lieberman? Jacob Lynch?

Jacob Lynch: Present.

Ameera Chaudhry: Jana Malinowski? James Mcclay?

James Mcclay: Here.

Ameera Chaudhry: Shelly Nash?

Shelly Nash: Good morning, present.

Ameera Chaudhry: Shea Polancich?

Shea Polancich: Good morning, I'm here.

Ameera Chaudhry: Stan Rankins?

Stan Rankins: Good morning.

Ameera Chaudhry: Mike Sacca?

Mike Sacca: Good morning, I'm here.

Ameera Chaudhry: Good morning. And then we have our federal liaisons, Al Taylor?

Albert Taylor: Present.

Ameera Chaudhry: David Kendrick? Okay, is there anyone on the line from the TEP who I did not call?

Zahid Butt: Yes, hi, this is Zahid Butt. I may have joined a little bit late.

Ameera Chaudhry: Hello, thank you. Is there anyone else? All right, so with that, we'll go through the meeting objectives. Again, we're just going to review and discuss some of the results of the environmental scan, clarify data quality as it pertains to this particular project and also identify additional sources of information as needed.

For this meeting, after each section of the environmental scan that we will present, the co-chairs will ask the following questions; they will ask the TEP

whether or not they feel this is an important section. And if they do, does the information accurately represents the current landscape? What needs to be corrected and what's missing from this particular section in the environmental scan?

So with that, we'll start the discussion of the environmental scan itself. So the environmental scan draft was shared with you prior to this meeting, hopefully you had a chance to look at it. Very quickly here's just an outline of how it is set up, we have the background and context of the scan; the goals, objectives, and also the approach for the environmental scan itself; followed by the scan results and the analysis which we'll go through today during our call.

So background and context, again as a reminder EHRs are primarily used to support patient care so that the environmental scan we're looking at the secondary use of EHR as a data source for clinical quality measures. The summary of the background in the environmental scan also includes a section about structured and unstructured data, some high level stats on EHR usage and also the scope.

So this slide I won't go through any detail, but it's here for your reference and it's just a summary of some of the key legislation, you know, as it pertains to the scan in this project. And again if you do have any comments or any discussion points, we'll try to get to them during the call; and if not, feel free to email our inbox and we'll be happy to address them there.

So again very quickly the overarching goal of this environmental scan was to identify and summarize key findings on the causes, nature, and extent of EHR data quality issues and how this impact the scientific acceptability, feasibility, and use and usability of clinical quality measures.

And again just as a reminder of the objectives that are included, you know, how developers use structured EHR data, what data is needed to test eCQMs, and we won't go through it, but again this is data for care to refer to as they're looking through the scan.

So with that, I'll turn it over to our NQF consultant, Chris, to go over some of the scan results and analysis.

Christopher Millet: Sure, sure, so preferred section within the scan results and analysis, we cover eCQM and EHR data, and to sort of cover the landscape for this section (unintelligible) some TEP members and the amount on discovering what's going on with the EHR. So for those who are familiar with eCQM may well be aware of the technical specifications we all use to create eCQM. What's on the current are the quality data model; CQL, clinical quality language; HQMF and QRDA. Those are all kinds of the key standard views to create eCQM.

On the next slide we have - yes, on this slide we have some of the future standards that have the development community is working towards. CMS is working towards where we have (unintelligible) moving towards the (unintelligible) for eCQM to align our - to have them implement FHIR and (unintelligible) there is that we'll have a better alignment to use our data because it's kind of the general idea behind to have it easier to implement standards by an easier, more better aligned standard of FHIR.

So we looked at that, as an example, QI-Core, there should be a newer data model for the data criteria and measure that will replace QDM and the idea is they'll have a better data model that's better aligned. Those are the kinds of things will be used to measure going forward and there'll be FHIR base that will be better aligned. These are the data we dealt with.

The other benefit of this that stood out in the sense that (is in is also) that FHIR standards as part of their development process are the standards are tested as they're being developed so that happens with regular connectathon events where the different implementers will get together and actually implement the standards while they are still being worked on.

And then another component of FHIR, they have what they call the maturity model which is a framework for ranking different components of FHIR and how well tested they are, so all pass to how to promote standards to either implement - so that's kind of putting the eCQM standards towards leveraging of benefits.

On the next slide we have …

Jana Malinowski: Hey, this is Jana from Kansas.

Christopher Millet: Sure, can I just make a comment?

Christopher Millet: Yes.

Jana Malinowski: I just wanted to let you know that kind of we're working actually on a CMS pilot for the FHIR and we just (unintelligible) last week, and so we're just waiting up the update of the eCQM qualifications and then also testing the new submission standards and submitting to their new API form (unintelligible).

Christopher Millet: Thank you. Great.

Mike Sacca: Hey, Chris, it's Mike Sacca and if it's not the right time to interject the question let me know. But on the prior slide where when we're talking about

the - what is that, I think a huge change, but a change in the right direction if we're talking about placing measure testing into the FHIR standards going forward and the impact on NQF requirements and/or whether we're talking testing actual FHIR standards through tests versus actually testing individual FHIR eCQM, so I just wanted to ask for a little clarity there.

Christopher Millet: Yes, here I was referring to - in the FHIR development process where they test the FHIR standards, so not necessarily a measure testing kind of way or making sure - like for example it will be better to use, you know, the things (unintelligible) on report, the things (unintelligible) for quality measure, or even standards as well opposed being tested on specific measure that uses - that were useful, you know, the FHIR-based standards.

Mike Sacca: Got it.

Christopher Millet: If there are efforts around that or that is happening and we just don't know that that is - you know, you're definitely welcome to be aware of things happening outside of kind of what outlined here. If there are other activities that we didn't put on, we want to make sure we did after that in the scan.

Zahid Butt: So, Chris, this is Zahid. So I guess since we've opened up the discussion, may I also ask a question?

Christopher Millet: Sure.

Zahid Butt: So my understanding is that technically the QUICK's data model which is sort of the logical data model aligned with QI-Core is the logical data model that will be replacing the QDM, but it's sort of a subtle technical difference between QI-Core being a profile resource versus a logical data model which is being QUICK.

Jana Malinowski: This is Jana. Let me touch on that just because I work on (unintelligible) and there really hasn't been a final decision and my understanding is that (unintelligible) that that will still be at first CMS to make the final decision. So as a vendor and kind of the industry the kind of CMS (unintelligible), everyone at a high level use that as - if you're going to use QUICK then it's going to be different than what we have at QDM.

It's another model. It's another (unintelligible) outside of (unintelligible) standard and look for quality measures, and so it's kind of that actual burden or kind of (unintelligible), another (unintelligible). They're kind of explaining this a little more and I think it's going to be kind of a 50-50 split (unintelligible). You know, basically, (unintelligible) so then, you know, you basically would have to wait on the FHIR version classification for US-Core and you have to have the QI-Core.

And then QUICK will be another tool, another - and it also has (unintelligible) so not the data model but (unintelligible). So there's just so many things going on it, so many layers that they can - they can make it easier on vendors on the different versioning so that they can write a layer that then converts to the different classification that you're on, whether it'd be easier or are harder than choice.

But there's going to be some (unintelligible) cases than that. It's not going to work through with FHIR having these elements, or you know, there could be factors that change, may or may not (unintelligible) forward. So there hasn't been a decision made and it's very controversial.

Cindy Cullen: Yes, this is Cindy.

Christopher Millet: Thank you.

Cindy Cullen: This is Cindy. Yes, really interesting discussion, I'd like to bring us back to the topic at hand and I think this discussion actually brings up one of the issues and concerns I have about this section. But I'd like Chris to be able to finish out his decision of the section and then we'll open it up for a more broader discussion about the appropriateness of this portion to the environmental scan. So, Chris, if you could finish up please.

Christopher Millet: Sure, we're going to the next slide. This touches on unstructured data and free text with - yes, we have another section that also touches on free text on a structured data so we can - we can definitely spend more time on that there.

But then the little thing we will need so far is that there will be natural language processing not yet mature enough and that NLP would still need to put process on structured data. But one of the goals of it would be to create structured data for that so that that can be used equal as EHR and to use structured data available to eCQM.

But again we do have another section that touches more on that so I think actually this is a place where we'll just open it up.

Cindy Cullen: Again, this is Cindy again and can someone please put themselves on mute when they're not speaking please. So what I'll talk on this section we have worked two distinct pieces to it. One is the focus on the unstructured EHR data, NLP which as Chris mentioned is included in another section of the report. So I think we can consider information in that section.

But I want to bring it back and host to just ask the question that is at hand which is should this environmental scan include section about the standards

that are used for eCQM? Would this be something that would be helpful to inform the audience for the scan and to inform the scan itself?

Jamie Lehner: So this is Jamie.

Zabrina Gonzaga: This is Zabrina. I'm sorry.

Jamie Lehner: Go ahead.

Zabrina Gonzaga: Yes, this Zabrina Gonzaga from Montana. I would say for environmental scan I think is helpful to have both current and emerging standards for eCQM sort of as a foundation for the reader and context for the reader. I would vote for including that.

Jamie Lehner: And this is Jamie, I was going to say too I do think that it will be valuable to have some of this context included there because I think that both standards themselves may be actually something that is presenting those challenges and it could present challenges both historically and also in the future. So I do think it's going to solve, as I kind of mentioned, some of the standards that are currently available and to the direction that it's going.

Cindy Cullen: Okay, great.

Stan Rankins: And this is Stan, I would just echo - sorry, I cut you off.

Cindy Cullen: No, that is - I'm just going to ask if others have any other comments.

Stan Rankins: Yes, I would echo what Zabrina and Jamie both said. I think it's pertinent to this (project).

Cindy Cullen: So we have three votes. Is there anybody - are there any TEP members who disagree that this should be included in the scan?

Zahid Butt: I think my only comment -- this is Zahid -- to you know put some sort of disclaimer because this is a one-time report from what I understand that as was evidenced the little small conversation just a moment ago that there's a lot that is unsettled yet in the standards community side and that it should be - that as of this point in time is what these standards present that people need to go and then look at the standards information for the most current standards.

Cindy Cullen: Yes, I think that's a great idea and maybe perhaps I'm going to put some points here, if a reader could find the most current, it would be great. And Zahid, I like the word "resolving" as opposed to "unsettled." It's a little bit more …

Zahid Butt: Right, right, right. Yes, yes. No, no, I agree. I - yes, I was colored by the conversation also.

Cindy Cullen: Yes, and Zahid, it was actually very interesting. So that brings one of the questions that I had in here, does that - the discussion between Jana and Zahid was very interesting because it was so deep-held and as I was reading the scan I saw that there was quite a bit of detail involved in it, talking about the various (processing) and the different standards. So what does this feels as an appropriate level of getting into the weeds of the standards for this return?

Zabrina Gonzaga: So this is Zabrina and I agree with your comment. In terms of the concepts of this report having the references to the standards would be great and also perhaps points the readers to the ISO 2019, the standard advisory because there is a section within that document that looks at quality measures and the standards are compiled nicely.

And then it also tells you what is the status, is it adopted? Is it emerging? You know, what is the adoption rate? And if they're interested, they can look there for some additional information.

Cindy Cullen: That sounds like a great resource for NQF. So thank you for pointing that up. Anybody else have any suggestions for this section? Is there anything here that is missing that we feel should be included?

Albert Taylor: This is Al from ONC. Hi, Cindy, good afternoon.

Cindy Cullen: Hi, thank you.

Albert Taylor: I wanted to also - in addition to the ISO which I think is a good general reference to the available standard, whether they're required or not, that's my disclaimer on the ISO. They are required (unintelligible) product list (unintelligible). That's something in addition to the ISO which is it catalogues all sort of - all EHR and other health IT that has been certified through all of the certification criteria that ONC puts out and people test through EHRs and other health IT people test to, including the eCQM criteria, C1 through I guess currently C4.

And the - and in particular not only do they - do they catalogue the - what (unintelligible) the EHRs are certified to, they also catalogue the specific eCQM that they're certified to. Some vendors, some products only certify, say, nine or four, or something like that depending on what kind of program they support and some of them are more comprehensive and certified all 64 - I think 63 or 64 existing eCQM.

So I can give you a blurb to fill in, to summarize what I just said, but I think having tackled, looking at EHR data quality or eCQM data quality, knowing that some EHRs are not even certified to - not even capable of measuring specific eCQM.

Cindy Cullen: Thanks, Al. I know I've used to tackle a couple of times before and I think that's a - that a really nice way to kind of set some of the stage for some of the concerns about data quality here.

I think later in the discussion we're going to talk a little bit more about, you know, findings - well-defining data quality so that we can discuss really how the scan supports the identification of what the particular issues are versus data quality. And I think, you know, putting eCQM down there and having products that just can't even see them is a little bit concerning with the data quality there.

Let's see, I am trying to be cognizant of the time. Are there any other comments or any other sources regarding standards and the application of standards that we want to provide to NQF at this time? And again, is there anything else that's missing in the section?

Mike Sacca: Cindy, it's Mike Sacca. I think to your earlier question, I think the level of detail currently is pretty good. I think we've done 11 pages with little text, right, that we get in the table for definitions and whatnot. So I do agree with the other comments that, you know, additional standards and whatnot make sense. But I don't have any problem with the current level or sort of detail that's in the context in that space.

Cindy Cullen: Okay, that's great. What about the inclusion of NLP in this section, is it appropriate here, or should - do we feel that maybe all the NLP should be included in the later section that refers to the unstructured data?

Mike Sacca: It's Mike again. I would agree with your earlier comment, when I first saw it here and I thought I'd say we kind of agree and I get where we're going, right? It's not a current standard to use unstructured EHR. It's siloed and there's some progress there. But I would agree I think it better fits in the subsequent section.

Cindy Cullen: I agree, I have to think of it.

Man: I would agree as well.

Jamie Lehner: Yes, this is Jamie, I agree.

Zabrina Gonzaga: This is Zabrina, I agree also.

Shea Polancich: This is Shea. We will move on, I just have a quick comment of do we - the expectations of the reader for the scan, like what do we expect them to be able to take away from that. I mean, I'm getting the discussion about this is being (unintelligible). What is the expectation to the reader from this scan?

Cindy Cullen: I want to ask - this is Cindy - I want to ask clarifying question, are you asking about what they should know beforehand to be able to comprehend this or what they should be taking away from the scan?

Shea Polancich: I think it's both, right, I mean, who - I think to really set up the scan document, I think there is an underpinning of what they need to know as they come in

reading it and then what takeaway they're going to get from it passed sort of years towards that level as well.

Cindy Cullen: Yes, I would agree on that and that was - this is Cindy - that is why I was kind of pushing on the level of detail regarding the standard. As I read this section, I'm aware of some of the - I'm - my - I mean, initially I'm very - you know, I know quite a bit about the current standards, CDM, CQL, QRDA. I know all three FHIR standards. I have not been working in the FHIR standards and I know that there's the QI-Core and the QUICK. Those are words that are familiar to me, but I don't know the significance of those. So, Jana, your explanation, that was very helpful to me.

So, you know, if we're using that as a single use case to somebody who's in the field and has a general understanding of the standards, but the expectation of, you know, who the audience for this is, I think is for - you know, I think, number one, it's for the sponsor which is CMS. And then, number two, it would probably be close to our - related to the field here.

So I think we can expect a basic understanding of some of the standards, but maybe not too far as we believe. So to (Jamie's) question, is that who you were targeting?

Christopher Millet: Yes, that sounds like - that sounds like what we have in mind.

Cindy Cullen: Okay.

Mike Sacca: Cindy, this is Mike. Would it - from what I'm hearing it sounds like do we need a little blurb or have efforts to only intended audience just so somebody doesn't come in to this and expect more than what's here or maybe it's beyond

their initial level. It sounds like there's some prerequisite level of experience that reader would need with, you know, the standards.

Cindy Cullen: I know.

Woman: Yes, and I agree. I was saying that I probably agree with that because I think that would help pace the reader to narrow what level that they need in here and it helps us to be around - yes, it gives me more range than what I know, like you have to have underlying knowledge of what it is to begin with.

Cindy Cullen: You know, I think that's a really good point and I'm glad you brought that up. Anybody else have anything to follow on to that? Folks at NQF, do you have any reaction?

Christopher Millet: No, I think that makes sense. That will help with the clarity upfront.

Cindy Cullen: Okay, yes, and it would help with the level of detail that we need to put in here and it might help with the overall as we get into some of the other discussions of what the appropriate level is.

Okay, any other comment on this section before we move on to the next which is EHR data and PAC settings? Okay, I think, Chris, I'm handing it back to you again for the discussion.

Christopher Millet: Yes, that's great. So during our first TEP meeting, we brought up some of the PAC settings and how some of the things we just went over may not apply. And we followed up with some of the TEP members and listed some follow-up on the, you know, eCQM that kind of Al said earlier, you know, the specific ONC certification criteria and how to certify the entire technology

program that mention capability for being able to handle - evaluate or report on the eCQM.

Those capabilities don't really apply to the PAC settings and that's definitely (unintelligible) even though - even that push for the (unintelligible) certification program of EHR and the dozens programs for using them also cover the PAC setting.

However, we've also - we still do have the IMPACT Act that's much more targeted for the setting in terms of only the use of standard assessment tools, what's in here, and the minimum data set, OASIS, the inpatient rehab ability, taking of that solutions and the CARE data set, either used for their effective settings that they have on the slide.

So, you know, we found efforts to not only that we have different tools for these different settings, but they also have efforts to kind of do better alignment across the different PAC settings that whenever the people in the CMS Data Element Library. We'll try to align questions and answers across these tools.

And then similar to (unintelligible) space, we found that there are also efforts to also align this effort with FHIR to better integrate - or better (unintelligible) and because that is an added benefit of FHIR, so specific piece of implementation. So it goes back to the data element library, the CMS Data Element Library I believe that they require implementation guide to help that CMS Data Element Library.

So those are the things we found kind of parallel to the things you saw and that you're seeking in space. What we noticed there's a lot in the space as well, so I guess I'll turn it back to you, Cindy, to open it up to see if we've

missed things that we just covered, or if there are things here that we didn't get already. So, yes, I'll turn it back to you to open it up.

Cindy Cullen: Okay, that sounds great. I still have one question and maybe I missed it in your discussion, are there established standards for the data that are collected in the PAC setting?

Zabrina Gonzaga: So this is Zabrina, I can - I'm sorry.

Christopher Millet: No, please go ahead, Zabrina.

Zabrina Gonzaga: Yes, I can help answer that. So in terms of standards, each of the post-acute care settings has their own classification for reporting their data, their assessment data to CMS. So that's currently the standard that they use in terms of reporting and they're available on the CMS Web site.

In terms of the post-acute care standard data element, CMS is working to standardize data elements within the defined domain, so they can simply go into that. And within those domains, there are actually quality measures that they are defining that a cross-setting across the four settings listed on this slide.

What haven't evolved yet is the work then of the eCQM, the inclusion for this cross-setting measures. I think it's helpful to have this information in the report. It provides context to what is actually going on to post-acute care setting because they are - you know, they're working to have data that can be compared at least across the different - used for different settings even though they don't have incentive through adoption or defer by EHR. They are still working towards standardization.

Cindy Cullen: Thank you, Zabrina. That's really, really helpful. I think it kind of tees up the question as to whether this section is important to include in here. I'd like to hear from other folks to see if they have an opinion on including information about the work that's being done under the PAC setting to the scan.

John Derr: This is John Derr. I have a couple of comments. I think you have to mention in this part that the vendors have tried to do a certification.

Of course, we did not get any money for that and I think the cost of doing certification, especially sometimes they are moving the target, should be noted on here because when we put these things out right there without mentioning the cost. I know you mention in the agreement we didn't get anything to upgrade our IT systems, but I think we should be entering it.

The second thing the cost that should be mentioned in this section because I do think it's important is, you know, we're undergoing now PDPM. And PDPM right now is changing a lot of the assessments and I think the changes mostly are where we get paid and I think that should be mentioned here too.

I think not to mention those two things - so the rule is ideal and it is not ideal that we're trying very hard to do the quality measures and do all those things that will (unintelligible) by the fact that we didn't (hit) being pushed to do that. And the vendors, of course, are profit-centered that the problem is they have to pass that on to the (unintelligible).

Cindy Cullen: Great, thank you for that contribution. So at least someone else was also has a comment?

Joseph Kunisch: Yes, hi, this is Joe with Memorial Hermann. First, a quick suggestion, in other TEPs that I've been on, they used the raise hand feature that kind of puts

a little bit of order and prevents people from, you know, three people have something to say and they're all trying to talk at once, so it moves things a little bit smoother.

But then the comment that I wanted to make on in particular, I like what they're doing in the post-acute care setting, but I also see this as kind of creating another silo, so you're creating a system that supports a certain setting being now the post-acute care.

But I like to use like falls and fall risks as an example. Fall should be assessed risk assessment in ambulatory settings in the inpatient settings and obviously it's a big thing in post-acute care setting. So if you create different standards in the PAC, it doesn't talk to the inpatient and the patient has a fall in the hospital, that information needs to transfer over into the post-acute care setting. So, you know, that's something that should be included. But also kind of a quick note to say that we really need to be looking at the continuum of care and not creating different standards in all those settings.

Cindy Cullen: Thanks, Joe. I think that's - I think that's important to include in here and it relates to one of the concerns I've had about this section which is that it's focused on a particular setting. We haven't - and the topic that we don't call out particular challenges with other settings like inpatient or ambulatory, and I was wondering the TEP felt about that, you know, whether this - the post-acute care maybe should be considered a use case or you can easily expand the - what we've included here, or what's included here to look at challenges in other settings too.

Mike Sacca: Cindy, it's Mike. Cindy, I guess they could go either way on this one because it's almost like what we're saying here is that basically the (unintelligible) are excluded from kind of eCQM standards, right?

Cindy Cullen: Yes.

Mike Sacca: While they're doing standard space work and looking at interoperability has been a different manner with their data on the library versus eCQM standards and you know, FHIR and CQL and whatnot. So I think it does need to be delineated I guess would be my one comment.

And then around just the (ramification) of is there any confusion if they include this specific to what the eCQM Data Element Library or whatever that current name for that is versus what the PAC setting is doing on the IMPACT Act which requires, you know, data element library for these assessments.

Cindy Cullen: Okay.

David Kendrick: So this is David Kendrick in Oklahoma. You know, my take on this is that location of care and service is sort of an artificial concept and just because it depends on what environment the patient was in and what convictions they have as to where they're going to go.

And unless we start to seriously monitor or put it in as a component of measurement, the scope of the data that was available for measurement and the amount of the patient's story that was available for measurement somehow, then we're really not going to be getting very accurate picture except for very specific things like, you know, location-specific and the hospital infection rate or something.

But population measures really rely on having sort of a global patient-centric, you know, patient wide view of their experience, and so I really feel like sort

of value set was the term I've always used to describe the data that's required for measurement and I think that's used by NCQA, NQF and others.

And the value set for me needs to be sort of the main and prominent specific, but the fact that I get a Medicaid - you know, the fact that a woman had a mammogram that I get it from the claim data or I get it from the EHR, or I get it from a PAC directly because there's such a procedure there is all true. And any one of those should be able to trigger the breast cancer screen event and notification.

So I guess I get a little concerned about focusing on any specific EHR as the center in the universe because their fragmentation for real patients is so broad that we know we have major gaps from the measuring firm and it's almost impossible without some estimation of that fragmentation for me to trust what population measure is that.

Cindy Cullen: Good point, thank you.

Zabrina Gonzaga: So this is Zabrina, I just wanted to put in another - as the CMS Connect from - I think it was last week, there were three PAC tracks. One is the data element library, FHIR API, and then there was actually a question on in cognitive track looking at the exchange of assessment data for function and it was center on cognition across settings.

So I think that would be helpful to show that, you know, the PAC setting isn't looking to be FHIR, but they're looking at the assessment data and trying to, you know, test what functional thing that was cognitive thing that could be shared across multiple settings, so inpatient, ambulatory as well is a different post-acute care setting that might help for this detection.

Cindy Cullen: I think that's a really good contribution here because I think it goes to Mike's - I think it was Mike who made the point about the - or someone made a about the siloing of the efforts here and - no, Joe, I'm sorry - about, you know, having data elements that are specific to these third settings and not being more broadly used. So I think that that makes sense, that ties there to say that there is an attempt to do that.

Any other comments on this section before we move on to the next? Okay, we're onto unstructured data and Chris, I think I'll hand it back to you again.

Christopher Millet: Thanks, Cindy. So what's unstructured EHR data, we didn't want to have a section for this. I think it came up a little bit in the last meeting and then it came - it come up in different places like the literature and it's often talked about from the slide that we had within the easy to run section, NLP, where it's promising, but so many comments which is not yet necessary.

In here we kind of - what we hope to identify for unstructured data is that, one, unstructured data is valuable so it's not something that is immediate or because we don't know how to use it yet. The narratives are kind of unstructured because they've seen that it have - it have things that are - that could be pretty valuable for (unintelligible). But they'll probably need more work to validate how easily it can be - natural language processing itself and the use of unstructured data with eCQMs.

We think some other benefits were highlighted there, what unstructured data can help people from (unintelligible). It'd be useful in a way that's perishable and maybe usable in different ways. So I'll pause there and see if there are any questions that we need walking it through on how you (unintelligible) and if so, are there things in the space that we should be covering - we should be

including in the scan and what have you. So I'll turn it back to you, Cindy, to kind of open it up.

Cindy Cullen: Okay, so unstructured data, so how do we feel about the utility of a discussion on this to (unintelligible)?

Joseph Kunisch: Hi, this is Joe. I think inpatient definitely should be included especially as noted here, there are advancements. But I think one of the things to kind of point out is it's very useful as kind of a support to identifying potential discrete data element that could be used in quality measurement.

If you think about it like our coding department relying heavily on our system, our vendor that has been - NLP that's going through reading and then suggesting the diagnosis codes for that coder. But I think, you know, one thing I'll go to add on there is - at least the current stage and probably in the future, they're always going to need to be a human validation.

So, currently, we have clinical decisions support rules that can trigger off, you know, kind of proxy indicators to suggest to the physician, "Hey, you may want to add this problem or you may want to add this diagnosis to this patient." You know, a lot of this is driven by the billing and DRG what they consider assisted coding. But it's all using NLP to raise the documentation of the entire chart and then making those suggestions. So I think it is valuable to include there.

Cindy Cullen: All right, great, and thanks for that example, Joe, that's kind of cool. Yes?

James Mcclay: Yes, so this is Jim Mcclay. I just want to say that, yes, we need to use algorithms to interpret the data. But in the end, we still needed to convert it into structured data for consumption by the measures. So we're in the path or

at a curve - in the billing example, the system is suggesting to the intermediary, you might want to consider adding this to the structured piece of data, but we're still converting it to structured data.

So it's not that we go from unstructured data directly to an eCQM. We say that the system will say that there is an opportunity to fill in a blank in the structured data that will operate the eCQM, would you like to do that? That makes sense, the difference there.

Joseph Kunisch: Yes, and just to follow up on that, we actually can auto-populate in a diagnosis or problem, but obviously the clinicians will - you know, when that comes out, they push back against the decision like, "No, I wanted - I need to validate that as appropriate." But there is the ability to auto-populate discrete data elements based on the NLP.

James Mcclay: Well, yes, certainly is, but I'm a clinician and I don't want to do that.

Joseph Kunisch: Exactly.

James Mcclay: Agree.

Karen Dorsey: This is Karen. And so I think it's an interesting point we talk about the - you know, continue to utilize clinical review of information that comes out of NLP. I think - I think there's - you know, I think there's a way to triangulate in the NLP where I can go down and I see some measurements at NLP in the context of elements that are in structured field can be independent without data then use.

I don't want like - you know, I just want to add on you always have to have some clinical review. I there are some algorithms that can process potentially,

that could better leverage NLP that can be validated. But when I think about sort of literature review is, you know, how important it is to be able to see - we'll just talk a little bit used cases for NLP, just a little bit discrete about where we think NLP is now and where it shows some promise.

I think that's helpful. It just sort of ground you in something concrete. I don't know if it kind of brings you like - we're kind of throwing things as high in the sky because it's, you know, effective. Everybody wants it to become something. But I think if you can ground these steps to the sand and be tangible used cases, and help that with our data that we have use around those used cases, that we maybe in a subsequent flow talk about it in the session.

Cindy Cullen: Yes, that's a really great suggestion, Karen, I like that a lot, and maybe some of the studies that are indicated on this slide have some information about that. I know I've looked at a couple - I've read some more article which focuses a little bit - in a little bit different area, but because NLP is so important to - you know, as that insurance stuff should get us from unstructured to structured, having that laid and you know, as we had suggested in the earlier section with the standard, looking at the current state and the movements of future state I think is a really great way to frame this section.

Any other folks have any thoughts, suggestions? Is there anything that's missing from this section that NQF should be incorporating here?

Man: Cindy …

Shea Polancich: Yes, sorry.

Man: No, go ahead.

Shea Polancich: Okay, this is Shea, I totally agree with that last comment about showing where we're at right now with NLP, but not negating the complexity of the (current shared) delivery process because I think (unintelligible) information (unintelligible) and it's really challenging.

We can't neglect the challenges and the complexity of being a clinician because they were written to that unstructured data that is not easily converted without some significant effort into structured data. When I think of my role versus now, and my role as clinician to write a narrative that has several pages before I can say this is a stage 3 pressure injury and the location, and et cetera.

And even if it's supported and talked about where we're making some grounds, but there's also complexity that's not going to be either way we change and I don't think even we change it for years.

David Kendrick: Yes, so I agree, this is David Kendrick. You know, let's face it, there's really no such thing as completely structured and completely unstructured data. It's in different degrees. Oftentimes in the blood pressure field, we have to fix them, or in the BMI field or the height field, I remember getting BMIs over a billion for a lot of people because they've messed up the units. So that's one thing to consider that there are different degrees of unstructuredness in the data.

And the second is if there are to be automated algorithms used on these things, they got to be open and transparent and tested, and they got to be done very well because if not, then who knows what's - when they're not calling measurement results and there's really no accountability for it.

Cindy Cullen: Yes, that's a really good point about the openness of the testing results so that we also feel that level of comfort with the algorithms that are being used with NLP. Mike, I know you had comment and then …

Mike Sacca: I have a comment too, Cindy. So I don't want to take more time because I know we're getting close to the top of the hour. But I think real quick just to piggyback on the prior comment, I was going to also suggest the potential use case around pressure injury stage.

And even stage 2 we just heard on a project that sometimes they choose a (cast off). So maybe even at the prior validation NLP could be used to dig through, you know, some of the more detailed notes to kind of confirm or inform, you know, what's being documented.

Cindy Cullen: Yes, Stan?

Stan Rankins: Yes, and just real quick, I would say though that NLP data I think is not the only way to deal with unstructured data. It's just a method, right? And so I don't know that we should get completely hang up on NLP. But I think I would consider things that we're having. But it's really about the data and what the quality of the data is at that time, and so it would be accurate in someone's report.

Cindy Cullen: Okay, maybe, you know, saying that NLP is one method to deal with unstructured data, maybe a further discussion in the scan about other ways to deal with unstructured data might be a good addition to us, or maybe not.

Stan Rankins: Those would great to me. But I think - yes, I think it would be very great to open up some possibility talking about otherwise, but it depends on how complex you want to get what this environmental scan.

Cindy Cullen: Okay, and thank you, Stan, for the recognition of the timeliness. I think it's time for us to move on to our next topic. We're going to spend a little bit more time here. This is on the quality issues and NQF endorsement. I think I'm handing it off to Katie to introduce this for us.

Kathryn Goodwin: Thanks, Cindy. Yes, so what we did in this section was take a look at the NQF circle, you know, of measures and specifically a close look at eCQM. And just to put this in context for you, NQF has endorsed over 500 performance measures, with only about 35 of this being in eCQM, so we do have, you know, a few number - a few amount of eCQM in our portfolio.

We suspect the lower volume is in part due to the testing that is required for NQF endorsement and we have received feedback from measure developers that have reported accounts of the number of EHR systems available for testing.

Recruitment for testing has been challenging. We've heard that particularly the test sites are sometimes not using validated tools and/or standardized methods of EHR reporting for screening or intervention. Additionally, identifying test sites that are currently collecting all required data elements is also challenging.

The next couple of slides we kind of started to look at the eCQMs that have been submitted to NQF for endorsement considerations and we looked at the criteria but let’s say they did not make it through. So we determined that several eCQMs didn’t pass the third criteria, which is muts-pass criterion, important to measure and report. So that includes both the evidence and opportunity for improvement sub-criteria.

So we found that committees found the eCQM to have either low or insufficient evidence to support the measure focus, or lack of performance data to demonstrate quality problems or opportunity for improvement.

The reason why I think it's important to note that this criterion is muts-pass is because it tends not to move forward and go through the rest of the process, so it's not evaluated for scientific acceptability, feasibility or usability and use. And therefore we don't have as much committee input on those criteria.

On the next slide, you'll see for those measures that did pass important to measure and report, they have been evaluated against NQF's scientific acceptability criteria, and that includes reliability and validity.

We were able pull a few examples of eCQM that did not pass this criteria. One eCQM did have empirical validity testing done at the data element and performance measure score level that showed poor agreement between the time a patient sees a provider and what is documented in the chart.

Another had data element testing performed only at one hospital site and also one measure has a lack of evidence to supply alignment with the measure specifications. And therefore the committee did not find the measure specified to be a valid indicator of quality.

Feasibility is the third major NQF endorsement criterion. Feasibility assessment is required that the assessment must address the data elements, and measure logic, and demonstrate that the eCQM can be implemented, or that feasibility concerns can be adequately addressed.

The domains addressed in this assessment are data availability, data accuracy, data standards and workflow. At this time, feasibility is not a must-pass

criterion for NQF endorsement, so it really hard for us to say it's a measure and eCQM did not pass endorsement yet neither to this point. We don't have clear data on whether or not feasibility, that's the really why it is not endorsed and it's not a must-pass criterion.

I will say that as part of this work with the test, we will be working for your input on NQF criteria towards eCQM and that the testing will happen at a later time. Okay, and I will pause there and turn it back to you, Cindy.

Cindy Cullen: All right, thank you. Can we move back to Slide 1C? That would be at the end of the section. Okay, the question - the first question that we post is, is this a report we should in the scan? I'm curious if anybody thinks this is not important to be included because I think this is - I get the sense from prior - our prior meeting that this is really the genesis of the - of creating this project, is to really understand what is affecting the ability for eCQM to be more successful at NQF for endorsement.

Does anyone have any concerns about that this should not be included in the scan?

Jamie Lehner: This is Jamie. I don't disagree. I do think that this should be a part of the (quite to share). I do have a concern with the last sort of kind - and some of the texts within the draft paper, and it's only because just knowing that the measure - so I'm worried about the fact that we put it to try to create a measure that kind of sort of build or implement it in a variety of set throughout the (system), and so this move sort of allowing a variety of ways to capture simply the things - type of information for a measure requirement.

So the notion that - and if our test sites do require that - our required data element is a challenging one because one institution may not actually ever

capture something. One knows that they'd capture another way that's included in the measure. And so from our perspective, that's Okay because they can still report on the measure or capitalizing essential information. But they - you know, they've opted to use one particular way to do that.

So I'm not quite sure that that's something that's appreciated by steering committees either, but that is something that I think we need to be a little bit cautious of. From my perspective, I think we need to talk about how we say that.

Cindy Cullen: I'm going to wholeheartedly agree with that statement because I agree, you know, that's the way we as measure developers and for those of us who are on the call who are measure developers design measures to provide - if we can provide equivalent ways to express similar concepts so that we can broadly see the data - a (portion) of it the data requirements for this so that we can make a - so that measure requirement can be met. So I think that's …

Jamie Lehner: Right.

Cindy Cullen: I think that's an important point to bring up. Okay, let's open it up then and then have some discussion about the - let's see - again I thought what we have here, importance to measure reliability and validity, and then feasibility as appropriate as inclusion for those concepts.

Zabrina Gonzaga: So this is Zabrina, in terms of data quality issues and eCQMs, one of the areas in my mind opting to the actual value set and sort of the value set represents the concepts. And this may be out of scope for the scan, but there are several repositories out there, so for an electronic health record standard where they know do I get to VSAC to get the value sets. Do I get into the eCQM data element repository? Do I go to the CMS Data Element Library?

So they (dissected) also an area where we could recommend - either recommend or pull together some of the repository before they could actually go to pull the value sets that make up the measures that the measure development - measure developers needed. So I just wanted to put that out there to see - you know, see what other thought.

Cindy Cullen: Okay.

Jamie Lehner: This is Jamie again. I recommend the items that were mentioned. I believe that the data element library and the repository are very different. It those that those are actually good points to review set. So as when we look at current doctor (RA) device that can have (unintelligible) are very, very - I just want resource because it's durable.

I do believe that they point to a single, you know, central repository to view. We just have to find about - sort of onion peel - or goal in terms of what information is presented or how it's presented.

Woman: Yes, because I believe even the measure for (unintelligible). Can I just ask a question? I'm sorry, this is so (unintelligible). This thing we're talking about in concept of eCQM specifically and not as effective measures?

Cindy Cullen: I'm going to throw that back to NQF.

Christopher Millet: Yes, that’s a good question. So I think there are two levels to that. There's a level of how does this whole conversation play out when we're talking about eCQM, and how does this play out when we're endorsing measures that the EHR (unintelligible). And also they could be the same, but

they're not necessarily and we don't want to treat them as if they're the same because there are different things.

And I'll just give one example of that from when we - you know, we do view eCQM further here. eCQM, the review is that - that's an area where we do need these data elements. The idea is that this data element is something that you can find and it's something that's structured which is why - not just structured, but something that is a structure is available …

Woman: As a discrete element.

Christopher Millet: I think it's a discrete element, exactly, which is why we have for every element viewed in the measure and the feasibility scorecard. It's not possible to either (unintelligible) intended if you just don't have this date element.

They may not true if you're just planning on using the entire data, but you're not necessarily - you're not necessarily finding the eCQM. You just want to use EHR as one of the data source where you haven't.

Woman: Yes, that's what I was hitting kind of some of the comments because if you are going to be scanned, the feasibility data element and (unintelligible).

Christopher Millet: No, I think we are too. I don't think these folks have thought either side of that. That's definitely helpful for us, be it someone who can play those two, but necessarily (unintelligible).

Zahid Butt: This is Zahid. A couple of comments relating to the value set comment, I think that a couple of important ideas to potentially discuss within that context is the need for again a single force of those value sets and harmonization of

the value sets because that directly impacts both quality as well as ease of implementation.

David Kendrick: This is David. I totally agree with that, value sets should be in the value set authority center and curated consistently, and (unintelligible) in multi-source so that you have value sets that are considered by the EHR technology and the equivalent concept from value set if it's coming from, say, the pharmacy (B), or from IMPACT system, or even from along here.

Joseph Kunisch: I think - this is Joe from ONC, as a caveat to the value set authority center which I think is an amazing and then it should be widely used, there is the issue about non-eCQM value sets, those in HL7 and in particular in moving FHIR that other domains are - other domains of HL7 as well. And there's still some pretty active work going in how to organize value sets across HL7.

Man: Hey, Al, can you say some more about that, just go deeper.

Albert Taylor: So within the - a lot of the findings for FHIR resources, there are - they're not all bound to terminology content. But those that are - the value sets are maintained in HL7 on the - within the HL7 self-maintained - or risk of value sets. They are not - they're generally not as - I don't want to say well-organized, that's not fair. But they're not as ingestible, downloadable as those on VSAC but - and they're not packaged the way that VSAC packages them like all of the easy program measures or something like that.

There is some work being done to make it more like the VSAC and I'm not sure exactly which workgroup is working on that, but I've got some connections. But it's a different way - they have a different way of handling HL7 value sets.

Man: Can you ask them to work together, or would that be a challenge to us?

Albert Taylor: Well, I mean, I can ask them anything, whether or not that would work or. So there's - you know, they're both aware - they're aware of each other. VSAC a fairly narrow scope because of their authority is around - mostly around support of federal program and HL7 obviously has a much broadly scope than that. So there is a question on the HL7 as to whether or not they levered VSAC for value set maintenance.

But they like to govern their own stuff like most people do and I think there's some - there is some hesitation on HL7 part and to some extent the VSAC part because VSAC is not only authorized but also funded to have narrower - somewhat narrower scope and all of the possible HL7 value sets. But they are aware, you know, that's one of the things on the table that HL7 value set is truly is the VSAC.

Man: And what they currently have is open course and accessible, or is it behind the HL7 …

Albert Taylor: I'll pull it up - I'm pulling up the job on.

Man: Great, thanks, but you're helpful. I'm sorry that I need an education on …

Albert Taylor: That's Okay.

Cindy Cullen: Guys, and I think it's a good discussion because I think it brings up one of the things that we've been kind of - we've been talking about as what's missing in here. And there really isn't a discussion of value set in the environmental scan and it sounds like that perhaps there should be some inclusion of at least where folks can go to obtain the value set because they do play into at least

the science acceptability when we get to that point. I do want to bring that - go ahead.

Man: I'm sorry, I'm just going to say, I mean, I think without value set, measurement doesn't exist.

Cindy Cullen: Yes.

Man: I mean, they are agreed upon concept list, right, for measurement and I don't care how many (unintelligible), without somebody - some authority saying these are the things that mean this, they don't mean anything.

Mike Sacca: Cindy, it's Mike.

Cindy Cullen: Go ahead.

Mike Sacca: But I'll take a minute to just - I think there are couple of key omissions on this slide here that I just wanted to ask the group seeking on this stuff.

Cindy Cullen: Yes, because I have a couple myself.

Mike Sacca: Yes, so the first one would be related to the first bullet and you know - and even in - I think this also applies to more detailed language in the narrative that I think has some omissions around these three areas that I'm going to talk about.

The first one is related to the first two bullets, but really I think we need to be transparent and explicit about the lack of readily available data from the EHR systems or test sites for testing scientific acceptability.

I think the second one really goes to an acknowledge of, you know, the cost associated with an individual site and/or their vendor to actually implement these measures in advance of inclusion in a program which we typically can only offset through an honorarium in some ways, or you know, a broader - you know, potentially a broader inclusion of the team as a partner with you.

And I think the third thing that gets to I think the NQF comment earlier where we're going to talk about NQF criteria for endorsement a little later. I think it applies here and I say that because I'm still confused that we request additional NQF clarity around whether or not the use of centralized EHR data from multiple vendors in site and centralized implementation of an eCQM is acceptable versus individual local site implementation using certified EHR technology within that site, because I think that's an important point and I think it's a bit confusing.

Christopher Millet: Hey, Mike, I'm trying to understand the phrasing there. I'm not too sure I follow what you mean by the centralized versus individual local sites.

Mike Sacca: Sure, so at times we could - and I don't want to get to name names, but there are organizations that have cloud-based large slots of data, that EHR data that comes from multiple sites, multiple facilities and multiple EHR vendors, right? So you can contract with that site at a pretty large cost to maybe have that site implement through measures engine your specifications.

But is that really the same as going to a local facility, outpatient, inpatient, hospital practice, whatever, and asking them to actually implement within their certified platform and then report out? So that's what I'm trying to get at because you can go at it from multiple ways and in various costs associated with each and I don't know if the NQF criteria around that is clear on what's acceptable.

Christopher Millet: Okay, yes, that makes sense. So in the first scenario, that's not an operational EHR system that comes out an aggregator.

Mike Sacca: Right.

Christopher Millet: Yes, yes, that they can make sense. Yes, I'm not the best person to speak to that, but I can talk to agents loop to - you know, like those are two different things. So, yes, that's worked really.

Cindy Cullen: So this is Cindy, wasn't that a registry and hasn't NQF endorsed registry measures?

Mike Sacca: Cindy, I'm talking about can you use that for eCQM-specific, can you hand off an eCQM spec and ask an organization like that? In this case, it was not an actual (QR) (CCDR) in my case. But they actually, you know, implement and doesn't have tests because it technically isn't a certified reporting agency.

Cindy Cullen: I see what you're saying, Okay.

Joseph Kunisch: So just to clarify, Mike, you're basically saying so like that our organization, we have a population health platform that in clinical world, you know, Allscripts and Cerner are feeding all the data into it. So if you tested your measure on that platform, you could then meet the NQF criteria of testing in multiple EHRs because update is coming from each of those EHR systems?

Mike Sacca: Right, and I think it does get a little nuance, Joe, but I think in that scenario, I think it would need it versus a centralized normalized database potentially that pulls in data and has some - its own data transmission methodology that just gets the source data and then it actually implements it at that centralized level

because you're essentially one or two steps away from the actual certified implementation, right? So that's what the distinction I'm trying to make on what's acceptable.

Man: Yes, why would the latter not be acceptable?

Mike Sacca: I think it goes back to whether the criteria you're going to see on NQF per se is that it specifically has to be implemented within a certified EHR environment and in Joe's case, it would be. In a case where it's centralized and the data elements and the data is coming from those certified EHR platforms, but that certified EHR technology is not actually implementing the measure. It's getting implemented at the centralized location which may not be certified.

Cindy Cullen: So you're saying that …

((Crosstalk))

Man: But if the centralized location is - go ahead.

Christopher Millet: Well, part of them is turned off (unintelligible) what you mentioned when the data is collected at centralized location and it's also manipulated. So, you know, it never gets submitted in NQF and it's tested - it tests well with the centralized location.

But if you got to a real site that's implementing the real certified EHR, they don't have that intermediary manipulation. Then, you know, that's really something different as I heard things …

Man: Yes, I mean, I agree that if there's the ability to - the transformation of a data should be clear. But I also know where among the 40 or 50 different EHRs that we work with, that there's a lot of local instance data (analysis) going on that's entirely in control of the practice, and that's something we almost singlehandedly invalid the measures coming from a system and just do the math.

Joseph Kunisch: Yes, and that - this is Joe. I think you bring up a good point. I was going to mention that it might be missing from this. The impact of localized practices to the data, so like you said there's - you know, a lot of the EHR content comes hourly mapped like ICD nomen codes and so forth.

But there's a good portion of it that is required by the local system to do manual mapping to say, "Okay, in our system, we use this and it maps to this in the EHR," and you go through that process, so that impacts the data collection. And typically we do your mapping to fit your localized workflow and how the data is already being captured because you don't want to have to change the workflow, so all of that.

And then the one other piece of it is the data governance and organizations that, you know, don't have data governance, it can be all over the place versus one that has a really strong data governance and has all their firms that say, "Okay, this is the start time date and start time of when that patient is actually in the hospital." Whereas you look in the EHR, there might be four or five different start dates and time - or date and time fields that could be associated to one of the patient who's actually in the hospital/

Cindy Cullen: This is Cindy, just again being cognizant of the time here, I want to make sure that we're moving along with the rest of the topics that we have to discuss. So this has been a - this has been a really good discussion because it's giving

some really concrete examples that I think NQF might be able to integrate into the scan.

Just quickly bringing us back to this topic about the various criteria for NQF endorsement and the application to the scan here, my opinion and I'm not sure whether we're gaining anything by including identifying measures that failed on the importance to measure and report because I think that that is aligned more with whatever the evidence faces on the measure concept and is independent of the data source and the way that the measure is structured.

I would say the same thing for exactly performance test so that that's indicated the performance test should not be dependent on the data I would hope. If folks have any questions - disagree with that, you know, I'd like to hear that.

With regarding scientific acceptability, I think something that might be useful to include in here is any additional requirements that are put onto eCQMs that are - or different requirements that are not required for other data sources. An example might be testing (DN) a minimum of X number of sites with Y number of EHRs. So that's something that I think is a requirement.

I think it might be helpful to see some comparisons, at least percentages between eCQMs and non-eCQMs as to the number of measures submitted, the percent endorsed and what they failed on to get a better sense of, you know, is there comparability or is there something else that's jumping out that's saying, "Yes, that could be a problem here with the eCQM."

And then, finally, if NQF has any data O&M the feasibility results you had mentioned that you can't tell if feasibility had an impact on the endorsement or not, but if there we're right to figure that out, I think that might be helpful

certainly with discussion of, you know, the validity and the feasibility assessment.

I think it's important, you know, to Jamie's point earlier, I think we need to make sure the folks have a good understanding of what feasibility is and that we correctly design it. Any other closing comments on this section before we move onto the next?

Zahid Butt: So this is Zahid, a quick comment I think that may touch upon a little bit on what Mike was saying in terms of the central aggregation of data versus also the validity that impacts both feasibility, validity and reliability.

The key is that the number of entities that are sort of defined as a combination of an EHR and EHR practice or even potentially practitioner level, or EHR and a facility. So as long as data - enough data is coming from that defined entity and meets the minimum of those combinations, it shouldn't matter whether it comes from a central force.

What you don't want is a central force had very first data for two of those EHRs and all of the minimum numbers being drawn from the larger EHR, and somehow considered having passed all three.

Cindy Cullen: It's a really good point, Zahid, thank you.

Zahid Butt: This is one - this might be a small thing probably for me, but in the feasibility assessment where we find important measures and just - but there's no data to support them so we always wonder what was the feasibility assessment. I wonder if there's not a need given the need to reduce the burden of measurements, also do the costs analysis like what is the level of effort

required for this measurement, and getting the data, and organizing it, and so on, not just is it feasible give one of the resources.

Cindy Cullen: So in addition to technical feasibility, financial feasibility.

Zahid Butt: Basically I guess resource feasibility, the level of effort.

Cindy Cullen: Okay, any other comments? All right, so we move onwards, we are going to discuss some framework for assessing EHR data quality. But I don't recall - oh, that was included in the scan here, in the slide. Do we have a section on the additional literature beforehand? Yes.

Kathryn Goodwin: Yes, this is Katie. I think what I'll do here is not spend time summarizing each additional literature that we summarized in the scan report unless requested to. I would suggest that if folks do know something or know of a resource that is not included here that should be to let us know because kind of this section where we have sort of written all of the articles, listed down. The results were validated but not necessarily taking into one of the previously discussed category.

Cindy Cullen: Thanks, Katie. I think one thing that I got from here was, you know, were there any themes that were coming out here that should be included in the scan, and one that I saw was implementation.

O&M Slide 25, the last three references all the way to implementation. There's more article with these items that talk a bit about some implementation concerns that I think were discussed like data accuracy. So that might be something that is not yet - has a section on the scan that might be helpful to include here. Anybody else has other thoughts on this section

because I know we still need to talk to next and then discuss our statements. Okay.

Man: Or you wanted to know that thing - like section that may have this?

Cindy Cullen: Yes.

Man: Or topics (unintelligible)?

Cindy Cullen: Yes.

Man: To me - one of the things we see I think like the biggest mover of the former measure is change in the patient's and the provider's denominator, and that all comes back to the attribution process. And we see a lot of variability in that attribution logic from one EHR vendor to the next, like how do you decide who is the provider for this patient and therefore gets credit for the blood pressure control and how multiple providers get that.

Cindy Cullen: So attribution as a topic that needs further exploring?

Man: It definitely undermines stability and measurement …

Cindy Cullen: Yes.

Man: … because it's not done in the same way everywhere.

Cindy Cullen: Yes, I agree. I know that's something that we still struggle with that too. That's great, thank you. Any other suggestions for topics that are missing here that might help to enrich and inform the scan? Okay, it sounds like folks

are thinking about that. So, Jean-Luc, I'm going to pass off this topic on the framework.

Jean-Luc Tilly: Yes, great, thank you. And here's the final - all right, so we did, and part of the literature here, identify a few different articles that had some frameworks around assessing data quality in EHRs.

You know, basically, these were meta-analyses that we're looking at some various efforts to get (conditions), just ways to kind of organize the different issues that we're identified in EHR data always. And then, you know, sort of by that point, what were the different strategies that have been used to mitigating these same issues, everything that foundation strategies that were involved, combing EHR data with other data elements to improve their reliability or just sort of a variety of different things.

Next, on the next slide, we had sort of a table here that compiled sort of the different kinds of issues that were identified across the - about the different articles and it shows how some key core concepts around, you know,, completeness, concordance, plausibility of the data and the timing of the data or currency. And so, you know, they pretty consistently appear across a variety of these frameworks. And then there were some kinds of concepts, you know, that arise on one order or together.

So what we did, you know, as part of the environmental scan, we sort of recorded this but with an eye for using it later when - you know, when these parenthesis potentially - we're going to be doing work that kind of foreseeing all on the same line. These are the identifying issues with the EHR data quality. We need to pull out some of the work that has been done before and (look on) that where we can and otherwise, you know, identify areas where it can be improved.

So I won't spend more time on that really other than if, you know, maybe we just want to have a little bit of conversation around either these different reports.

I'll just say on the next slide, on Slide 28, we did also - you know, we've heard on the same where we can probably (compile) a little bit of - some of the guidance after already - from standard-settings bodies and some - kind of some legislation that includes (unintelligible) or director of EHR data quality, just you know some kind of major (unintelligible) that are, you know, guided efforts in the field so far.

I think we're all familiar with these and these are only to (unintelligible) the conversation there other than, you know, if we missed something or there's some additional, you know, components to that that there's a reason we want to add around CHIPRA that's here as well.

So, yes, I mean, (unintelligible) and you know, these are the time - I think we have about 10 or 15 minutes or so left before we close our conference call. So, yes, I know (unintelligible) if you want to have a conversation about this.

Cindy Cullen: Yes, I'm happy to open it up to folks to see if they have any thoughts on the framework and their inclusion in the group work. Okay.

Zahid Butt: I think the - this is Zahid, I'll just take a shot at it. So I think the framework we possibly want to focus on is the one that is pertinent to the use case here which is to use this data for, you know, quality measurement, performance measurement especially eCQM.

So perhaps some of the items listed may not be as relevant although all of them are probably relevant in the generic data quality of EHRs. But perhaps we can try to focus on the ones that directly impact what we're at for here.

Cindy Cullen: I think that's a great idea to narrow the scope to some that's directly applicable because there are quite a few - quite a few concepts here that …

Zahid Butt: Right, right, and so those could then sort of become, you know, things that you can actually use in their own data quality checks then potentially could be used with in future audits and so forth, I mean, whatever the framework is within this realm. We should try to narrow it to those areas.

Cindy Cullen: Any other thoughts?

Mike Sacca: Cindy, it's Mike. Generally speaking, can I throw out something that might be in another area to at least look at or get more information on in terms of what others doing and try to help with the data access issue?

Cindy Cullen: Sure.

Mike Sacca: So I think both AHRQ and - AHRQ under their action for IDIQ and CDC under I forget which vehicle, both are trying to stand up and a number of you guys are already probably familiar with this, a national test that of sorts that build upon some what I want to see in CMS try to do previously as well as baking in some automated sidelines for CDS, et cetera.

So I don't know if that is - they're probably too early in the game to sort of inform this environmental scan, but it might be something to keep an eye on.

Cindy Cullen: That's great. Some additional sources there, I think that's a great idea. Like for instance, is there - they can give (construct) to …

Mike Sacca: Exactly.

Cindy Cullen: All right, I know we wanted to get to the scope and the introduction of the true north statement. So, Chris, why don't you we - let's move on to Slide 31 and Chris, if you could introduce this so that we can discuss.

Christopher Millet: Sure, so during our first TEP meeting, we had some discussions on what exactly do we mean by data quality because it's a pretty broad topic. I think it was a little topic today where we focused a little bit on these are the - kind of what's under the circle where we're looking at EHR data and how well do you support quality measure or quality measurement, and then performance measurement whether that's some eCQM or other kinds of electronic measurement we will be less involved, so moving at looking at some electronic measurement more broadly.

So that's - you know, that's probably impressions as to, you know, what exactly that means. I think that's a general direction for what we'll - where we'll be moving towards. We've included a bullet here on what we're not referring to which is we're not trying to use this topic to look at how well EHRs simply collect data for the primary purpose of delivering care - of supporting delivery of care.

And as part of kind of our process to try to focus to what exactly are we focusing on, we drafted a true north statement that we wanted to review here to make sure - to see if it resonates with the whole (task) and if it doesn't, we can find for I think some feedback on it because it will be reporting data to the

- well, this will be more importantly around the topic when we are looking at recommendations and solutions and those kinds of things.

So I'll read through it here. It's on the slide as well. "The purpose of this Task Order is to establish a technical expert panel to recommend best practices for improving environmental scan data in ways that support healthcare performance measures at all phases including measure development, measure endorsement, and implementation."

So with that, I'll - Cindy, maybe we'll open it up for the thoughts and feedback.

Cindy Cullen: So how does this resonate with you? Is this - now that we've come through the environmental scan, we've given some thoughts about some aspects of data quality as it relates to EHRs and eCQMs. I guess that we're looking at, this is kind of a wrap-up. Are we feeling to the statement? Is the statement something that we feel we support and do we feel that what we've discussed today in the environmental scan also supports the statement?

Joseph Kunisch: Hi, this is Joe. You know, the second bullet point there, I don't care for that. You know, I realized that it's same - you know, there is a bigger pool of this data and we're really did focus on the subset.

But really what is the primary purpose of the EHR, period, outside of quality? There are clinical decisions, poor research, communication to all providers, billing, so there are a lot purposes. So really - but the end thing is to support the delivery of the care to the patient, period, and that we're really looking at a subset of that data.

I just - I don't know if that statement in there should either be in there. You know, we are looking at primary purpose. If you're looking at did the patients get medication when they were supposed to, that's primary purpose for supporting on how well the delivery of care was done.

So our quality is really measuring that delivery in care, so maybe there's a way in putting in that this is a subset of the overall purpose which is supporting the care of the patient.

Cindy Cullen: Yes, I have been bringing up that too and I think one thing that's missing from this definition true north is what we may not call a measurement because that's technically structural process and outcome, and so it's really the care of the patient and supporting that. So I think a little bit - not that people in some way not understand quality measurement, but at least they get all access of quality measurement that may need to be articulated a little bit more.

Man: Yes, that's the thing that I hate to follow on. But in addition to that, I agree with those statements, but I also would add that the purpose of the measurement is while they're different, potentially it could be for internal quality improvement. It could be for reporting on a contract and it could be for reporting for accreditation or (MIPS) or other things. That doesn't really - it just changes the bar and the perspective on the measurement, what they are in my mind.

Cindy Cullen: I don't consider covering on it all. I think they're great comments and I'd like to hear more from others in the TEP.

John Derr: This is John Derr. I just wanted to add to what you said before the last person and that really the ultimately goal is it affects outcomes, and everything the outcomes are good or bad, you know, what maybe we should do to improve

them. So push the center on the improvement of care based on the person giving the correct care to give them a favorable outcome and quality of life.

Zabrina I think - this is Zahid, so I think, you know, clearly the purpose of the EHR is to primarily provide assistance to clinicians for good patient care so I think no one would dispute that.

There is a big difference in sort of the general goal of information documentation and sharing versus the use of those data elements or information for specific purposes as in quality measurement broadly or more specifically for eCQMs, and especially in the case of eCQMs, there are very, very strict constraints in somatic understanding of those data which in the care delivery process, can overcome by a human being reading the information and interpreting it and filling those gaps.

You don't have that luxury in quality measurement, and so I believe if the purpose is to focus on that aspect, then we should really focus on that aspect. So it is a specific subset of data quality within the broader EHR that has some unique aspects to it the way I see it.

Cindy Cullen: Okay, anyone else? Okay, I think that covers our agenda for today, so I will hand it back over to NQF for the remaining portions of the program. I want to thank everyone, my fellow TEP members, for your contributions today. This was a really great discussion and thank you for your time today and your preparation prior to this meeting.

Man: Thank you and take care.

Ameera Chaudhry: We still have a couple of things to wrap up on. So thank you, Cindy, and thank you again everyone for participating.

So before we go, we did want to open the line for public and member comments. So if there's anyone on the phone who would like to share their thoughts or if you have any questions, we'll keep the line open for a couple of minutes.

(Sherry Fischer): Hi, this is (Sherry Fischer) from (MAND). I wanted to ask about what you were discussing at the very end, how to address the issue of the entire mapping at (risk) on that data that is being used for very well-designed quality measures that are based on fields that are inactive.

Cindy Cullen: NQF, is that something that you might want to consider including as part of the environmental scan and investigation to that?

Christopher Millet: Yes, I just want to make sure we understood the comment. Is that - is that a - are you asking a few focus on where the data may not be accurate and then (focusing) on the metrics, or did I hear that wrong?

(Sherry Fischer): Yes, that's right, what to do about that when the measure has cascaded well, but the data coming in is not accurate? I mean, you can't fix that in a measure, but it has implications for the findings. There was an outcome of any measure.

Christopher Millet: Okay, got it. Yes, we will - I think that ties into some of the sections of this that we were looking at so (unintelligible).

Ameera Chaudhry: Okay, thank you. So hearing no other public comments, I'll go ahead and turn it over to Jean-Luc for next steps.

Jean-Luc Tilly: Great, thanks. So the next TEP meeting where we need some help really is we're going to secure - we'd like to hear into account to be prepared is a version of the draft report that will be submitted for public and member comments, where a 30-day public comment period will go on from February 3rd through March 4th.

So - and this is the TEP meeting, we still have about a week or so for you all to submit this to us by email. Of course, we account for that in the slide so if you got any other type of questions or guidance to include, we will do so.

You know, after that, our third web meeting, we'll review the public comment for you to see it so far and you know, get started with the - with, you know, the real major work of this project which is we'll fill out the framework thesis. So we will work on that in web meetings 3 and 4, and just, you know, revisiting pieces of the environmental scan as needed to support that work.

I won't get through the rest of the web meetings, but I'd say there'll be quite a bit of work to take us through the end of the year and more details of this as we go through each web meeting as we get a little bit closer to those.

I did also want to say that (unintelligible) really ends up. My last day is this Friday. I really appreciate working with you all over the last - for a while. I think everyone is quite good in a short period of time in the conversation and you know, many of you, of course, have worked on other issues in any TEP or across in different respects and I really appreciate all the time that you're (unintelligible) and other (unintelligible), your measure submissions and so on, and other aspects of the work which I'm on quite a bit.

I'm going to the (unintelligible) group. I'm going to leave the - to give you the work in all the measurements so thank you all very much for your work so far.

And I think that’s actually all we had into the next steps, so with that, I'll turn it back over to the co-chairs to say any closing comments and otherwise we can adjourn.

Cindy Cullen: This is Cindy. Jean-Luc, sorry to see you go, but glad you're staying in the landscape so I’m sure we’ll cross paths again. Again, I wanted to thank my fellow TEP members today for your contributions and please do provide comments on the scan back to NQF folks over here so that they can provide us an even better draft to put out to public comment. I think that’s all for today, so thank you very much, everybody.

Woman: Thank you.

Man: Bye, thanks.

END