

NATIONAL QUALITY FORUM
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eMEASURES FEASIBILITY ASSESSMENT
EXPERT PANEL MEETING
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FRIDAY
DECEMBER 7, 2012

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The Expert Panel met at the National
Quality Forum, 9th Floor Conference Room, 1030
15th Street, N.W., Washington, D.C., at 8:30
a.m., Michael Lieberman, Chair, presiding.

PRESENT:

MICHAEL LIEBERMAN, MD, MS, Chair, Oregon
Health and Science University, Chair
HOWARD BREGMAN, MD, MS, Epic
ZAHID BUTT, MD, Medisolv
KERI CHRISTENSEN, American Medical Association
JOSEPH JENTZSCH, Kaiser Permanente

SAUL KRAVITZ, Mitre
JINGDONG LI, MD, Lantana Consulting
CATHERINE EIKEL MAJOR, MBA, Booz Allen
Hamilton
RUTE MARTINS, MS, The Joint Commission
GINNY MEADOWS, RN, McKesson Corporation
J. MARC OVERHAGE, MD, PhD, Siemens Medical

Solutions, Inc
MARTHA RADFORD, MD, NYU Langone Medical
Center
SHANNON SIMS, MD, PhD, Rush University
Medical Center
ALDO TINOCO, MD, MPH, National Committee for
Quality Assurance

PAUL TANG, MD, MS, Palo Alto Medical
Foundation

NQF STAFF:

HELEN BURSTIN, MD, MPH

BETH FRANKLIN, MS, RN

ANN HAMMERSMITH, JD

ROSEMARY KENNEDY, PhD, RN, MBA, FAAN

KATHRYN STREETER, MS

REVA WINKLER, MD, MPH

ALSO PRESENT:

ALYSSA CRAWFORD, Mathematica Policy Research

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(8:40 a.m.)

DR. LIEBERMAN: Okay, I think we'll go ahead and get started. Welcome, everybody, to the NQF Panel on eMeasure Feasibility Assessment Expert Panel Meeting rescheduled from last, around Halloween, thanks to Superstorm Sandy.

I'm Mike Lieberman, I'll be the Chair today. And I'm going to really keep the introduction or welcome to a minimum here and turn it over to Ann to go through the disclosures. And then we'll go around the room for introductions. Thanks.

MS. HAMMERSMITH: Good morning, everyone. I'm Ann Hammersmith, I am NQF's general council. I see a few familiar faces so I think some of you know the drill about disclosures, but I'll review it briefly before we go around the table.

When we had the call for nominations, we asked people to fill out a

1 detail conflict of interests disclosure form.

2 So what we do at the beginning of these
3 meetings is ask you to orally disclose.

4 We are not looking for you to tell
5 us everything that's in your CV. Please
6 don't, because we'll be here for a very long
7 time.

8 We only ask you to mention things
9 orally that you believe are relevant to what's
10 before the committee today. Specifically
11 we're interested in grants, research or
12 speaking engagements that may be relevant to
13 what the committee's going to look at today.

14 Also want to remind you that you
15 serve as an individual on the committee. You
16 don't represent your employer, you don't
17 represent any group that may have nominated
18 you or supported your nomination for the
19 committee.

20 Sometimes committee members will
21 say, I'm so and so and I'm here representing
22 the American Society of fill in the blank, and

1 actually you are not. You are here as an
2 individual expert; that's why we chose you for
3 service on the committee.

4 The last thing that I want to remind
5 you of is that disclosures don't necessarily
6 turn on money changing hands. Sometimes
7 people will say, I have no financial conflict
8 of interest. Financial conflicts of interests
9 are important, financial disclosures are
10 important. But, because of the world that you
11 all work in, often you'll serve as volunteers
12 on committees and things of that nature. So
13 we're also looking for you to disclose any
14 relevant volunteer service as well.

15 So with that, we can go around the
16 table and combine disclosures and
17 introductions. Tell us who you are, who
18 you're with and then if you have anything that
19 you would like to disclose.

20 And Michael, since you're the Chair,
21 you get to start.

22 DR. LIEBERMAN: All right, Mike

1 Lieberman from Oregon Health and Science
2 University and I have no disclosures to make.

3 DR. KENNEDY: Rosemary Kennedy, Vice
4 President of Health Information Technology at
5 NQF.

6 MS. RUBINI: Juliet Rubini, Senior
7 Project Manager, NQF.

8 MR. JENTZSCH: Joseph Jentzsch, I'm
9 with Kaiser. I have no disclosures.

10 MS. MARTINS: Rute Martins with the
11 Joint Commission, no disclosures.

12 MR. KRAVITZ: Saul Kravitz, Mitre,
13 no disclosures.

14 DR. TANG: Paul Tang, Palo Alto
15 Medical Foundation, no disclosures.

16 DR. LI: I'm JD Li from Lantana, no
17 disclosures.

18 MS. MEADOWS: I'm Ginny Meadows from
19 McKesson and I have no disclosures.

20 DR. SIMS: I'm Shannon Sims from
21 Washington University Medical Center. I've
22 been the primary investigator on sub-level of

1 grants and contracts for measure development
2 organizations and CMS contractors, but I've
3 not received any direct compensation for any
4 of those.

5 DR. TINOCO: Good morning, Aldo
6 Tinoco. I work with NCQA. I participate in
7 work with developing quality measures under
8 CMS-funded contracts and AHRQ-funded grants.
9 Otherwise no disclosures.

10 MS. CHRISTENSEN: Hi, Keri
11 Christensen from the AMA-PCPI, also grant work
12 developing measures.

13 MS. MAJOR: Catherine Major with
14 Booz Allen Hamilton and we do measure-
15 development contracts with CMS and with ONC.

16 MS. JAVELLANA: Minet Javellana,
17 CMS. No disclosures.

18 MS. KRAUSS: Good morning, Debbie
19 Krauss, CMS. No disclosures.

20 DR. BREGMAN: Howard Bregman, I'm a
21 physician and I work for Epic, the EHR vendor
22 in Verona, Wisconsin. And I have no other

1 disclosures.

2 DR. RADFORD: I'm Martha Radford.
3 I'm a physician. I am Chief Quality Officer
4 at NYU. And I'd like to disclose that I'm a
5 member of the ACC NCDR Management Board.

6 That's volunteer, I have no
7 financial disclosures which means I live below
8 the Manhattan poverty line.

9 (Laughter.)

10 MS. FRANKLIN: I'm Beth Franklin,
11 Senior Project Director at NQF. I can't
12 remember.

13 DR. WINKLER: And I'm Reva Winkler,
14 I'm the Senior Director here at NQF in
15 Performance Measures.

16 MS. HAMMERSMITH: Okay, thank you,
17 everyone, that was a world record for
18 disclosures. You did very well. Do you have
19 any questions or anything that you want to
20 discuss with each other based on the
21 disclosures this morning? Okay, thank you.

22 DR. WINKLER: Okay, thank you all

1 very much for being here today. We have a
2 couple of little introductory things before we
3 get into the meat of the conversation and let
4 you all talk it out.

5 It's important that we'll go through
6 the, sort of the project goals as well the
7 objectives for today's meeting. Next slide.

8 Just so everybody remembers, I think
9 we talked about this on the conference call:
10 the background for this effort. From NQF's
11 perspective, here in Performance Measures, we
12 look at all measures that come through for
13 potential endorsement for several criteria.

14 But two that are particularly
15 pertinent to what we're talking about today
16 are scientific acceptability. In other words
17 reliability, validity as well as feasibility.

18 And so that's going to be sort of
19 the focus of your discussion today. Several
20 previous efforts that NQF has done has touched
21 tangentially on these topics but, if anything,
22 probably prompted more questions than provided

1 answers.

2 And so those were our testing task
3 force report that identified criteria for
4 evaluating EHR measures for reliability and
5 validity. And then there was, last spring,
6 there was a draft proposal on how NQF would
7 review and assess eMeasures that prompted
8 comments from stake holders who were
9 identifying a need to have greater clarity and
10 more direction around assessment for
11 feasibility.

12 So the recommendation from the
13 comment period on that effort was that NQF
14 criteria should incorporate feasibility of
15 data capture for the data elements utilized as
16 well as looking at reliability and validity.
17 So that is really the purpose of what we're
18 here today to do, is to respond to that need
19 out there as we're trying to develop and
20 implement the EHR measures. Next one.

21 So specifically this project, to
22 address those issues, has a couple of goals.

1 The first one is the environmental scan that
2 Beth, I think, described in great detail, when
3 we had our conference call on October 30th.

4 We asked a series of questions of
5 EHR vendors, developers as well as some
6 providers. Since that call, we've had some
7 updates as well as we do want to hear some
8 input from some of the measure developers on
9 the Panel, to make the environmental scan a
10 little more robust and be sure that we have
11 representation from as wide a group of folks
12 as possible.

13 The discussion memo that we sent to
14 you earlier in the week is meant to be the
15 starting point for your discussions to help us
16 pull together what will ultimately be the
17 deliverable from this effort, which is a
18 series of recommendations.

19 We've given you some draft thoughts
20 around principles and guidance for eMeasure
21 feasibility assessment that should prompt the
22 major part of today's discussion. And then

1 hopefully that will also lend itself to
2 identifying some starter set of criteria that
3 NQF could use to further look at feasibility
4 when we're reviewing eMeasures for potential
5 endorsement.

6 So those are the goals of this
7 particular project. Does anybody have any
8 questions about any of those? Okay, next one.

9 Okay, so our objectives today with
10 this particular meeting, in other words when
11 everybody starts to peel out and leave this
12 afternoon, what do we hoped to have done by
13 then, is having you review or discuss any
14 additions to the environmental scan. But also
15 the discussion to help us pull together what
16 should be the principles and guidance for
17 eMeasure feasibility that will become part of
18 the report, any additional recommendations.

19 During your conference call in
20 October you talked about a potential scoring
21 system, so talk about what that might look
22 like, as well as any starter set

1 recommendations for criteria for NQF to use
2 when evaluating eMeasures.

3 So those are the discussion points
4 and we'll be trying to maybe perhaps bring the
5 conversation to some decisions around how
6 we're going to characterize these different
7 elements in the draft report deliverable
8 that's the outcome of this project. Next
9 slide.

10 And just the project timeline going
11 forward from this point, from our meeting
12 today, is as soon as we finish, our job here
13 at NQF over the holidays will be to draft that
14 report and pull together the discussion and
15 the recommendations that you all are
16 discussing and helping us formulate today.
17 After that the first couple weeks of January,
18 happy new year to all, we'll ask you to review
19 that draft report and give us your feedback
20 and any revisions or suggestions.

21 After that, that report will go out
22 for a 30-day public comment, which is likely

1 to generate some recommendations and comments.
2 And so after that we will spend some time
3 looking at those comments to make final
4 revisions to the draft report.

5 That draft report deliverable will
6 then go to both HITAC, CSAC and finally to
7 NQF's Board of Directors. So that's
8 essentially what we're looking to do over the
9 next couple of months as a result of this
10 project.

11 So we will be coming back to you on
12 a couple of occasions after this discussion,
13 as we try to pull the report together and be
14 sure that it represents the thinking and
15 response to stakeholder input around the topic
16 of eMeasure feasibility.

17 So any questions from anybody about
18 what we're doing, where we're going and what's
19 your role in the activities is going to be
20 going forward?

21 Okay, I'd like to just briefly let
22 my colleague, who arrived, introduce herself.

1 Helen?

2 DR. BURSTIN: Good morning,
3 everybody. I'm Helen Burstin. I'm the Senior
4 VP for performance measures. I arrived last
5 night, as I suspect Howard did, from our
6 meeting we were at in LA for the IOM.

7 So I got up at 1:30 in the morning,
8 it was a little hard to get the children to
9 accept the fact that, yes I've been home for
10 15 minutes and I'm leaving. So anyway, good
11 morning, add my welcome, thank you all for
12 coming and I think it will be a great day.
13 Thanks.

14 DR. WINKLER: We still have a couple
15 of the other committee members who have yet to
16 join us. Did anybody new join us who hasn't
17 introduced themselves? I don't see anybody.

18 Okay, with that, I would like to
19 turn it over to my colleague, Beth Franklin,
20 to talk about just some updates to the
21 environmental scan and we'll be asking some of
22 our committee members to offer their

1 contributions as well.

2 MS. FRANKLIN: Good. Thanks, Reva.
3 Yes, so since we meet by conference call in
4 October, we had two additional people, groups
5 if you will, submit their environmental scan
6 results. One was Abt Associates and the other
7 was Siemens. They were in your packets and
8 hopefully you've had a chance to read them.

9 And then we have three groups or
10 three representatives today who are going to
11 talk. And they're making my life easy because
12 they're all sitting right in a row to my left.

13 So we're going to start with
14 Katherine. Sorry, Katherine, to put you on
15 the spot, to talk about -- Katherine Major
16 from Booz Allen, to talk about measure
17 development and what they're doing with
18 measure development, what their role is.

19 MS. MAJOR: Sure, good morning,
20 everyone. And we actually sat in a row on
21 purpose, because we all knew that we'd been
22 asked to speak a little bit about our

1 development and testing approaches and they're
2 very similar. And so we'll kind of maybe tag-
3 team it a little if that's all right.

4 So as I mentioned, Booz Allen helps
5 support measured development contracts to do
6 electronic clinical quality measures for
7 meaningful use. Including the feasibility
8 testing portion.

9 And our approach to the feasibility
10 testing I think is similar to a lot of what is
11 included in the environmental scan so far.
12 And again is similar to what I think Keri and
13 Aldo will talk to as well.

14 So we've collaborated with both Keri
15 and Aldo and their organizations on our
16 approach and have leveraged a lot of the AMA-
17 PCPI approaches, in terms of doing an
18 assessment around technical feasibility,
19 implementation feasibility, mostly through
20 test sites.

21 We're trying to get a variety of
22 test sites to participate in filling out a

1 data-collection tool that helps understand
2 sort of what data elements are currently
3 available that would support the various
4 measures that are being tested, and at what
5 rates those are collected, where their
6 collected, where the data are stored, things
7 like that.

8 And then also included in the data-
9 collection tools are sort of questions around,
10 not only can my EHR do this, but do my work
11 flow processes support this kind of measure
12 and support collecting the data and at what,
13 how frequently and how embedded are those kind
14 of workflow processes to support collecting
15 the information?

16 So there's a combination of sort of
17 the more quantitative information: which data
18 elements are present at what rates and where
19 are they. And then a little bit more of the
20 qualitative of, what are my workflow and what
21 would need to change. And with free text
22 boxes please explain. That sort of thing.

1 And then the analysis of that is a,
2 again sort of a combination of taking a look
3 at the quantitative data, what's there and at
4 what rate. And then how do the various test
5 sites sort of feel about their ability to
6 implement the measures?

7 I mean that's just a very high level
8 summary. But again, I don't think it's that
9 different from a lot of what's in the current-
10 version environmental scan, so I don't know.

11 MS. CHRISTENSEN: I will add just
12 some history on why we started doing that the
13 way that we're doing it right now. Which is
14 probably not how we'll do it exactly in the
15 future. It changes a little bit every time we
16 do it.

17 But what we were finding, our
18 primary way of testing measures for
19 reliability and validity in EHRs is to run a
20 report out of the EHR and then go back in and
21 manually extract and compare the two results.
22 And we were finding that there was some pretty

1 systematic or maybe systemic problems that we
2 were seeing with where things were not
3 matching, where data was often being found not
4 in a way that the EHR was able to capture it.

5 So we wanted to find that a little
6 bit sooner than when we were doing to
7 extraction. I'm sure many of you are aware
8 that extraction can be very expensive.

9 So that's find of where this
10 feasibility assessment methodology came from
11 so that we could kind of know in advance where
12 we were likely to see problems. And if we
13 were going to see a lot of problems we did
14 want to both to do the extraction, we wanted
15 to fix the problems first.

16 So like Katherine said, we're
17 looking at very specific pieces of information
18 and we just use an Excel file right now. It's
19 nothing fancy, it's just a systematic way to
20 collect information. Is it discrete fields,
21 what code sets are you using, what can you map
22 to if you're not using a code set

1 individually.

2 And then that concept of the
3 technical feasibility. Can you capture the
4 field and are you able to do the calculations
5 that are necessary for the measure versus a,
6 we're calling it implementation feasibility
7 which is, do I really think that clinicians
8 are putting the information in that box. Just
9 because you have the box, you all know,
10 doesn't mean that you're using it.

11 And I might just throw out there, I
12 know at least one person at the end of the row
13 here has actually used that as a site, so
14 maybe he might want to say a couple words too.
15 But to Aldo.

16 DR. TINOCO: So to be clear to those
17 on the call, I'm not the one that Keri was
18 pointing to. That gentlemen sits to my left.

19 But let me try and build upon what's
20 already been said and already documented.

21 Because you are all hearing common themes.

22 At NCQA, we are very fortunate to

1 have some clinicians, users of the EHR systems
2 in the past. Non-clinician, health care
3 professionals who have been tasked with
4 extracting data from these systems and also
5 people who've worked with health IT modules
6 that are designed to actually calculate these
7 measures and report them out.

8 So to make this interesting, I
9 think, under our grant work we've used a
10 slightly different approach. We went earlier
11 and we started asking the potential test sites
12 and people who would be willing to respond to
13 a survey, what are your EHR systems capable of
14 doing. Secondly, during configuration and
15 during implementation, what did you enable or
16 disable? Thirdly, can you get the actual data
17 from the data source itself or are there tools
18 or APIs, Application Programming Interfaces,
19 that are required to get access of that data?

20 So how hard is it to get that
21 information out? And we've been able to do
22 that under our granted-funded work for

1 development of pediatric quality measures.

2 So we are -- based on experiences
3 learned on other projects, we are looking at
4 feasibility earlier, we trying to tease out
5 some of those nuanced issues that impact data
6 quality as we try and calculate a quality
7 measure.

8 And we are trying to understand how
9 do we both use attestation-based methods, but
10 also direct queries-based methods from the EHR
11 data based such as count queries or
12 understanding the prevalence that a particular
13 value exists in a data field. So those are
14 just trying to build on previous comments.

15 MS. FRANKLIN: So can I ask you a
16 quick question, the three of you? The data
17 you're extracting, although first the data
18 we're extracting, is it from inpatient and
19 ambulatory systems? And is it multiple EHR
20 vendors you're looking at?

21 DR. TINOCO: Thanks for asking. So
22 within our previous experience in the past

1 year, we have focused on the outpatient
2 setting because these are outpatients
3 mentioned. Should mention that. And the
4 second part of your question?

5 MS. FRANKLIN: Are you using
6 multiple vendors?

7 DR. TINOCO: Thank you, appreciate
8 that. So of approximately ten respondents, we
9 had three vendor products represented.

10 MS. FRANKLIN: Okay. And Shannon,
11 can I put you on the spot and ask you since I
12 believe you're the one that they were pointing
13 to, to talk a little bit about having used the
14 tool that they, the process they were
15 describing. Just your experience.

16 DR. SIMS: Yes. So the DT is a
17 Excel spreadsheet that asks you to fill out
18 various information about each data element
19 for a given measure. I think I filled it out
20 for three separate CMS projects. So I've done
21 it dozens of times.

22 And it's an interesting process

1 because it forces you to delve into your EMR
2 and think about where you collect this
3 information, can it be collected in multiple
4 ways. An example would be, I didn't do this
5 for the DT process but I was thinking about it
6 as Keri was talking on a prior project.

7 We were looking at whether an EKG
8 had been done in the emergency room or not.
9 And as an example you would think that would
10 be simple, so you can look at an order and
11 that caught most of them but not all of them.

12 Then I pulled data from our ECG
13 system, which is called MUSE, it happens to be
14 separate from our EMR. And that had
15 additional patient in there that had gotten
16 it.

17 And then a third way was that the
18 physician could actually not order it and it
19 doesn't end up in MUSE. I have no idea how
20 that doesn't happen, we're investigating that
21 now.

22 But documenting in our EMR and flow

1 sheet that it had been done. So in terms of
2 feasibility, it seems like a home run. Was an
3 ECG done: I mean that should be a basic
4 fundamental component of EHR and it turned out
5 that there were three, I'm sure there's more
6 that I'm missing, ways to do it.

7 So those are the kinds of things
8 that you have to think about. And then what
9 I do is you do that and someone like me kind
10 of geeks it out and thinks through everything
11 and then documents it.

12 And then I go talk to my clinicians
13 and I talk to them, what's the work flow
14 impact. And that gives us kind of a big-
15 picture feasibility.

16 We are an Epic client and I don't
17 know if this is an endorsement or a
18 lamentation, but you can make the doctors, I
19 can torture them to collect any piece of data
20 that I want, but they won't necessarily do it.
21 But that's where you kind of come into this
22 kind of gray area of feasibility.

1 It's kind of like pornography, it's
2 harder to find but you know if it's feasible
3 or not at this point. I do at least, as soon
4 as I look at a measure.

5 So anyway, but what that DT tool did
6 was force you to kind of codify those thoughts
7 that are bouncing around in my head into
8 numbers and categorizations. I think you had
9 an ordinal scale from one to five for
10 feasibility and other issues and so I thought
11 it was a pretty effective exercise for me and
12 it really helped solidify and I think was a
13 good way to approach it. So that's what we
14 did.

15 MS. FRANKLIN: Great, thank you.
16 Does anybody have any questions for the four
17 who presented, clarifications? Paul.

18 DR. TANG: This may not be a
19 question for what was presented, but I wonder
20 if we're, just to understand the scope of our
21 activity. So this sounded a lot like, how can
22 we assess the past measures?

1 And it's part of our scope also to
2 say, how could we prospectively describe
3 things to make future measures feasible, even
4 if they may not be in the EHR today, captured
5 in it today? So it's a forward-looking.

6 Because you know we have the retool,
7 the de novo. So I think this is a lot, the
8 retool sort of approach.

9 I like Ginny Meadows description
10 because it talked about some of the things
11 that you like to have prospectively as you
12 develop new measures, with the EHR in mind.
13 And again, it doesn't anchor itself into
14 saying, oh, let's only think about what we
15 have today, but what would be needed to get
16 what we really want from a measure.

17 DR. BURSTIN: I think both are
18 definitely in scope. I think there's very
19 different approaches to both of those. I
20 don't think it's as simple distinction as
21 retooled or de nova.

22 There maybe de nova measures that

1 you can test in today's EHRs as well. So I
2 think it's more an issue of current tense
3 versus things we don't think we can yet do in
4 an EHR, but we think are going to be important
5 and what's the approach for those?

6 DR. TANG: So I guess the catch is
7 then, what we can do in EHRs today? And
8 that's what I don't want to have us, I mean I
9 assuming we don't want to be anchored there.
10 So I wouldn't want to be weighed down with
11 what's "feasible" in an EHR today.

12 MS. FRANKLIN: Keri.

13 MS. CHRISTENSEN: And if I can just
14 add, that's a great point that I left out. We
15 asked folks if it wasn't feasible today what
16 would it take to get there?

17 Is it something as simple as adding
18 that field, whether or not you want to do it,
19 which Shannon alluded to. Or is this a full,
20 we've got to talk to our vendor and do a full
21 upgrade kind of thing?

22 So we tried to assess that as well.

1 And obviously it doesn't mean that you might
2 not go there someday.

3 If it requires a full EHR upgrade,
4 but we did use that as criteria how it would
5 not be an appropriate measure for a program
6 today. If that was going to be necessary.

7 MS. FRANKLIN: Yes, Martha was going
8 and then I'll get you Saul. Martha.

9 DR. RADFORD: I'd like some
10 clarification on whether we're talking about
11 feasibility of elements or feasibility of
12 measures? Because I think some of the issues
13 that we're dealing with have to deal with how
14 we design our measures so that we have to
15 focus on a lot of different element issues.

16 But perhaps we need to rethink how
17 we design measures to make them fit into the
18 clinical work flow better. Because that's one
19 of the big elephants in the room.

20 MS. FRANKLIN: That's a great point
21 and I think that's something for this group to
22 talk a little bit more about. But I'm going

1 to go to Saul and we'll put that on the list
2 of questions to discuss. Saul.

3 MR. KRAVITZ: In terms of the
4 approach to data element feasibility, I can't
5 speak at all to the clinical work load. I
6 would hope that we would get to a point where
7 someone would be able to triage and measure
8 without having to talk to people in the field.

9 In other words there should be some
10 catalog of data elements that everyone would
11 agree are accessible in some setting. It
12 would have to be qualified by some notion of,
13 everyone would agree that the patient's birth
14 date is fair game in a measure, for example.

15 Whereas when you get to other data
16 elements you're really going to have to do,
17 it's going to be a big question mark. Is this
18 data element developed, we don't know without
19 further investigation.

20 So if you stayed within the agreed
21 to catalog, the kind of it should be possible
22 to give a, to have high confidence that the

1 measure might work. Okay, I'm saying might
2 because you have to qualify it with the work
3 plus.

4 So I think if we're always in a
5 state where we have to go into the field to
6 collect information, no one's going to do that
7 early enough in the process to really cutoff
8 some of these measures that people considered
9 in the bud early, before we've invested a lot
10 of money in them.

11 MS. FRANKLIN: Good point. Paul,
12 Ginny I'll get you --

13 DR. TANG: Maybe I sort of
14 complement that point because I don't know
15 that we can't be working in the field almost
16 from the start. It's sort of the agile
17 methodology.

18 Because I don't know that you can,
19 with rare exception, like date of birth,
20 there's almost nothing that you can't benefit
21 from how it's done in the field. How it's
22 input.

1 The other point I want to ask is, is
2 this EHR feasibility or this HIT feasibility?
3 So the point would be the PROs, the Patient
4 Reported Outcome measures.

5 Those aren't typically captured by
6 EHRs. I think they should be fair game in
7 terms of what can HIT make possible. And of
8 course that opens up a whole new set of
9 measures and data elements.

10 DR. BURSTIN: Any eMeasure of any
11 kind, yes.

12 MS. FRANKLIN: Thanks Paul, Ginny?

13 MS. MEADOWS: So the discussion
14 about whether we're talking about data
15 elements or measures? I mean that's a good
16 point because one of the things we were
17 actually in discussion last week with some
18 folks from ONC, CMS about was the data element
19 catalog that we received for Stage 2, which
20 was really helpful.

21 But what we found is that we could
22 look at that data element catalog and say, yes

1 we have those specific data elements in our
2 EHR, but without the measure and the measure
3 logic it leaves a lot of information out. And
4 when you look at the actual measure and the
5 intent of the measure, it can very
6 substantially change what has to be collected
7 versus just looking at a single data element.

8 So I think we really have to think
9 about the entire measure as well. And the
10 whole process, thinking about an agile
11 iterative process of working kind of down that
12 whole path is really I think very valuable.

13 MS. FRANKLIN: Great point. Aldo.

14 DR. TINOCO: Thank you. You know
15 I've heard a lot of discussion about clinical
16 workflow. I've heard a lot of discussion
17 about, let's build measures only around the
18 data that's currently captured in a prevalent
19 in structured fashion.

20 And I think to discuss feasibility
21 we've got to consider the quality measurement
22 development process in mind. Quality measure

1 development process as a whole. And I think
2 Ginny was alluding to that as well.

3 So one question for example. Let's
4 identify, as Keri suggested, a data element
5 that's really important for the measure, but
6 it's just simple not captured.

7 As a measure developer I'm learning
8 that there are some things that are important
9 enough to merit changes in workflow. And that
10 speaks to the importance question in the NQF
11 criteria.

12 So if we encounter feasibility
13 issues at a data element or technical level,
14 we ask ourselves, well what's the evidence
15 saying? Is this a flag or indicator that the
16 person responding to the feasibility
17 questionnaire may not be actually capturing
18 information that's allowing us to assess
19 whether or not they're adhering to a best
20 practice.

21 So hopefully today we'll discuss
22 that. Because again, through many discussions

1 and meetings such as these, I keep on hearing
2 workflow, workflow, workflow. And measurement
3 is designed to change workflow to be better
4 aligned with a best practice that's out there.

5 MS. FRANKLIN: I'm going to go to
6 Shannon and then Debbie and then if you could
7 just move, if you want to speak if you could
8 just put your, so Shannon, go ahead.

9 DR. SIMS: Thanks. I just want to
10 build on Martha's comment that as we think
11 about data element versus measures, I think we
12 also need to think about composite measurement
13 and we need to put that in the parking lot
14 thinking about implications, if most but not
15 all elements are individual components of a
16 composite are viable or not?

17 MS. FRANKLIN: Debbie.

18 MS. KRAUSS: So at the end of the
19 day I'd like to see us give recommendations
20 for a three categories, at least, of
21 feasibility testing. One the structured data
22 element that we've talked about.

1 Two, look into the logic. Look
2 into, if it's a new measure how we're going to
3 represent the logic. But clearly a lot of
4 time for feasibility of that logic needs to be
5 considered.

6 And also, as I believe Keri
7 mentioned, feasibility related to the
8 terminologies being used. Not that it would
9 hold things up because we could or stop the
10 measure development, but we could know early
11 on that we need to make new value sets or
12 request new terminologies and do our due
13 diligences in research to make sure we're not
14 duplicating value sets and things like that.

15 So I think It's an important check
16 point to have early on as we're looking at the
17 different types of feasibility that should be
18 required throughout the development of the e-
19 spec.

20 DR. BREGMAN: Can you give an
21 example of a measure of logic that would not
22 be feasible? Because I cannot, nothing comes

1 to mind of an example of that.

2 MS. KRAUSS: I bet Rute could give
3 an example. I'm not, it may not, I'm not the
4 expert on that but I know that we have
5 struggled with the tools that we have
6 representing logic based on availability of
7 the QDM representation, the use of the tools
8 that we have.

9 So it may be able to be represented,
10 but the complexity produces a 25- page
11 electronic specification for that measure. So
12 you may want to step back and look at the
13 measure and say, should we break this down
14 into different categories, is it really
15 reasonable to ask for this information, is
16 there a simpler way to do it, can we represent
17 it simpler, shorter, easier without knowing
18 that there's going to be so many twist and
19 turns that it may make it very difficult to
20 assure the accuracy.

21 DR. BREGMAN: Okay. Well I think
22 that's fair. I don't think that that's

1 something that the EHR vendors are going to
2 have an issue with.

3 There is no logic that you could
4 express in a pseudocode that we couldn't
5 handle.

6 MS. KRAUSS: I'm sure.

7 DR. BREGMAN: So it's, our issue is
8 not the feasibility of logic. And I do think
9 the QDM is an issue, but it's not really
10 something that we will address. But I don't
11 think that it's something that we will have an
12 issue with.

13 MS. KRAUSS: I guess it's looking at
14 everything that goes into making the logic
15 represented, with using the tools that we have
16 today. And I guess the main point that I want
17 to make is that it's not just feasibility at
18 the structured data element, it's feasibility
19 of every section of that measure that we're
20 representing and is it going to be useable.

21 DR. BREGMAN: Well I do think that
22 the logic does effect the validity of the

1 measure very much. Because you certainly want
2 the logic to represent the intent of the
3 measure from a clinical point of view.

4 You want it to have meaning and I
5 think there are examples in the current
6 measures where the logic, in my opinion, does
7 not reflect the intent of the measure. But I
8 might point that out, but it's not really
9 feasibility in terms of the EHR. It's a
10 different issue.

11 MS. CHRISTENSEN: Just to provide an
12 example from some of the testing we've done.
13 It's not that an EHR could never make it
14 feasible, it's that many EHRs currently on the
15 market wouldn't be able to make it feasible.

16 A lot of times it's with linking.
17 So something like, maybe I placed an order for
18 a consult and I have a result from the
19 consult, but I can't link those two up.

20 Some vendors can do that, some
21 vendors can't. Some vendors are working
22 towards that.

1 So right now it's a feasibility
2 issue for a lot of people, but it wouldn't
3 have to be a feasibility issue, you're right.
4 Probably most vendors could tackle that
5 eventually. Does that kind of make sense?

6 DR. BREGMAN: Yes, it does make
7 sense. That is certainly an issue. I think
8 it's more of an issue of the data structure.

9 I don't think of it as an issue with
10 logic. I'm not trying to, I'm getting a
11 little technical here.

12 I'm just saying of the feasibility,
13 the parts of feasibility metric. I'm not sure
14 logic is really an equal part to the data
15 element, feasibility.

16 DR. LIEBERMAN: I'll give one other
17 example for meaningful use. There's a measure
18 on, was a medication reconciliation done after
19 a transition of care and trying to determine
20 a transition of care.

21 A meaningful transition of care is
22 very, very difficult. I mean we come up with

1 ways of working around it saying, perhaps at
2 any visit is a transition of care. But I
3 don't think that's really the meaning of the
4 measure.

5 MS. MARTINS: So I'll start with
6 Aldo and then I'll move to Debbie and Howard
7 and Keri. Because I have things to say about
8 all of those.

9 I completely agree with Aldo that we
10 need to keep the eye on the prize. We need to
11 continue to measure what's important.

12 And certainly workflow needs to be
13 taken into account. And that's typically
14 something that measure developers haven't had
15 to think about because there was someone
16 looking for the information, wherever it was
17 in the record.

18 So I do think that we need to
19 consider workflow. But workflow cannot be
20 considered to be static and something that
21 cannot change, period.

22 So having said that, I think there

1 are feasible measures that are useless or that
2 are no longer valid. So we need to retain the
3 balance between feasibility and the validity
4 and reliability and the usefulness of the
5 measure for care improvement.

6 Moving onto feasibility of the
7 logic. I do agree that there are issues and
8 I wouldn't call it feasibility of the logic.
9 Whatever is represented can probably be coded.

10 I don't think that's the problem. I
11 think the problem is, is the logic
12 representing the intent of the measure and do
13 we have all the tools as measure developers to
14 represent what we intend to represent.

15 And an example of that would be the
16 discharge medications. The QDM couldn't
17 handle certain data types so we couldn't
18 represent it given the buckets of information
19 that the QDM gives us.

20 We couldn't specifically and
21 accurately represent that in the logic. There
22 was some information that would have to go in

1 guidance.

2 So I guess, and maybe I'm wrong
3 Debbie, but what you're talking about is more
4 of the representation of the measure. Whether
5 that's, I don't think that stands into yours.

6 I think that's, what are the
7 limitations of the QDM, what are the
8 limitations of HQMF? And how does that pose
9 issues in terms of if we're trying to
10 represent something that doesn't exists?
11 That's a problem.

12 And then I would also add that, if
13 we can make a measure, if we decide that a
14 measure is feasible or in order to decide
15 whether a measure is feasible, the use of
16 standards, such as HQMF, such as QDRA
17 certainly needs to be a part of the
18 discussion. How far into the weeds we go into
19 that, in feasibility assessment, and who
20 should be doing that assessment, is it the
21 measure developers, is it a collaborative work
22 with standards, consensus organizations and

1 that sort of thing is a question mark.

2 But if we are able to represent
3 something in QDM, in HQMF, but then there
4 isn't a QRDA bucket for it, we have a problem.
5 So I think that all of these things need to be
6 considered in terms of feasibility of any
7 measure.

8 DR. RADFORD: Listening to this
9 discussion, if I were an EHR developer, I mean
10 I would just be asking for a priority list
11 here. And I think we probably need to address
12 the fact that some workflow changes, both
13 human and electronic, which is what I'm going
14 to put in like the connection between ordering
15 a consult and actually getting it, it's sort
16 of an electronic connection.

17 I think we need to help prioritize
18 that work. It's all hard work. And the
19 expectation that it get done is becoming more
20 of a national kind of hoof beat. So that's
21 what I would do.

22 I'd like to also tell you a story,

1 it's going to take a couple of minutes. I may
2 be the only person in this room that actually
3 uses quality performance measurement to change
4 for your workflow behavior, whatever you want.

5 And I'm going to tell you a story
6 about how that happened at my place. Because
7 it might help us understand some of the
8 issues.

9 So when I first came to NYU we were
10 performing really terribly on the national
11 measures, which everybody knows. AMI, all
12 those things. Really terrible.

13 We gave about 55 percent perfect
14 care, which I thought was pretty dismal. We
15 then had a change of leadership, some of us
16 called it a coup d',tat.

17 But anyway, I went to the new
18 leadership and I said looked, this is
19 terrible. We can't call ourselves any good
20 and say we're good if we are actually
21 performing in on this.

22 He said, yes you're kind of right.

1 This is necessary, maybe not sufficient to be
2 truly excellent, but it is necessary. So he
3 said, okay you can have your executive group.

4 So we got a group together and over
5 the period of the first year we got to 90
6 percent. Second year 95 and now we're
7 consistently, for the last couple of years, 99
8 percent.

9 Now how did we do it? We had a lot
10 of PDFs, some successful, some not. One of
11 the most successful was putting into our EHR,
12 kind of standard order sets that involved
13 following the rules for the national measures.

14 And that did seem to help and people
15 like it. Well let me put it this way, some
16 people liked it.

17 What we found after we looked at
18 this, we did a little research project on it,
19 was that although we were at 99 percent
20 perfect care, we were doing all the right
21 things, half of the residents didn't use them.
22 Even though the patient had pneumonia they

1 answered no, because they just didn't want to
2 be bothered.

3 But having read the change of
4 management literature, realizing there's only
5 two things that change physician behavior.
6 And that's prompts and audit and feedback.
7 Maybe money, but that's sort of audit and
8 feedback I guess.

9 It really was a prompt and even
10 though they weren't using the order set, they
11 were actually doing the right thing in giving
12 the right stuff. So I didn't care. I want
13 the patients to get the best care, I don't
14 care if they fill in all the forms.

15 So I'm just telling you this story
16 because to me it exhibits lots of the
17 challenges and it keeps my eye on the ball of,
18 that we are trying to change workflow with
19 these measures. We are. But we have to be,
20 changing workflow is hard.

21 DR. BREGMAN: Well to follow up on
22 Martha's point and also to respond to what

1 Rute said. And what I want to say is, I
2 missed the opportunity to endorse what Aldo's
3 comment about, that workflow in some cases,
4 you do want to change workflow.

5 And I certainly, from my
6 perspective, I don't think we have an issue
7 with that. And I certainly don't have an
8 issue with that. I'm speaking for myself and
9 not necessarily for my employer.

10 But let me give you an example of
11 that. An example would be, we don't currently
12 have, in Epic, a way to store, we don't have
13 a list of patient preferences.

14 So you can imagine patient has some
15 claustrophobia, if they're going to get an MRI
16 they want it to be an open MRI. And you can
17 imagine if we had a list, just as we have a
18 problem list, we have a medication list, we
19 would have a preference list.

20 And the preference list would
21 include, prefers open MRI. Or wants to be
22 personally consulted before any blood

1 transfusion or no blood draws in the left arm.

2 You could imagine that it would be,
3 and I'm saying this because we're actually
4 actively talking about. You can imagine
5 having this list.

6 It could be reconciled, it could be
7 prominent, it could be available to the
8 patient in the patient portal where they can
9 edit it. And it would be just as prominent as
10 any other list.

11 I think everybody in this room would
12 probably endorse a tool like that which we
13 currently don't have. The issue is, from our
14 point of view is, if we were to go down that
15 path, how long would it take us to get there
16 to actually build a tool, test it, make sure
17 it fits into everything else, functions
18 correctly and then could be trained as it is
19 rolled out?

20 How much time would that take to do
21 it? If we were given a mandate with a six
22 month period to say, you need to start

1 recording this information and we had to solve
2 it in six months, we would basically jerry-rig
3 a solution based on our other tools, which are
4 kind of generic and not build for that
5 purpose.

6 And that's what we would come up
7 with because we wouldn't have the ability to
8 build it in six months. But if we were told
9 several years in advance, in Stage X, this
10 will be required and then with some hint of
11 specifications for it, then we can go down the
12 path of building it.

13 And then in that case the quality
14 community would be pushing us to create that
15 solution. And I think that's great. It's
16 great for the quality of care. But that's
17 what will happen if we are only given a short
18 time.

19 DR. LI: Agree with Howard said.
20 Regarding the eMeasure of feasibility, I think
21 there are two aspects related to the
22 feasibility.

1 One is, some challenge caused by the
2 eMeasure. For example, the eMeasure, that
3 element, to define more clearly. The eMeasure
4 logic has some certain level of ambiguity. So
5 basically there is some quality issue about
6 the measure itself.

7 Such as an improper code or code
8 system was created, that criteria which is
9 sometimes impossible to be captured in the
10 EHR.

11 So that's the one aspect. So
12 feasibility difficulty was caused by the
13 eMeasure itself.

14 But I presume these aspects should
15 be captured during the other testing. Such as
16 validity testing and reliability testing,
17 science acceptance testing.

18 So most of these issues should be
19 detected and addressed during this testing.
20 So really to my understanding, the feasibility
21 testing is really, to answer the question, if
22 we have a measure specification created,

1 approved by the steward and reviewed by the
2 domain expertise and there's no logic,
3 ambiguity. All the data criteria, data
4 elements are clearly defined.

5 But is these measure feasible to be
6 implemented by the majority of the EHR
7 systems? So to me the feasibility is forced
8 into the area of the EHR implementation.

9 So once the key factors related to
10 the eMeasure feasibility from the EHR
11 prospective, it's the essential aspect of the
12 obvious data. These are the data element
13 required by the eMeasures, are routinely
14 collected, generated during the daily clinical
15 walkthrough.

16 Number one question. Number two
17 question is that these data are captured, but
18 are these data captured in the proper
19 structured format?

20 For the IOM, even they are captured
21 in the proper structured format. Do they have
22 the corresponding or proper code value set to

1 bound them or how hard, if they use the local
2 terminology how hard, how much the effort will
3 be for the mapping between local terminology
4 to the standard of terminology defined by
5 eMeasure?

6 The concern is that if this data not
7 captured today in the EHR, when will they be
8 captured? In six months window or a year in
9 12 months window or 18 months window.

10 And how these future captured time
11 window will be weighed in the overall
12 feasibility, I mean goal or scale? So I add,
13 so really my hope is that by the end of the
14 meeting we can come up with some reliable
15 quantified approach that if we see this
16 measure goes through all these criteria, we
17 come up total score like 80 points.

18 We see this measure is immediate
19 feasible to today's EHR implementation. If
20 the measure is like, the score is between 60
21 to 80, we see is maybe feasible to be
22 implemented in the next 12 months. Something

1 like that.

2 So by doing that we can have a
3 consistent systemic standard approach to
4 evaluate whether the measure is truly feasible
5 to be implemented or not. It's just some
6 thoughts.

7 MR. KRAVITZ: I'd like to build on a
8 comment that Rute made during the phone call
9 which is, you know, if we're trying to get to
10 a score for a measure, a single score, I think
11 that's kind of a fool's errand because clearly
12 a measure that's feasible within an integrated
13 delivery network's outpatient EHR may not be
14 feasible within an individual provider sitting
15 out on the prairie someplace who's not
16 connected to anybody else.

17 Likewise, I think the point that
18 Rute made in the phone call was that, you
19 know, there's the, what is it? The HL7
20 maturity model for EHR?

21 MS. MARTINS: It's the HIMSS --

22 MR. KRAVITZ: The HIMSS.

1 MS. MARTINS: -- EHR Adoption Model
2 which already establishes --

3 MR. KRAVITZ: So I think the example
4 you gave in the phone call was that, you know,
5 an inpatient measure for a hospital where the
6 ER and the inpatient systems don't talk to
7 each other, that presents a different set of
8 challenges from a hospital where those two are
9 integrated.

10 And unless there's going to be some
11 kind of mandate from on high that everyone has
12 to achieve the same level of interconnection
13 and maturity, we're unlikely to have any
14 measure which works everywhere, right?

15 We're going to have some measures
16 that, you know, that don't require any
17 information from elsewhere that'll work
18 everyplace.

19 But any measure that requires any
20 kind of integration of information across
21 settings or across facilities is going to
22 require different scores.

1 I think we really need to think
2 about not just a, even if you had a criteria
3 for, you know, as people have seemed to be
4 aspiring towards, you know, if we had a score
5 that we could compute for a measure, I think
6 we're really going to have to compute that
7 score against a matrix of different
8 assumptions in terms of interconnectivity and
9 maturity of the EHR for it to be meaningful.

10 And then someone's going to have to
11 make a decision. You know, if the government
12 is choosing measures for inclusion in
13 programs, someone's going to have to make a
14 decision about whether a measure that's
15 appropriate in three of the nine setting
16 configurations that we do the scoring in,
17 whether that's appropriate for inclusion in a
18 program, but at least it would be an informed
19 decision.

20 MS. MARTINS: Yes, and to build on
21 that, I think that the question is what is the
22 average EHR we are measuring feasibility

1 against? What is that reference?

2 And I do think that there are
3 different levels of maturity and I would even
4 go further in terms of interoperability across
5 facilities. That's wonderful but we're not
6 even there in a single facility.

7 The lab systems may connect to the
8 EMR. The ER systems are almost certainly
9 separate systems. Operating room systems, oh
10 my God, those are silos. You know, all of
11 those are silos within a single, or may be
12 silos, within a single organization.

13 So when we're developing a measure,
14 let's talk about the paper-based measure.
15 There are no concerns about that. The medical
16 record is the medical record.

17 Someone will go in the different
18 systems and a person is highly interoperable
19 because it can interact with all of these
20 different systems and paper and derive meaning
21 from all of it.

22 So the bar is really high in terms

1 of where the clinical quality measures are on
2 the paper-based side. They're very
3 sophisticated because they can be very
4 sophisticated.

5 And I do think that what we can do
6 given the frame of reference of what the
7 average EHR does today is pretty much did the
8 patient get this medication during this
9 hospital stay? And that's, I think, very
10 consensual.

11 Anything above that would really
12 need to go through, you know, are we capturing
13 it? And it's not just the time frame, again,
14 because the time frame will be different for
15 each EHR.

16 So it's the maturity level of each
17 EHR and what I was suggesting in the call
18 actually is do we have measures for different
19 maturity levels of EHRs and do we have
20 feasibility criteria for these different
21 levels?

22 DR. LIEBERMAN: It seems that we

1 have a framework in place that would try to
2 address that, which is EHR certification and
3 criteria around that.

4 So we know as of certain dates EHRs
5 are supposed to be able to do certain things.
6 Now, I don't know, you know, I know what my
7 EHR can do.

8 But I don't know, you know, how well
9 those certification processes are working in
10 general to give you that kind of baseline that
11 you can then create measures against, and
12 perhaps we can comment on that as well. But
13 let me go to Ginny first.

14 MS. MEADOWS: Thanks, so I have a
15 couple of comments. One is actually back to
16 the conversation that Howard started about how
17 we could potentially build almost anything
18 into our EHRs, and that's absolutely true.

19 But I think when we're thinking
20 about feasibility, we really need to look at,
21 as one of the aspects, the cost versus the
22 value of collecting the data because we could

1 build anything in an EHR.

2 You know, pretty much the sky's the
3 limit and providers could collect any
4 information that we kind of force them to do.
5 But I think we really have to think about how
6 much is it taking to get there and is there
7 true value in what we're asking them to do?

8 And I think that's part of the whole
9 measurement of this feasibility of what we're
10 asking for, so that was kind of my first
11 comment.

12 The second comment goes back to the
13 conversation about maturity levels of both
14 EHRs and provider organizations.

15 I mean, that's kind of a tough thing
16 to think about because there are certainly
17 different EHRs that have a different level of
18 sophistication and a lot of that depends upon
19 which type of providers they're really
20 targeted to.

21 So some of these ambulatory EHRs
22 that are really targeted to the small

1 physician practices, the one-to-three doc
2 practices, are never going to have the
3 sophistication of a system like Epic that's
4 really working or a McKesson that's working
5 with large academic institutions.

6 So that's, I think, a little bit
7 more of a difficult thing to think about
8 because, you know, the question I guess is
9 whether we would want to have measures that
10 would only be targeted to those more mature
11 organizations? Would that be helpful or would
12 that not be helpful?

13 So I think it's something we really
14 have to think about when we really consider
15 that whole maturity aspect in both the EHRs
16 and the provider settings.

17 DR. TANG: I want to endorse what
18 Ginny said about the value of the measures.
19 We talk about value of health care and the
20 benefit over the cost. I think this is a
21 really important point.

22 I do want to respond to Howard's

1 point about the six months. Now in 2009, six
2 months was a legitimate complaint in terms of
3 time to develop.

4 I don't think in 2012 it's a fair
5 criticism anymore because we talk about so
6 we're doing Stage 3, which is 2016, so we've
7 been talking about it for a year so there's
8 four years and preference list is on that.

9 So if a vendor in 2012 is not
10 listening because we already have a track
11 record of how much the administration, you
12 know, pays to the recommendations, I don't
13 think that's an excuse anymore, which means I
14 don't think we should hold back for things
15 that are important, high value, sometimes
16 involving a burden of cost, if it's the right
17 thing to do.

18 So I think the game's changed and
19 similarly in our measure specification,
20 measure design, we shouldn't hold back on
21 yesterday's EHR either. So I think that's a
22 big -- this is an inflection point and I think

1 this committee is positioned to make advice.

2 So CMS has to go let out contracts
3 and other organizations for measures three
4 years from now. We can't wait any more and we
5 can't be anchored by yesterday's EHR.

6 And there's plenty of advance
7 warning now about what we're, you know, PROs
8 is not, it's already in the vocabulary. It's
9 not a dream, that kind of thing. And
10 similarly preference list is already in the
11 discussion.

12 So I would say to EHR vendors, you
13 need to be working on those things. But from
14 a quality measurement point of view, we should
15 be assuming that we can have access to it if
16 it's important.

17 So, I mean, again, I think this is
18 really an important document that's going to
19 come out that CMS will really take into
20 account and hopefully will create a brand new
21 set of measures, if we're providing some good
22 advice anyway.

1 DR. LIEBERMAN: Along those lines
2 though, it sounds like when you're talking
3 about kind of concurrently coming out with the
4 specifications for meaningful use Stage 3 and
5 the measures, the quality measures associated
6 with them, which is I think going to be a
7 little bit difficult in that you want to
8 implement something before you start measuring
9 it.

10 I mean, just when we've tried to
11 bring up different modules of EHR, there's
12 always this issue of we want reports on that
13 module.

14 And we know that there's going to be
15 issues when it comes up and so that if we try
16 to have a report ready at go-live it's very
17 difficult and usually doesn't work.

18 It's once we have the information
19 coming in for a little while, we can see what
20 it looks like, we can understand changes in
21 work flow, changes in where the data actually
22 shows up. You know, I think that having the

1 idea that there will be broad categories of
2 information available is very valuable.

3 So patient-reported outcomes, I
4 mean, you know, having measures related to
5 that seems reasonable if we know that, if
6 that's part of the criteria for Stage 3.

7 Yet, you know, having very detailed
8 measures around new functionality, you know,
9 you may be better able to measure
10 functionality required for Stage 2 by the time
11 Stage 3 comes around.

12 DR. BREGMAN: So, Paul, you're
13 saying that we should infer, the industry
14 should infer, that we need to develop a
15 discrete preference activity of the kind I
16 described from looking at the Stage 3
17 measures? Do you think that it would be, well
18 --

19 MR. KRAVITZ: When you said, well
20 when, Paul, when you are talking about we are
21 predicting, you're talking about the HIT
22 Policy Committee?

1 DR. TANG: But the value of this
2 process that was created, and it's not
3 executed all the time, but the track record's
4 already been that CMS, ONC takes about 90/95
5 percent of the recommendations of the HIT
6 Policy Committee.

7 And the importance is not that this
8 one -- it's that the body does all of its work
9 in public. Right now there's a request for
10 comment before the NPRM.

11 There's tons of opportunity for
12 people and every comment's read and it makes
13 a difference so it's not as if it's some
14 secret deliberation and somebody says a word.

15 This is just like NQF. It's a
16 totally public process. It shouldn't be a
17 surprise to anybody that as an NQF measure
18 goes through the pipeline, oh, I didn't know
19 until the board approved it. It's gone
20 through a process.

21 Similarly so has the
22 recommendations, at least for meeting these

1 objectives and quality measures, so it's out
2 there for a purpose.

3 And CMS is clearly interested in
4 hearing the feedback and makes adjustments
5 which is why I think this committee and the
6 results of this committee is so important
7 because it, I hope, will help the measure
8 developers both be empowered to use things
9 other than what you had before but also to
10 think about -- so instead of referring to this
11 as feasibility testing, I might look at our
12 objective as feasibility design because we
13 have to, again, work with the vendors and the
14 providers all along the way, developing the
15 concepts, testing it along the way, not just
16 here's the thing to test, go at it. And we'll
17 end up with far better measures I think that
18 way.

19 What would be nice is if this report
20 said what would you consider but, importantly,
21 and who would you consider it with and at what
22 time, which is at the beginning, not at the

1 quote "testing end."

2 But not thinking, oh, there's no
3 preference list in EHR so there goes that.
4 You know, we'll just do the same old same old.

5 MS. MARTINS: I actually wanted to
6 comment on two things that you said. One of
7 them is the certification criteria and that is
8 a baseline and that certainly is a baseline.
9 It's just not consistent with the eMeasures
10 that are being used with the program.

11 So I think there's a huge barrier
12 and a huge difference and gap between what the
13 EHR functionality measures or metrics are and
14 what the quality measures associated with
15 programs are.

16 MALE PARTICIPANT: Can you give an
17 example?

18 MS. MARTINS: Oh my goodness, I
19 can't think of an example in terms of a data
20 element. What I can think of is the
21 compliance.

22 So for instance, if we're saying the

1 patient has at least one problem in the
2 problem list, and it's also a feasibility
3 issue but more of a reliability and validity
4 issue.

5 If we're just saying that 20
6 percent, 80 percent of the patients have at
7 least one problem in the problem list, do we
8 have the confidence in the data being in the
9 problem list to use in a measure? So, you
10 know, and that I think is another discussion.

11 But my point is the fact that we
12 have labs and the fact that all of those ONC
13 certification criteria may not necessarily
14 translate into all of the QDM categories and
15 what can be used for developing an eMeasure
16 specification.

17 And we know that certification right
18 now is requiring that all of the data elements
19 used in the eMeasures are collected, but that
20 is it and that's a sentence.

21 MS. JAVELLANA: Hi. Actually I just
22 wanted to echo Paul's comments because at CMS

1 we are always looking to better improve our
2 process, especially getting measures ready for
3 certification. I mean, there's a lot that's
4 involved in that. It's multi-layered.

5 And so if this group can come up
6 with how, let's say for example, vendors can
7 get involved earlier on in the game, how we do
8 test decks earlier on in the game, I mean,
9 that's exactly what we're looking for so that
10 would be great.

11 MS. MEADOWS: So I'd like to speak
12 to both your comments and to Paul's about how
13 we as vendors should be looking forward.

14 And Paul's absolutely right. I
15 mean, we're following very closely the
16 discussions for Stage 3. It definitely
17 signals to us on some things that we need to
18 be focusing on.

19 But one of the key areas that we've
20 found takes the most effort is actually in the
21 quality measurement implementation and we
22 really didn't have enough to work with until

1 we got the measure specs at the end of October
2 which was a couple of months after the final
3 rule.

4 And we're still working with CMS and
5 the measure developers and they've been
6 fabulous and really having a lot of great,
7 open working sessions to work through some of
8 the issues we found as well.

9 So I would say that being involved
10 earlier and having more transparency and
11 ability to see what those measures are going
12 to look like is going to be a key to us being
13 successful and being able to get Stage 3 out
14 the door in a reasonable amount of time.

15 DR. TINOCO: Thanks. I'm hearing
16 this theme of transparency and one of the
17 reasons why I accepted the opportunity to be
18 on this panel is to try and lend a little more
19 transparency into how we approach measure
20 development.

21 We haven't really talked about what
22 we do very, very, very early in the measure so

1 much in process. We do take guidance from the
2 ONC HIT Policy Committee.

3 And just like I did when I was
4 working in the vendor space, we built our
5 products based on what we learned from our
6 customers. We went out to the field and you
7 cannot imagine the amount of innovation that's
8 happening at the local setting.

9 And I'm looking to Shannon, for
10 example. You know, yes, Shannon, I think you
11 said you have Epic but it's not just Epic.
12 It's the thing that he does with Epic.

13 I know that vendors also go out to
14 their reference sites and find out what are
15 those fantastic things that are happening now
16 and which one of those things should we
17 consider offering in our standard products?

18 Same thing with our measure
19 development. Our CEO and President Peggy
20 O'Kane, one of our Senior Vice Presidents
21 Phyllis Torda, Sarah Scholle, lots of folks
22 who are involved with making these decisions

1 are out in the field seeing what kind of
2 innovation's going on within the space of
3 quality improvement and quality measurement.

4 These are inputs to our process
5 early on to say is this worth improving? And
6 when we ask about feasibility assessments
7 early in the process, we don't really make
8 things up. We learn from what's out there in
9 the field and what these high-performing
10 organizations are doing.

11 And our vision, in part, is to learn
12 more about them and then to show other folks
13 how they could reproduce that level of
14 innovation and success and improvement through
15 these types of programs.

16 So, again, I'm hearing themes here.
17 When we talk about what an EHR vendor should
18 or should not be able to provide in their
19 products, we're also listening to what people
20 are doing with those fantastic products
21 already available.

22 DR. TANG: So it's a perfect set up,

1 these two comments. So, one, wanted to
2 respond to Ginny's having to wait for the CMS
3 measure.

4 Our goal, Policy Committee goal, is
5 for that not to happen in the future, that
6 there be a platform so that you don't have to
7 program what is specified.

8 You know, you already have a
9 platform and you just make available the data
10 elements that are needed to calculate a
11 certain measure so that we don't have a one-
12 to-one tie between some decision and then some
13 hardwiring of something because that's where
14 we are now.

15 But we're trying to move in a
16 different direction so we have the flexibility
17 to not only do what a CMS measure is but also
18 the things that would improve ourselves as
19 providers, so that's where we're headed and
20 that's in our RFC.

21 The other thing that's in our RFC is
22 what Aldo had just mentioned which is how do

1 you take advantage of all the innovations
2 already going on? CMS would like that too.
3 Right now they only primarily can use NQF-
4 endorsed measures.

5 And by the way, this is an NQF
6 initiative too that Helen had where she tried
7 to gather all the what's going out there
8 anyway?

9 So in the RFC is a proposal to have
10 an innovation track where if Shannon has
11 something and it works for him, he did it
12 because it works for him, he wants this
13 information, submit that to CMS and that can
14 be in lieu of one of the required measures.

15 And what happens is then that gives
16 you credit for doing work that you already
17 want to be done and it's a feeder system to,
18 oh, what else could be of use or interest if
19 somebody's finding this helpful?

20 So one of the pleas is just like
21 NQF's public process. There's an RFC out
22 here. If people don't respond and say, yes,

1 I'd love to do that, it'll fall on deaf ears.

2 We just had this in RFI and then
3 only the vocal against won out because all of
4 us, silent majority, didn't speak up and what
5 happens is the silent majority doesn't rule.

6 So it's really important because
7 these things are going to have a direct
8 influence on Stage 3. So if like the platform
9 is of use to the vendors, if the innovation
10 track's of use, speak up because otherwise it
11 won't come to pass.

12 But I think these are the kinds of
13 ideas that I think, I mean, it'll be very
14 empowering for measure developers and
15 providers.

16 MS. MARTINS: So, Paul, I think
17 that's really good because that speaks to what
18 we've seen, is when we talk about these
19 communication representation standards such as
20 QRDA and HQMF which are new to us as measure
21 developers, we're talking about standardizing
22 the communication of information.

1 And what you're talking about is the
2 step prior to that which is standardizing the
3 representation of information and kind of
4 getting a common ground across the EHR so that
5 we can build from that, and I think that's
6 really important.

7 DR. TANG: The more you give the
8 justification and even concrete proposals, the
9 more likely it'll make itself through the
10 system, and basically because it'll take
11 advantage of the experience you have, the
12 experience that's already out there that you
13 all have so that the right regs can go out and
14 it'll just make the world a better place.

15 MS. MARTINS: The other comment that
16 I would like to make, and it goes back to the
17 whole issue that we're discussing here which
18 is feasibility, is feasibility exists, at
19 least in our view, in paper-based measures as
20 well. So feasibility testing is not new in
21 terms of the measure development process.

22 What I do believe is that the

1 stakeholders that have been involved typically
2 in feasibility testing traditionally are not
3 enough. So we sure need to involve EHR
4 vendors in this process.

5 And while there is some sort of
6 formal assessment after a draft of the specs
7 have been put together, this needs to start
8 even earlier for EHR-based measures for sure.

9 The other thing that I think is very
10 important in terms of how different eMeasures
11 are from traditional paper-based measures is
12 that the cost of putting forward a measure and
13 the impact of putting forward a measure that
14 is not feasible has much greater impact.

15 It has vendors developing new
16 functionality within their EHRs and it needs
17 a lot more consideration in terms of whether
18 we want to include this data element or not.

19 And one really good example of how
20 that was managed in the environmental scan is
21 the Yale example where they studied the
22 incremental effect of adding a data element.

1 But that does bring a lot more
2 burden to the feasibility testing piece which
3 is there's going to be a lot of work, and I
4 think that's important work though, prior to
5 actually rolling out these specs for testing,
6 for pilot testing.

7 But it does require a lot more
8 thinking and perhaps a more quantitative
9 assessment than we are used to in terms of
10 feasibility or at that stage.

11 MS. FRANKLIN: I think we've all
12 stated on the webinar we had and now the
13 importance of the early feasibility testing.

14 And I think we're stating that there
15 are different parts of feasibility testing
16 throughout this cycle that we need to include,
17 so I agree with all that.

18 But let me also put a plug in for so
19 what do we have now that we can do as part of
20 this feasibility testing?

21 And one is a request for folks to
22 participate in pilots that are requiring the

1 electronic specification reporting because we
2 can learn from that and make changes moving
3 forward.

4 You know, there's the CMS EHR
5 Incentive Program 2012 reporting pilot for
6 hospitals, there's the one on the ambulatory
7 side, there's The Joint Commission pilot and
8 so I think we do look forward and we need to
9 improve our processes.

10 But right now this is what we have
11 and we can also learn from that, so we've
12 requested vendors for participation in these
13 pilots.

14 And we had one vendor participate
15 with us and they successfully reported four
16 hospitals, all 15 clinical quality measures
17 for Stage 1.

18 So that was thrilling on one hand
19 but disappointing that we didn't have more
20 participation even on the test file.

21 So I just want to restate that in
22 any pilot you can learn and you can learn as

1 we try to change things moving forward.

2 And we're also looking for test
3 partners. So we're looking for the vendor
4 community to work with us with current e-specs
5 and with future e-specs and with de novo e-
6 specs so that we can learn and not have any
7 surprises at Stage 3, to receive your input
8 all along the way, and so I think this is
9 critical and welcomed.

10 DR. RADFORD: I would certainly
11 endorse what I'm hearing as earlier
12 feasibility testing and I would rephrase it a
13 little bit as really earlier collaboration
14 among the vendor developer and provider
15 communities, you know, from the get-go.

16 And I think one example of this is
17 the concept that the providers are actually
18 doing the R&D on measure development, as you
19 have mentioned, where we develop measures for
20 our internal use and some of them may very
21 well be generalizable to other providers.

22 It's all about creating win-wins in

1 a lot of ways. You know, okay, so I've
2 developed hundreds of measures for my
3 organization.

4 Have I ever put one through the NQF
5 process? No. And, you know, there's nothing
6 in it for me except headaches. So, you know,
7 how do you do that? And I think there's
8 probably ways to do it.

9 One of the forces at work that we
10 haven't even mentioned or marshaled yet is
11 this new ACGME business and maintenance of
12 certification issue about providers
13 participating in quality improvement.

14 What that means is aggregate
15 reporting on themselves and so if you provide
16 that, particularly in the form of friendly
17 decision support in your EHR, bingo, you've
18 got measures. You've got everything. You've
19 got improvement too.

20 So, you know, I think there are some
21 new strategies we might be able to recommend
22 that would kind of speed this process along.

1 DR. LIEBERMAN: I want to make just
2 one comment on something you said earlier,
3 Martha, about I think it was the core measures
4 that you were discussing and about how you
5 implemented workflow changes and tools in your
6 EHR and you improved but not everybody was
7 using the tools.

8 So we've had, you know, similar
9 experience in meaningful use reporting where
10 we realized we were reporting on the same
11 measures that we were already doing through
12 abstraction, through the core measure process.

13 And there's quite a bit of disparity
14 between the two, so we do very well when we
15 abstract and we don't do as well when we look
16 at the electronic measure.

17 And in your example where you had
18 made a big improvement in your abstraction
19 rates but probably wouldn't in the electronic
20 rates because half the people weren't clicking
21 the button.

22 And that's where you get into this

1 issue of you've made change, you think that
2 your quality has improved, but it's not
3 reflected in the electronic record.

4 So then you get into this issue of,
5 again, the cost versus benefit. We've gotten
6 a benefit from it, but in order to prove that
7 benefit, there's going to be additional cost
8 to make people use those tools that they've
9 been choosing not to use. I don't know where
10 we're going to go with that but it was a
11 shared experience.

12 Where are we on our agenda? We
13 could either --

14 DR. WINKLER: You can be flexible.

15 DR. LIEBERMAN: Okay. So should we
16 take a short break here and then, because
17 we've kind of been going on with our eMeasure
18 feasibility assessment and whatnot.

19 But let's take a short break and
20 then come back to the discussion. So about
21 ten minutes, 10:15 or so that we'll get
22 restarted.

1 (Whereupon, the foregoing matter
2 went off the record at 10:03 a.m. and went
3 back on the record at 10:33 a.m.)

4 DR. LIEBERMAN: All right, thank
5 you. So I think we're going to have Reva talk
6 a little bit about the guidance and principles
7 now, to kind of steer some more discussion.

8 And then eventually I think we're
9 going to have to get down to work about
10 defining what the criteria associated with
11 feasibility assessment should be. So I'll
12 turn it over to Reva for now.

13 DR. WINKLER: In trying to help put
14 some structure around this conversation, and
15 sort of anticipating what we're going to need
16 to put together in our report, we've drafted
17 a set of guidance and principles essentially
18 drawn from your conversation in October.

19 So that's where a goodly amount of
20 this has come from. And so we tried to figure
21 out a framework to organize the thoughts. And
22 it is, you know, in the materials that you

1 were sent. And I hope everybody has access to
2 that. Because that's what we're going to be
3 referring to.

4 It would be a great help if we could
5 go through this and, with the intent of, you
6 know, I sort of envision taking this as being
7 sort of the first draftiest part of the report
8 and building it all out around that.

9 And so your help in understanding
10 did we capture it right? Did we capture the
11 right things? Are there additional things,
12 you know, structural organization?

13 So if we could just go through this
14 as a way of organizing the thoughts it would
15 be very helpful for us as we're trying to put
16 together your recommendations, you know, in
17 some sort of report afterwards. And so this
18 is kind of like the nitty gritty sort of work.

19 But just -- This is the memo we
20 sent you on Tuesday. It's dated December 4th.
21 eMeasure Feasibility Meeting, Additional
22 Materials. It starts out Project Goals. And

1 at the bottom of the first page it says
2 Guidance and Principles for eMeasure
3 Feasibility Assessment.

4 But just, I realize, perhaps we have
5 one more panel member join us since we did
6 introductions. And perhaps see if you'd like
7 to at least introduce yourself.

8 DR. BUTT: I'm sorry. I was caught
9 on the Baltimore-Washington Parkway for two
10 hours. It was probably easier to fly out from
11 California than to drive from Baltimore.

12 But yes, I'm Zahid Butt. I'm CEO of
13 Medisolv. I'm also a practicing physician,
14 and quite involved in various activities
15 pertaining to EHRs and quality measurement.
16 And I do not have any conflicts. I guess that
17 was one of the things that I'm supposed to say
18 publicly.

19 DR. WINKLER: Thank you very much,
20 and welcome. I'm sorry you had such a
21 difficult morning. Don't envy you. So if
22 everybody's got the document, we are able to

1 show it.

2 It was not easy to create slides
3 that weren't anything but totally wordy. So
4 we're trying to maximize it to be helpful.
5 But again, as I said, this was put together
6 based on your conversations. So these are the
7 things, these are a lot of the things that you
8 all talked about.

9 We tried to put some, turn them into
10 kind of principles, guidance sorts of
11 language. And we need to know if, one, we
12 captured it correctly. Would you alter?
13 Would you expand? Are there things that are
14 missing?

15 We want to be able to present these
16 to audiences about the general thoughts that
17 this group has had. And then finally the
18 recommendations around feasibility assessment.
19 So that's how we get started.

20 You know, it's your choice if you
21 want to -- Do you want me to read them? Or
22 do you want to have the group look at each

1 section perhaps? I don't know which is more
2 useful to the group, in terms of prompting
3 discussion.

4 If everybody has a chance to look at
5 it, perhaps there, you would want to identify
6 bullets you'd want to discuss further. Or
7 feel that are inappropriate or not captured
8 correctly. That would be very helpful.

9 DR. BREGMAN: Can I ask if we can
10 start with a understanding of the definition
11 of feasibility?

12 DR. LIEBERMAN: You can ask. But I
13 think that -- So let me throw out what I kind
14 of see as an output from this meeting. Is
15 that I think we've all talked about scoring
16 the data elements.

17 But we realize that's not enough to
18 adequately get an idea of the feasibility of
19 a measure. So it seems that we, what we
20 really are looking for is a feasibility
21 report, a feasibility assessment report that
22 can be used as a communication device between

1 the measure developers, measure sponsors,
2 measure implementers.

3 So that really the idea being that
4 we're going to expose or make as transparent
5 as possible what the issues are with the
6 measure. Or issues might be a little word,
7 but just to get, expose kind of the, any
8 issues with the measure up front.

9 So that we don't end up putting a
10 lot of time and effort into a measure. And
11 then once it's developed, implemented and out
12 there, we realize that it actually was not
13 very feasible to get good data, useful data
14 from this measure.

15 And so I would see it as being a,
16 some sort of potentially structured document
17 that would be a living document that you could
18 start with early on in the development
19 process, that allows you to address kind of a
20 set of criteria around that measure that makes
21 people understand what needs --

22 You know, is this going to be, how

1 is this going to be implemented? Or is it,
2 you know, what are the issues around
3 implementation.

4 DR. BREGMAN: That would certainly
5 be the definition of feasibility assessment.
6 But let me suggest a definition of actual,
7 just of feasibility.

8 And I think it is, a measure would
9 be 100 percent feasible if all the data that's
10 required for the measure can be captured in a
11 valid way, meaning accurately. With using the
12 existing workflow of the average user with no
13 additional actions by the user other than what
14 they're usually --

15 And this isn't very elegant to say.
16 But what they're usually doing in their
17 clinical workflow. So if they do what they
18 usually do, they record the data they usually
19 record. And all the data is validly captured
20 in that way, and can then be used to calculate
21 the measure, that would be a completely
22 feasible measure.

1 DR. TANG: But I would like to speak
2 against that as a goal. Because that's sort
3 of regressing to the lowest common
4 denominator. I'd like to piggy back on what
5 Ginny talked about on value.

6 And so in a sense, if we're only
7 talking about feasibility, it's just like
8 talking about health care costs. We don't
9 just want it lower. We want it to have the
10 maximized value to health.

11 So similarly I think we want to look
12 at the value of eMeasures. And we have this,
13 what's its contribution to health, which is a
14 big deal in the sense that we have -- It's
15 not just because you can measure it. It's
16 will the feedback change behavior?

17 And then look at the burden of
18 achieving that. And it's a balance. So I
19 think that may be something that we want to
20 discuss. Whether that's our goal, versus just
21 a "cost" side, the feasibility side.

22 DR. BUTT: So I think both those

1 concepts can be incorporated. Because within
2 feasibility I guess what Howard, what I heard
3 him say is that, what is feasible either today
4 or at any given stage of whatever criteria?

5 Whether it's through the meaningful
6 use certification, are determined to be
7 feasible according to the data that's captured
8 within that framework.

9 And then the other is, yes, it's not
10 feasible today. But it should be feasible in
11 the future because it's important. And the
12 importance then comes in that people are asked
13 to incorporate those data elements. And some
14 of them might be easy. Some of them might be
15 very difficult. And some of them might be
16 impossible.

17 But within that scale of what needs
18 to be done beyond what is already sort of in
19 the pipeline, would be determined based on how
20 important or relevant it is for the quality
21 measurement. So in that sense it is really a
22 sequencing and timing issue, more than whether

1 it should be one or the other.

2 DR. TANG: That's what I meant to
3 say. The assessment is to say it's either
4 feasible today, it could conceivably be
5 conceivable in a short period of time or
6 sometime in the future. But still, that's
7 what feasible means.

8 DR. SIMS: Well I guess from my
9 perspective I think we have to be cautious not
10 to boil the ocean. I mean, I think I'm
11 sensitive that NQF needs to have a deliverable
12 in early 2013. I guess I hear what Paul's
13 saying.

14 From my perspective I think we can
15 push the ball forward with some technical
16 parameters. Meaning that if we can tell
17 people what data elements, and thus perhaps a
18 roll up into what types of measures. And then
19 rolling up further into composites are most
20 feasible.

21 I think that allows policy makers to
22 decide what's important or not. I think that

1 that's an important piece of work that would
2 be nice for us to accomplish. Knowing that
3 it's in the larger context of what brings
4 value to healthcare.

5 And frankly, I think that's the
6 payer prerogative. I mean, if you know that
7 an element or a measure is going to be
8 infeasible, and you're going to impose a huge
9 burden on to your providers, that's your
10 prerogative if you want to do it from my
11 perspective.

12 So I'd like to see us design a more,
13 take a more technical approach here. Because
14 I think that's work that needs to be
15 accomplished. From my perspective, I'll tell
16 you my bias.

17 I mean, if you're going to think
18 about feasibility you need a -- I mean, the
19 quality eMeasurement world is not an infinite
20 universe. It's a fairly -- There are a few
21 hundred endorsed measures.

22 There's a quality data model. There

1 are other data models out there that provide
2 us a list of data elements. That might be
3 thought about as not comprehensive. But
4 certainly most of the way there.

5 And I think if we can find a way to
6 use something like that as a starting point,
7 I think that's a rational basis. I think we
8 also need to make some baseline assumptions
9 about, you know, I think use of --

10 Clearly feasibility is a moving
11 target. This is going to be the first
12 iteration of feasibility as we progress down
13 our HIT journey. Things are going to get
14 better.

15 But I think we need to have a
16 rational starting point. And certainly the
17 certification criteria for Stage 2 seemed like
18 a rational starting point to me.

19 So as we think about feasibility, is
20 that the right place to begin? Maybe it's
21 Stage 3, or maybe it's something else. But if
22 we get too far afield of that I think we're

1 going to lose ourselves, lose the forest for
2 the trees.

3 MS. MARTINS: And I would like to
4 completely resonate what you just said. What
5 I was going to say is really that, what is the
6 reference point? Feasibility against what?

7 To me feasibility is answering,
8 trying to answer the question within the
9 feasible, I would say the feasibility of the
10 process. So how deep can we go into
11 feasibility?

12 We could do everything before we
13 actually develop final eMeasure specs. Is
14 that reasonable? Probably not. So when do we
15 stop in terms of quantitative assessments?

16 Does feasibility involve
17 abstraction, human abstraction? Probably not.
18 It's probably more about structured interview
19 surveys and questionnaires, which is a more
20 qualitative assessment. But it still needs a
21 point of reference.

22 And again, is that the average EHR

1 today? Is that 80 percent of the EHRs? Is
2 that 50 percent of the EHRs? So as Shannon
3 was saying that the certification criteria may
4 be a starting point.

5 I would argue though that the
6 certification criteria tend to be general.
7 And I'm out of my league here because I
8 haven't read the rule. So this is from my
9 sense.

10 But when you're talking about
11 specialty measures it may provide you nothing.
12 So I guess some expansion of what the
13 certification criterias are, or criteria are,
14 or a framework that would work for measures
15 that are outside of meaningful use, should be
16 thought of.

17 DR. LIEBERMAN: So I'll ask a
18 question much like Howard's. You know, who
19 are we -- Who are the consumers of this
20 assessment? So when we, if we talk about
21 develop -- I mean, it's two questions really.

22 It's like who's going to develop

1 this assessment? Who's going to be
2 responsible for it? But then also who is it
3 going to be used and how is it going to be
4 used? And I think that, I mean, that will go
5 a long way to helping us determine what should
6 be part of it.

7 DR. BUTT: Not -- I guess on the
8 consumer side, I mean, clearly in the current
9 context the consumption is both internal, for
10 quality improvement, and for external, as in
11 whether it's pay for performance activities,
12 or the other mandated accreditation related
13 activities.

14 And in future perhaps public
15 reporting. So my guess is that those are the
16 three or four consumers of this type of
17 quality measurement.

18 But what I was going to comment on
19 again, in terms of trying to sort of put the
20 feasibility sort of framework discussion on
21 the table. That perhaps one approach is to
22 really use sort of a gated approach in

1 feasibility.

2 So in that sense the first gate is
3 really the data availability. So the
4 reliability and validity are actually
5 irrelevant if the data's not even available.
6 So you can't get to the second gate unless you
7 get through the first gate.

8 So maybe some kind of sequential
9 type of gated approach of feasibility might be
10 useful. Because it sort of goes from a
11 foundational layer to more refined things.
12 All the way to field testing, which is sort of
13 the end goal eventually, to make sure that you
14 get the same results that we expect.

15 MR. KRAVITZ: I'd like to build on
16 what Zahid was saying with the gated approach.
17 I think in terms of who the customers of
18 feasibility assessment, I think they're --

19 My perspective on this is all from
20 within the meaningful use program. So I'll
21 frame it within that. There's a whole process
22 where a measure gets selected for e-

1 specification, and then selected for inclusion
2 in the program.

3 And at several steps along the way
4 there should be opportunities to kill off that
5 measure as a candidate. And thus the gated
6 approach.

7 You need to do an initial, you know,
8 when the TEF is considering selecting a
9 measure for inclusion you don't want them to
10 think, to spend too much time thinking about
11 measures that don't have a snowball's chance
12 in hell of ever making it out into successful
13 deployment.

14 So we need some sort of course
15 filter at the beginning of that process, the
16 first gate. You need some kind of guidance
17 for the developers, while they're developing
18 the measure, that will help them avoid
19 stepping into areas that will cause their
20 measure to become less feasible.

21 And then there's some final gate
22 which says, yes this measure is sufficiently

1 feasible across the appropriate range of EHRs
2 that, in this case CMS thinks is important,
3 such that we want to foist it on the
4 community.

5 So I think there are, you know,
6 gates, like Zahid was saying, where we want to
7 provide feasibility feedback to the sponsor of
8 the measure development process. So they can
9 allocate their resources appropriately.

10 DR. LIEBERMAN: And, you know, just
11 to kind of build on what Shannon and Paul both
12 said. I think that we don't want to -- I
13 think we need to be clear on kind of what the
14 role of this group is. In that determining --

15 We all agree that if a measure, if
16 there's enough value in a measure, you know,
17 the absence of data currently should not be
18 enough to say you can't do it. Yet we, I
19 don't think as part of the feasibility
20 assessment are going to be the ones
21 determining the value of the measure.

22 I mean, I think that has to come

1 from elsewhere. And I think this group, the
2 feasibility that we're talking about really
3 is, I think more technical feasibility
4 throughout, that covers the life of the
5 measure.

6 I mean, it can be data elements. It
7 can be, you know, a number of different
8 sources for the data, and that sort of thing.
9 But it's not -- I don't think that we can
10 really address kind of the value issue.

11 Other than to say, you know, that we
12 need, that having a low, what could be a low
13 score in terms of data availability now should
14 not be a don't pass type of issue. Rute, did
15 you have something to say?

16 MS. MARTINS: So to build on what
17 Saul said regarding measure selection, and I
18 think we need to think about two different
19 types of measures.

20 The measures that are already out
21 there that we can do feasibility assessments
22 on the concepts that already exist in the

1 measures in order to decide whether they
2 should be re-tooled, for instance. Or do some
3 sort of high level re-tooling, and then do a
4 feasibility assessment on that.

5 And then there's the de novo
6 measures, for which, you know, maybe we're
7 just talking about the name of the measure.
8 And it doesn't really exist in the form of
9 specifications or measure concepts.

10 And that work needs to be done
11 before we can actually assess the feasibility
12 of the components of the measure. I mean, and
13 I guess there may be two different
14 assessments.

15 One that is a high level discussion
16 on the concepts that could be part of the
17 measure. And the other one is when we have
18 agreed on concepts that are important for the
19 measure, do a feasibility assessment on that.

20 And as we are talking about a gated
21 approach, which makes a lot of sense to me, I
22 think that we also need to think about how

1 providers that are not at the very, you know,
2 at the tip of the blade in terms of using
3 eMeasures in their systems.

4 Should we block them from using
5 simple feasible measures? And the possibility
6 of considering different levels of maturity in
7 EHRs, and are there measures for different
8 levels of maturity?

9 Maybe they're not the same measures,
10 and I'm being borderline heretic here. But
11 maybe there are versions of the same measures
12 for different EHR maturities that could
13 potentially be compared within that maturity
14 level, but not across maturity levels.

15 MR. JENTZSCH: Even as a consumer
16 the output of the feasibility, I think it's
17 important that the output is enough for us to
18 look at and say, is this enough information
19 for us to provide public comment before it
20 becomes something we actually have to
21 implement?

22 So if it's not sufficient to do

1 that, or it's too vague, that's of no value to
2 us. It has to be very specific so that we can
3 do public comment.

4 DR. TANG: I'm trying to figure out
5 how to put together some of these comments.
6 One, it sounds like we do have to have, not a
7 yes/no, but a score. But I wonder if we need
8 multiple categories.

9 I would worry if -- So CMS is not
10 going to be served well if we only use what's
11 in the EHR. There's no way we can get the
12 value based purchasing. Because we've never,
13 ever contemplated value.

14 And for example, you couldn't do
15 patient reported outcomes. So I wonder if we
16 have to actually categorize two different,
17 some of the future measures.

18 De novo doesn't mean necessarily new
19 concepts. It's new ways of measuring what we
20 really want it to measure. Not being tied to
21 billing and clinics. So that's, the input is
22 maybe we actually need two different scores

1 for a measure.

2 Considering what can we do now,
3 versus what we'd like to do. Because
4 otherwise we will penalize a lot of the
5 forward looking measures we're thinking about.

6 DR. BREGMAN: Well I appreciate
7 everyone's comments. But I want to go back to
8 my original question. Because I don't think
9 anyone addressed it at all.

10 And that is, I simply asked whether
11 we can define feasibility. And I proposed a
12 definition. And I would like to come up with
13 a clear definition of feasibility.

14 Again, the definition I proposed is
15 just that the data's available in the current
16 workflow without any additional input from the
17 user required.

18 Now the process by which we come up
19 with an assessment, the fact that we may have
20 different categories in the assessment, the
21 fact that we might say not feasible today, but
22 potentially feasible two years from now.

1 Or potentially feasible if we do A,
2 B and C, you know, all those can be part of
3 the feasibility assessment. But I think just
4 the, you know, I would like to just arrive at
5 a definition of feasibility.

6 MS. KRAUSS: Howard, I agree with
7 part of what you said, that part of the
8 feasibility definition should include
9 capturing the data. I don't think we need to
10 assign a timeline yet. But we could talk
11 about that in the report.

12 I disagree within the existing
13 workflow. I think we've had good discussion
14 to show that we can't stick to existing
15 workflow. Because existing workflow, hospital
16 A versus Hospital B, it can be completely
17 different.

18 And so I think we need to be agile
19 with the workflow and how hospitals implement
20 it. I've helped to implement many systems and
21 we've had to change the workflow. And we've
22 had to twist some arms. But we've always

1 found that we can come up with a more
2 efficient process.

3 So I think we all need to consider
4 workflow, but not put it within the existing
5 workflow. But I think the second component
6 that we've talked about is that the ECQM is
7 implementable in the EHR.

8 And that I think speaks to a number
9 of points that people mentioned. So I'd like
10 to definitely see those two points captured.

11 DR. BREGMAN: I actually think that
12 workflow is an important part of feasibility.
13 And I think the problem with, you know, when
14 I look at Epic, and when you ask, how does
15 Epic do feasibility testing?

16 The answer is generally not that we
17 have to survey a large sample of customers and
18 come up with an answer. Because in fact, for
19 the most part, and I speak of course on the
20 average.

21 But for the most part there are only
22 a few ways that something can be captured.

1 And maybe it's really just one way for a lot
2 of situations. But in other cases it may be
3 just two. It's not like there are really six
4 ways to capture it, and then we have to
5 evaluate all of the six ways.

6 And the issue with workflow is, if
7 we have a standard workflow to do something,
8 and then the alternative is to change
9 workflow, that makes it less feasible.
10 Because yes, it can be done. Yes, it is
11 possible. But the cost to the organization.

12 And we are trying to represent the
13 organization in our responses. To get users
14 to do something differently, to change the
15 appearance of the software, to do that. And
16 to train them. And then to get compliance is
17 very high. And that would factor into our
18 feasibility scoring.

19 So it's not just a sense of yes,
20 there's potential workflow. And therefore,
21 it's absolutely feasible. Because you could
22 do it that way.

1 We try to factor in the fact that a
2 change in workflow is costly and difficult.
3 And therefore, it lowers the feasibility
4 score.

5 MS. MEADOWS: So I agree with Howard
6 and many of the things he's saying. I think
7 the whole topic of workflow is definitely a
8 really interesting topic to think about.

9 Because as we've looked at some of
10 the things that meaningful use has kind of
11 forced our providers to start doing, that they
12 weren't doing before. A lot of those things
13 are very valuable.

14 And if we think about the future of
15 where we want to be headed with coordination
16 of care and all the things that we're trying
17 to impress upon to improve the quality of our
18 patient care, those are definitely
19 aspirational aspects of workflow that we
20 really have to get to.

21 I think one of the challenges that
22 we've seen is trying to drive those workflow

1 changes by implementing technology solutions
2 before the actual process of care has really
3 been defined.

4 And I think that's where we struggle
5 as a vendor. Because we don't want to impose
6 workflow changes on our customers that don't
7 really have a well defined process of care
8 behind them.

9 So that's where I would think we'd
10 have to think about really -- As we think
11 about the workflow aspects, concentrating on
12 how we would influence the development of
13 those new process before we actually force the
14 technology on people.

15 DR. BUTT: So I think workflow is
16 extremely important in the data capture. But
17 in this context, the question we have to ask
18 is, what is the measure looking for? The
19 measure is looking for data, and not
20 necessarily the workflow in most cases.

21 So the question is, does it really
22 matter if workflow A, B, or C get to the same

1 data that is well defined in the standard,
2 according to the code sets?

3 Yes, one might be less efficient.
4 And one might be a best practice. But from
5 the standpoint of measure consumption of data,
6 does it really matter?

7 My concern is that the most
8 variability you'll find, even within the same
9 EHR implementation, same vendor EHR
10 implementation, is in the workflow
11 differences. And we could really get bogged
12 down in trying to define those workflows as
13 part of an assessment.

14 And so I think that's one thing we
15 should probably discuss, in terms of how
16 important it is. As important as workflow is
17 for sure in data capture, in this context
18 we're looking for certain data elements. How
19 important is workflow as part of that
20 assessment?

21 DR. LIEBERMAN: I think actually in
22 the initial sort of criteria we had for HITEP-

1 1 there was kind of -- One of the criteria
2 was captured in usual clinical workflow.

3 And I think that that resonates with
4 what Howard is saying as well. It's not --
5 We know that we can always make changes in the
6 EHR to capture something. I mean, we can
7 always put it into the workflow.

8 And really, oftentimes the magic of
9 the implementation, or how successful the
10 implementation is, is how do you -- It's a
11 combination of both workflow and back end
12 things. I mean, we can -- In the system, yes
13 we can, there are multiple ways of capturing
14 it.

15 And you can always ask somebody to
16 click a button. But that's not going to work
17 very well. If you can figure out other ways
18 where in their usual workflow they're already
19 recording information, and get it from there,
20 then that is preferable.

21 But I guess I hesitate to endorse
22 Howard's definition in that again, it's not a

1 yes/no, this is what feasibility is. I mean,
2 I think we can talk about what a desired state
3 is, or what an optimal state is.

4 But then we have to measure, or have
5 to determine how well a new measure fits into
6 that state, to give us an idea of again,
7 whether the value of that measure meets the
8 cost. Or how do those two come together?
9 Let's see, I think -- I'm not sure which of
10 you two was first. Saul, go ahead.

11 MR. KRAVITZ: I kind of like
12 Howard's definition as a starting point.
13 Because I think we could all agree that if a
14 measure met Howard's definition, that it's
15 highly feasible, right.

16 So I think the concern is really
17 from the folks who really want to push quality
18 measurement to the next level. That if they -
19 - That Howard's definition handcuffs them,
20 such that no progress can possibly take place.

21 But I think if you look at -- If
22 you take the definition that Howard put

1 forward, and you qualify it just a little bit,
2 I think you have the start of a really good
3 definition.

4 So if you look at the, as Paul was
5 saying, we have pretty good foreshadowing of
6 what's going to be required in these programs
7 as we move forward.

8 So for example, the -- What was the
9 popular one? The patient, the PRO? That's
10 something that's promised or threatened, or
11 however you want to look at it. So you could
12 -- Wasn't that funny?

13 So if we scored measures against --
14 If we're talking about scoring measures for
15 Meaningful Use 3. If we said, okay, well we
16 know what's expected -- Let's imagine we
17 could say this. We know what's expected when
18 a system, when a provider deploys an EHR
19 that's certified for Meaningful Use 2.

20 That establishes some bar against
21 which we could apply Howard's definition,
22 right. So if I have a measure, and the data

1 elements that it requires are all ones that
2 are required to be captured in Meaningful Use
3 2.

4 And it doesn't violate any of the
5 other clauses in Howard's definition, we
6 should all be able to agree that that's highly
7 feasible in a Meaningful Use stage 2 EHR.

8 But that doesn't say anything about
9 what we're really trying to do, which is we're
10 trying to take up the process of developing
11 and updating measures for the next round of
12 changes, right.

13 We're trying to say, well if we're
14 investing now. If we're paying NCQA, or the
15 Joint Commission, or AMA or somebody to
16 develop a new measure that's to be deployed in
17 the Meaningful Use 3 time frame, we need to
18 predict. We need to assess the feasibility
19 against that time frame.

20 So I think you really need to -- I
21 like Howard's definition. But I would move
22 that it has to at least be divided into two,

1 which is clearly if it's against today's --
2 If it passes Howard's original definition, I
3 think we would all agree that the measure's
4 highly feasible.

5 But you'd also need to have a score
6 which says, I project that against the
7 background of the certification requirements
8 for whenever this measure's supposed to be
9 required, that it would pass the requirement
10 then. So it's kind of a today and tomorrow
11 kind of score.

12 MS. MARTINS: I don't agree with the
13 definition because I think it's incomplete.
14 And I think it's incomplete because data
15 capture is only one aspect of feasibility.

16 I do think that workflow needs to be
17 considered in terms of the data capture
18 process. And I actually think there are
19 multiple components to data capture, in terms
20 of feasibility, that we should be looking at.

21 One of them is data availability.
22 Where is this data coming from? And

1 accessibility. Is it structured? Is it not
2 structured?

3 And then the other one is data
4 standardization. Are vocabularies being used
5 to, standard vocabularies being used to
6 represent the mapping? Are these mappings,
7 are the data conformant with the QDM? So for
8 instance --

9 And that bridges to eMeasure
10 representation, which I think may also be a
11 feasibility issue. Because if the data is
12 available in the EHR, but we can't represent
13 it in a standard information model, that's a
14 problem.

15 And then also the data quality
16 viability, which is the likelihood of
17 documentation, how it feeds into workflow.
18 Then the other aspect I think needs to be, or
19 other aspects that need to be considered in
20 feasibility, besides data capture and data
21 representation, are the data extraction and
22 transmission.

1 So the effort to pull the data out,
2 you know. Do we need APIs or not to get this
3 out of the system? Is there a single system
4 versus multiple systems? That may complicate
5 things there.

6 And also the transmission. So the
7 transmission standard, such as QRDA, can they
8 handle it or not? And I think that's all part
9 of feasibility.

10 DR. BREGMAN: Well believe it or
11 not, all of that was implied in the
12 definition, which basically is about validity.
13 You know, can the data be collected,
14 transmitted, assembled, in a way that you're
15 going to get it. And that's implied in saying
16 the data needs to be valid.

17 PARTICIPANT: If not, what's the
18 gap?

19 DR. BREGMAN: Yes, sure. And then
20 it gets less -- If there's a gap then it's
21 less feasible.

22 DR. SIMS: Yes, I mean, I don't know

1 how you disentangle feasibility and workflow.
2 I mean, for me at the provider level, when I'm
3 sitting at a provider's level asking them, you
4 know, explaining to them why we're doing this
5 and how to collect the data, it's --

6 I'm trying to explain to them how to
7 work it into their workflow. I mean, at the
8 end of the day feasibility is combination of,
9 is it structured data? And is it, how much of
10 a byproduct is it of the doc or the other
11 providers daily workflow?

12 I mean, that's kind of, it's not
13 that complicated I think. I guess, I think
14 that we -- I understand that we need to
15 improve health care. And that there's a lot
16 we could do to do that. And there's some
17 aspirational things we need to do.

18 But at the end of the day, I mean,
19 and again, I'm speaking entirely for myself,
20 not for my organization. My survey of the
21 landscape is that many of us right now, for
22 the existing measures, don't use them for

1 substantive quality improvement, because they
2 don't accurately reflect the quality that's
3 being provided.

4 And that's simply because they're
5 not capturing the right data at the right
6 time. So it's probably in a note, or it's
7 somewhere else, or whatever. So I think we
8 ignore workflow to our absolute peril.

9 I was having a conversation with my
10 colleagues on this committee. And we were
11 talking about this sort of novel notion of how
12 we're actually developing a strategy of using
13 the meaningful use and PQRS metrics to
14 actually drive quality improvement at our
15 institutions. And that's new.

16 So I think to ignore workflow, or to
17 try to disentangle it from feasibility, I
18 don't -- I think they're kind of the same
19 thing, frankly. So I think at the provider
20 level at least, I think that we'd be penny
21 wise but pound foolish to let go of that.

22 I have a straw man proposal for --

1 I think that Howard defined one end of a
2 spectrum. I would propose that, two things.
3 So two straw men I'll throw out there for the
4 group to chew on.

5 One, I do think we need to start at
6 the data element level. I think when you
7 implement a measure, either at the vendor or
8 at the provider, if you have one bad data
9 element in a list of 25 data elements, you're
10 in trouble on this measure.

11 So for example, if you are trying to
12 capture patients with persistent asthma, and
13 you only capture that they have a generic form
14 of asthma, so you can't disentangle it and
15 have intermittent or persistent, for which
16 there are two different treatments, for which
17 there's measures for, you're in trouble. So
18 I think you need to assess at the individual
19 data element.

20 And so my straw man proposal is that
21 that's our starting place. And then we need
22 to eventually move up to creating some sort of

1 a squaring methodology, which I'll have a
2 proposal for as well, that goes to the
3 individual metric, and then up to a composite
4 at some point.

5 Because you're going to get in
6 trouble if you have the annual adult wellness
7 visit that has 12 components to it, and one of
8 the measures has two bad data elements, and
9 the other one has three. But the rest are
10 good. What does that mean for feasibility?
11 Think about that.

12 I would propose an ordinal scale,
13 meaning from most feasible to least feasible.
14 Perhaps with an addition of future stake
15 considerations as Paul has alluded to. So I'm
16 thinking three, four, maybe five categories of
17 designation for each data element.

18 I would propose that the quality
19 data model is a rational place to start to
20 look at a list of quality data elements. I
21 realize that that's going to be a big lift for
22 some human beings. And I'm happy to semi

1 volunteer for that.

2 But I think at some point we're just
3 going to have to get down to brass tacks and
4 rate all of these data elements against some
5 sort of feasibility scale.

6 DR. TINOCO: Actually, I support
7 much of what Shannon said. I think I'd like
8 to challenge the rest of us, if we -- And
9 myself included.

10 If we talk about workflow let's get
11 concrete examples, particularly from those who
12 have lived and experienced workflow. Here's
13 a concrete example. We've got a measure that
14 assesses blood pressure improvement.

15 And I used to assess hypertension
16 amongst patients when I used to be in the
17 clinical setting. Our EHR systems right now
18 have a place to capture blood pressure. That
19 place is very structured. And that place has
20 LOINC codes.

21 When we actually went out and
22 assessed feasibility, sure, the EHR systems

1 can do it. When we spoke with our subject
2 matter experts, we were in the field.

3 They said, oh yes, but actually what
4 I do is, the medical assistant puts the blood
5 pressure in there, that structured field.

6 But I think that patient has glycol
7 hypertension. So I'm going to put my
8 reassessment in my notes. So let's be very
9 clear and careful about what we mean about
10 workflow barriers, burden, using very concrete
11 examples.

12 Secondly, my first task when I
13 joined NCQA was, could you please come up with
14 a way to assess feasibility for our proposed
15 measures? And I went looking. And I found
16 ways that were provided through NQF's measure
17 evaluation criteria to say, here's
18 feasibility, here's a definition, and here are
19 four sub-criteria.

20 So as we continue to discuss what
21 those feasibility criteria might be, let's see
22 if we can draw upon what's already out there,

1 and what may already be implemented in
2 documents such as the CMS blueprint for
3 developing some of these eMeasures.

4 DR. RADFORD: I'm going to pause it.
5 First of all, I like Howard's definition too.
6 I think it's workable. And part of the reason
7 is that usual workflow is a little bit vague.

8 I actually think that it's not
9 incompatible with Rute's point of view. And
10 I also like Shannon's addition about the
11 different categories. I think there needs to
12 be some explanation about workflow though,
13 underneath of it. And it acknowledges the
14 fact that there's tremendous variability in
15 provider workflow.

16 And one EHR implementation is one
17 EHR implementation. And they all reflect
18 variations on the workflow themes that are
19 going to come out inevitably.

20 I personally believe, this is my
21 personal opinion, that providers own some
22 accountability for that variability. I'm fine

1 with there being variability.

2 But it's up to us to specify in this
3 emerging world of accountability and
4 transparency where we're going to park all
5 this information in our EHR.

6 And that that's part of an EHR
7 implementation, is to develop that grid of
8 where you're going to park what data elements.
9 And have that accessible to those of us that
10 want to measure stuff so that we can pull it.

11 And I think that that accountability
12 at the provider level has not really been
13 strongly acknowledged. We really kind of need
14 to push that.

15 And I believe it needs to be pushed
16 with the professional communities, with the
17 specialty societies. The NQF might be a
18 perfect platform for airing this
19 accountability proposal.

20 DR. BUTT: So I agree with Shannon
21 in terms of data limit level. I just would
22 like to make sure that we specify that it's

1 data elements of codified data.

2 Because I can see a scenario where a
3 measure, an eMeasure would consume non-
4 codified data. Whether that data was capture
5 structured or it was using some technical
6 algorithm that was extracted.

7 But it still needs to be a codified
8 data element for it to be consumed, I think.
9 Unless someone thinks that there might be
10 consumption of non-codified data within an
11 eMeasure.

12 DR. LI: I agree Howard and
13 Shannon's comments. At least we can use
14 Howard's definition as a starting point to
15 define what's the feasibility, what's the goal
16 of that.

17 And also I want add, to echo Rute's
18 comment that, what's the target of the
19 feasibility? So you may come up consensus
20 based framework, hoping to validate the
21 eMeasure's feasibility, then what's the goal?
22 Or what's the target?

1 If we see this eMeasure is feasible
2 to be implemented we see, you know, a specific
3 EHR, or most of the EHR, the ambulatory EHR,
4 or even hospital EHR. So I think we should
5 also cover the target part in the definition.

6 MS. MARTINS: So I agree with what
7 Shannon and Aldo and Martha said, in terms of
8 further specifying what workflow issues are.
9 And that workflow really is a really important
10 part of feasibility.

11 What I would like to say about workflow
12 is that there are bad workflows out there,
13 regardless of measures. And so we need to be
14 very careful in terms of assuming that if this
15 requires a workflow change, is it justified or
16 not?

17 So I think that's an important
18 aspect of workflow as well, in that there is
19 good, meaningful workflow change. And there's
20 bad workflow change from the perspective of a
21 measure, if we're just pushing something into
22 an EHR as a new workflow.

1 And it really isn't critical for the
2 measure, for instance. You know, there's
3 certainly discussion to be had around workflow
4 changes and how meaningful they are. And then
5 there are meaningful workflow changes that may
6 be implemented in bad ways in EHRs.

7 And so I think we need to take into
8 account all of these aspects of workflow when
9 we think about feasibility and workflow. And
10 then to Shannon's point in terms of having the
11 QDM as a starting point for feasibility.

12 I think NQF already started that
13 process with the QDM, was it a style guide?
14 The QDM style guide, with kind of an
15 assessment of how vendors see these QDM
16 categories in states.

17 I would like to put a word of
18 caution there though. Because QDM feasibility
19 is not data element feasibility. And a good
20 example of that is actually a data element
21 that we've been struggling with, which is
22 gestational age.

1 Probably all EHRs that deal or that
2 deal with hospitals and providers that have a
3 significant population of pregnant women and
4 deliveries will have some sort of structured
5 way to represent gestational age.

6 So under that assumption, when you
7 start looking at the QDM -- And this is where
8 representation I think needs feasibility.
9 It's really hard to assign a QDM category in
10 the state to gestational age.

11 And there are also vocabulary issues
12 associated with gestational age. So while QDM
13 feasibility could have been okay, when you
14 start looking at specific data elements it all
15 changes.

16 DR. LIEBERMAN: But if we're trying
17 to develop a framework for eMeasurement, and
18 we're saying that QDM is going to define the
19 data elements, then something's got to give.

20 We can't say that a measure's
21 feasible, or that a data element is feasible
22 if a current QDM data element does not exist.

1 Then it means that we need a process in place
2 to make changes to the QDM.

3 And at some level somebody has to,
4 there has to be a decision as to whether or
5 not there's enough value in that measure to
6 make a change in the QDM.

7 MS. MARTINS: Let me just clarify
8 that I don't mean that it can't be
9 represented. In some situations you can
10 represent it using the QDM. It's just that it
11 doesn't provide, the QDM itself doesn't
12 provide you enough detail on how that
13 particular concept is feasible.

14 DR. LIEBERMAN: Are there additional
15 comments? Or are these new comments from --
16 Martha, are you, you're done. And JD, are you
17 done? Or did you have a new one. Okay, JD.

18 DR. LI: I want to comment on the
19 workflow. So today's eMeasure are all
20 retrospective to check the existing EHR data.
21 So the EHR data availability is the key to the
22 eMeasure correlation. Although really,

1 through workflow this data get captured.

2 And starting in EHR the sense is
3 relevant. So my opinion is really, we should
4 try to avoid to assess the workflow, various
5 different workflow, the impact to the data
6 capture.

7 You should leave it to the workflow
8 assessment to the vendor and the clinician.
9 Let them to decide what's the best workflow to
10 capture the data. So the feasibility
11 assessment part should really focus on the
12 data. Not how the data gets captured.

13 MR. JENTZSCH: I go back to my
14 original comments. And I'm going to kind of
15 second Howard's concept of what we know. The
16 output of this document, this feasibility
17 document that it comes out.

18 When you do the measure it should
19 have the assumptions of the workflow, or
20 whatever we've all been discussing here. It
21 should have those assumptions. Then the
22 feasibility based on those assumptions.

1 And then there should be a whole
2 other section that says, but to approve this
3 measure, these are the things that need to be
4 done, workflow changes, whatever the case may
5 be.

6 I don't think you can just go to a
7 score, or something of that nature, and say,
8 this measure is worthwhile because it got a
9 score of ten. I don't think that works. I
10 think it has to be that robust to cover
11 everything that's been discussed.

12 MS. KRAUSS: Just one final quick
13 word that I have on workflow. First of all,
14 I'm not saying workflow should not be
15 considered. The only concern I had with the
16 term "existing" workflow. But I think it
17 should be a consideration.

18 And there should be some points to
19 consider about workflow, if you could
20 implement this ECQM. And not that it should
21 hinder or drive completely the final decision
22 whether or not to re-tool a measure. But it

1 should be one of those buckets that we
2 consider rather early on.

3 And I feel important that technology
4 should completely drive the process. But it
5 should be a factor, just like workflow's a
6 factor that we consider whether or not we
7 proceed with it.

8 So I just wanted to make sure people
9 didn't think I was against workflow. Because
10 I'm one of the most proponent of assessing and
11 evaluating.

12 DR. SIMS: I didn't mean to paint
13 you as an evil anti-workflow person, Debbie.
14 I knew in your heart of hearts we thought the
15 same thing. So, Joe, I guess I have a
16 question for you.

17 So in the example I was thinking of,
18 it's just as easy for me to determine how many
19 people are measuring blood pressure, as to
20 determine how many people are controlling
21 their patients with a blood pressure of under
22 140 over 90.

1 And clearly one of those metrics of
2 blood pressure control brings a lot more value
3 to the enterprise and to our country's
4 healthcare. But I don't know that -- They're
5 both equally feasible, right. It's the same
6 data. So it's just a different calculation,
7 different logic, basically.

8 So I guess the question I have is, I
9 mean, are we trying to disentangle -- I mean,
10 I guess what I hear from you about workflow,
11 I mean, the obvious implication for workflow
12 is if we're going to force people to change
13 their workflow, it's got to be valuable to the
14 healthcare system.

15 But again, I don't think that's our
16 job. I think if we provide valuable
17 information about just the technical clinical
18 feasibility of things, I think that pushes the
19 ball forward and gives decision makers the
20 information they need.

21 When I think about this information,
22 who's the consumers? I think that, I'm

1 thinking primarily of CMS and other payers, as
2 well as the measure developers. That they
3 have early information to think about, you
4 know, as measure concepts come up.

5 How do we -- How viable is this, or
6 not viable? And I think that the people
7 probably who could provide the most
8 information about feasibility is the vendors,
9 probably have the broadest view I would say.

10 And us as providers who tend to have
11 a narrower provider specific view. But is
12 that a safe assumption? That we imagine the
13 primary consumers of this to be of an output,
14 whether it's an ordinal or binary scale, to be
15 CMS and the measure developers? Is that a
16 safe assumption?

17 DR. LIEBERMAN: Well, you mentioned
18 two different people who are very different.
19 So it is the, I mean, the measure developers,
20 and then the measure, I mean, CMS or the
21 payer, or whoever is going to decide which
22 measures they use.

1 I think those are two of the
2 customers. And then it's I guess the other --
3 but the implementers or the providers are the
4 other ones.

5 Although I think, are you saying
6 that they actually would not have as much need
7 for this document?

8 DR. SIMS: Well, I guess what I'm
9 saying is, depending on who we imagine to be
10 looking at this feasibility, whether it's a
11 score or a yes/no designation, I think that
12 affects how, whatever scoring methodology we
13 come up with, right.

14 I think simpler's always better.
15 But if I'm CMS I may want to know on a scale
16 from one to five how feasible it is. If I'm
17 measuring health maybe I want one to 100. I
18 don't know.

19 If I'm a provider organization
20 thinking about implementing a random NQF
21 measure, maybe some other designation, just a
22 yes/no is what I want. So I think what I'm

1 trying to do is serve the greatest immediate
2 need to try and keep in mind things.

3 But I'm a, you know, a dark hearted
4 pragmatist at my core. And I just want to
5 make sure that we're bringing the most value
6 as soon as possible.

7 DR. LIEBERMAN: Yes, I would say
8 that, you know, that I foresee something where
9 yes/no, it might be what people want, think
10 they want. But that's not going to be
11 helpful. Because too many things would end up
12 probably being either no or yes. It wouldn't
13 mean enough.

14 So it's going to be some sort of
15 multi axial or multi category type of thing.
16 And it could be a combination of qualitative
17 and quantitative data.

18 I just wanted to make some
19 observations on this issue of workflow. So I
20 can think of two examples. Well, one example
21 has been given around blood pressure control.

22 And I think somebody mentioned that,

1 you know, the medical assistant puts in the
2 initial one. And then the physician will re-
3 take it at some point. And actually I think
4 the measure's written for the lowest value
5 during that visit should be the one that
6 counts.

7 I mean, you know, my own experience
8 I will re-take the blood pressure. And
9 sometimes I'll put it in as structured data,
10 and sometimes I won't. Depending on whether,
11 you know, what my clinic data's like.

12 And that's going to be very
13 difficult to overcome. I mean, the more that
14 that information is being used, being
15 circulated, whether it's the basis of bonus
16 payments and whatnot, may steer me towards
17 putting it in as structured data.

18 But it does take more time. And
19 right now it's more just for my own, you know,
20 clinical management of that patient. Just
21 putting in my note is enough.

22 Likewise with diabetic foot exam. I

1 mean, I know I look at the feet of my
2 diabetics. But in the current system that I
3 use I need to go through another two or three
4 clicks to make it, put it in as structured
5 data.

6 And for me, most of the time that's
7 not worth it for me. So I don't do it. So
8 there's an issue. And that's where that
9 definition of feasible becomes very tricky.

10 I mean, there is a current work flow
11 that allows me to put in diabetic foot exam.
12 But it's not, you know, it's not usual. And
13 it's more difficult to make it structured data
14 as opposed to just data available for clinical
15 use. Minet.

16 MS. JAVELLANA: Sure. And I'm
17 already probably going to say things that have
18 already been talked about. So as far as
19 workflow goes, again it's more about, you
20 know, is it really like bad workflow, or
21 something that's really for quality
22 improvement?

1 You know, our goal is, you know,
2 everybody, CMS, providers, is that we use
3 these measures because we want to, not because
4 we have to. And so that will take change in
5 clinical workflow if we all want to get there.

6 But there were also a couple of
7 other things. So now can we measure whether
8 that workflow is for quality improvement? I
9 don't know. Is there something we could add
10 as a part of feasibility?

11 And the only way to do that really
12 is to ask the providers. You know, is this
13 something that would be useful to you or not?
14 So those are just things to consider as far
15 as, you know, where --

16 Because at CMS we do consider that.
17 We do consider administrative burden. Because
18 that's what EHRs are supposed to do, is to
19 lessen that. So, you know, we don't --

20 We're a little bit conflicted I know
21 in the conversation that we're going on here
22 as well. But also, you know, to cast the

1 biggest net we could possibly cast, as far as
2 what --

3 And I know I'm kind of delving into
4 the actual, you know, quality measure
5 discussion. But, you know, as we were saying,
6 it's like, you know, what do most vendors
7 have? No, I should say, what do all vendors
8 have in their product? Not just most.

9 So something that would cross not
10 just the most providers, including
11 specialists. Because a lot of the comments
12 that we receive is, you know, these measures
13 aren't applicable to specialists.

14 So again, you know, if we want to
15 make it that basic. And also eventually take
16 it across all healthcare settings. So, you
17 know, just to kind of think of that as we're,
18 you know, looking at feasibility.

19 DR. BUTT: So I think in terms of
20 the workflow there's sort of two levels of
21 workflow that one can sort of try to further
22 define.

1 So in this blood pressure example,
2 no one argues that blood pressure can be
3 captured, and is captured. The issue is
4 whether it should be captured by a P.A., by a
5 nurse assistant, or by the front office
6 person, or the doctor.

7 The question would be, is it the
8 purpose of that assessment for us to define
9 who should do it, or how it should be done?
10 So it's that level of granularity and workflow
11 that one can get into.

12 On the other hand, I think the more
13 important workflow that perhaps is more
14 relevant here, is that no one is doing a
15 certain data element that Paul's committee
16 decides is very important for National Quality
17 Measurement for the National Quality Strategy.

18 And that's where the value question
19 comes in. That as Ginny was saying, you know,
20 one can, you know, beat up on the providers.
21 That they need to capture something which is
22 not just part of their normal routine of

1 patient care.

2 But it's an extra form that pops up
3 that needs to be filled with five clicks. And
4 it's very difficult for them to do as an extra
5 burden, which is not part of -- But it's very
6 important for the National Quality Strategy
7 somehow. I'm just making this up
8 hypothetically.

9 So the question then becomes, you
10 know, how much do you flog the provider until
11 morale improves, and they sort of, you know,
12 start capturing it?

13 But, you know, that's where that
14 question comes in. That yes, you know, it's
15 a very difficult thing to accomplish. But
16 maybe the value is not there. So let's not do
17 it.

18 So I think that's where the
19 feasibility is more relevant from a workflow
20 standpoint, rather than getting into the
21 granularity of that workflow that was just
22 given as an example in the blood pressure.

1 MS. MEADOWS: So I wasn't going to
2 so much speak to the workflow of discussion
3 we've been having, but more to Shannon's
4 question about who really is the end user of
5 this feasibility evaluation.

6 And it does go into workflow a
7 little bit. But you know, and this may seem
8 pretty obvious to most people here, but just
9 to kind of quantify what I'm thinking is that
10 there's a couple ways to look at who the users
11 are.

12 The people that should be completing
13 this evaluation would be both the vendors and
14 the providers. And the providers would be
15 looking at it from the aspect of their
16 workflow.

17 So it would actually be something
18 that they could provide a lot of value to. So
19 really, it would be a very collaborative
20 process.

21 And the folks that would benefit
22 from it, I think, would be the measure

1 developers and the measure stewards who could
2 then, especially if collaboratively they were
3 working with the vendors and the providers in
4 completing this survey, would really
5 understand how they should proceed with
6 whatever they're trying to measure and really
7 think about potentially even doing it in a
8 little bit of a different way, different
9 concepts, different ways of thinking.

10 So that was really kind of my answer
11 to Shannon's question.

12 DR. TINOCO: So let me be concise
13 and concrete again. I think Ginny, excellent
14 point. I think quality measure developers
15 are, in fact, consumers of the information
16 derived from feasibility assessments at the
17 data element level.

18 One point of guidance we can provide
19 for quality measure developers, I think is, is
20 it sufficient to allow providers to attest to
21 feasibility data elements, or do we need to
22 think about other methods such as

1 interrogating the data base and saying give me
2 a count query, show me the prevalence of this
3 data element is actually used in your
4 organization.

5 And then a developer with a sponsor
6 says oh, okay, yes, that's really good
7 information. The slippery slope is well, the
8 measure developer may start saying let's go
9 find an organization that we know is doing
10 this today.

11 You know, this is not research, this
12 isn't randomized controlled trials, I know,
13 but we have to be conscious of what people
14 will do with the guidance that we provide in
15 terms of the methods at which we start
16 building this ordinal scale and how that
17 impacts the quality of results of feasibility
18 assessment.

19 DR. TANG: Going back to the
20 customer, in principle, we would like to have
21 metrics about a measure that says gosh, I
22 would like to find something that has a high

1 impact, has a high scientific validity, and a
2 high feasibility.

3 And without knowing all the things
4 that go into those criteria, I would like to
5 have scores of hundred, hundred, hundred. So
6 it would really concern me if we used Howard's
7 definition because that would calcify the
8 current thought of what's possible today.

9 One of the reasons workflow is such
10 an issue is because today's EHRs are not very
11 usable. So most of the cost of the workflow
12 is the work arounds of today's EHRs.

13 We can't calcify the benefit of the
14 value of this measure based on today's work.
15 And so that scares me to come up with
16 something where I would score 100 percent if
17 I just dealt with today.

18 So I think we have to think more
19 about what would be in more of an ideal EHR,
20 and the workflow of the clinician. The
21 workflow of the clinician, does the clinician
22 capture blood pressure? Yes, they have to.

1 So that's already in the workflow.

2 The fact that they have to stand on their
3 heads to enter it into an EHR is not a penalty
4 against meeting the capture of the blood
5 pressure, or that it is not in the workflow of
6 the clinician to capture blood pressure.

7 So we cannot penalize a measure, a
8 good measure that produces good results by
9 today's EHRs. That's sort of the concern I
10 have with, you know, anchoring it there.

11 DR. SIMS: Paul, I mean, I agree
12 with you. We're ideologically aligned. But
13 where does pragmatism begin because, I mean,
14 we think we know maybe what's coming for Stage
15 3 and that's really going to drive, really
16 functioning a lot of what is available in
17 Stage 3.

18 But how do you create a system that
19 estimates the aspiration of what an EHR might
20 be in the future right now? I mean, how do we
21 do that?

22 DR. TANG: So Stage 3 is four years

1 away. I think the HR vendors, within the next
2 four years, can find an easier way of
3 capturing smoking cessation than five clicks
4 away, as one example.

5 I mean, it's just one of those do we
6 need to do it, do we want to do it? Yes. Is
7 it hard to do in today's EHRs? Yes. In four
8 years time, it shouldn't be.

9 That's what we should go towards
10 instead of well, let's throw all that out
11 because it's really too hard to do today.

12 DR. LIEBERMAN: Paul, what is your
13 alternate definition?

14 DR. TANG: I think feasibility has
15 nothing to do with anchoring it today.
16 Everything that you said was what can I do
17 today with no work and using today's EHRs.

18 The alternative is to take a lot of
19 what Rute was saying. There's a lot of
20 aspects to feasibility. We want to have
21 something where you could put a high score,
22 and that would say yes, it fits.

1 Blood pressure's a good one. It's a
2 really important parameter. Everybody wants
3 to do it. It's in the clinical workflow.
4 It's just got to be a lot easier to put the
5 doctor captured blood pressure than it is now
6 in today's EHRs.

7 So if we put into these various
8 aspects of "feasibility," I think that the
9 word is maybe a problem. We will have
10 something that a high score should be
11 something, both the measure developer aspires
12 to and a payer would say hey, if there's these
13 three high scores, that seems like something
14 that I should put out there.

15 And we should have that to be, it's
16 balanced. That's the whole thing about the
17 lead, and there's a lead time to what we're
18 doing right here.

19 But CMS is working on the lead time.
20 They have to work today for Stage 3, for a few
21 years from now. But we cannot anchor it in
22 the past. We will have lost a whole lot, I

1 think, if we anchor it in the past.

2 DR. BREGMAN: Well, how will I
3 respond if you were to ask me to give a
4 feasibility assessment, which is again, I
5 think it's accurate to say it's either the
6 vendors and the providers that are going to
7 give this assessment, how would I respond to
8 that request? On what basis would I respond?
9 How would I generate a score on your paradigm?

10 DR. TANG: We're going to come up
11 with a way. And I think that's our afternoon
12 exercise. There'll be different weights to
13 what, see CMS is looking for not today.

14 It's what would a measure be like if
15 it was highly feasible in 2016, as an example.
16 We can specify that, I think. If I were to
17 say how easy is it, because that's the only
18 dimension I see in yours to put it in your
19 EHR? Not easy at all.

20 But that's not a property of the
21 measure, that's a property of the EHR system,
22 I think, largely. I mean, it's all many

1 things.

2 But we want to get to what's a good
3 measure. That's what NQF is concerned about,
4 and that's what CMS, for example, is concerned
5 about.

6 DR. BURSTIN: Just to jump in for
7 one sec, just a point of clarification and CMS
8 could help here.

9 I think it's important to consider
10 the fact that there are some of these measures
11 in the here and now that as of 2014, if I'm
12 correct, people could use their meaningful use
13 measures, for example, to apply them to other
14 accountability programs like value based
15 purchasing, the physician modifier.

16 So I think it's really, I agree with
17 you, Paul, we need to be future tense. But I
18 think this has to be a stratified discussion.
19 I think we need to have one that's feasible in
20 the short term, and one that's more
21 aspirational.

22 But I think if we blend them, we

1 loose the ability to say which of these
2 measures in the short term are appropriate for
3 accountability, because they're valid
4 representations of quality.

5 And if we have systematic missing
6 data, it's not a valid representation of
7 quality. So I think we need to just have it
8 as a stratified stream of both accountability.

9 And I would love to hear CMS'
10 perspective on this because I think it's a
11 really important real life consideration
12 that's beyond meaningful use three.

13 DR. TANG: I know, but you were out
14 of the room when we talked about having two
15 categories.

16 DR. BURSTIN: Sorry, okay, okay.

17 DR. TANG: Just like you said, yes.

18 FEMALE PARTICIPANT: And Helen, I
19 think that's a great consideration, and it's
20 a great point that we have considered. And
21 when the hospital side, and I read some of the
22 other vendor methodologies when we did

1 feasibility testing for the structured data
2 elements, we specifically asked the vendors
3 that we had. We had a range of eight or nine
4 vendors representing multiple systems.

5 And we looked at the data element
6 feasibility capture to be captured today, and
7 within the next 18 months and across. So
8 certainly as we use them for currently retold
9 measures, we want to be aware of what's going
10 to be going on in the programs we're going to
11 be implementing in the short term.

12 But we also want to consider, and
13 everybody should consider in the feasibility
14 testing, the future, the 18 months, the two
15 years and how systems can adapt to capture
16 that data.

17 So definitely it's a spectrum.
18 That's why it's going to be difficult. We
19 just need to have these various buckets of
20 what we're going to include in feasibility in
21 some ranges, in some multiple considerations.

22 DR. OVERHAGE: Dave, you already

1 talked about this morning, and I apologize for
2 joining late, but to me, it seems like we're
3 talking about measures and feasibility and
4 workflows and all this stuff. But at some
5 level, it comes down to what does it cost to
6 capture a data element?

7 And it costs something different to
8 capture different data elements in reality.
9 And I think we, at some level, have some
10 commonality of there's certain data almost
11 that we think should be a low cost for an EHR
12 or a provider to capture.

13 So a laboratory result, we would
14 hope would be a relatively low cost thing for
15 them to capture. Something else, like a
16 pyschosocial assessment of the patient's
17 readiness to change might be a very expensive
18 item to capture.

19 And so I think about things, the
20 world more in terms of what are the data
21 elements than I do about measures or workflows
22 or whatever. So maybe this didn't make sense

1 to anybody else.

2 And I think about data elements in
3 at least three buckets. You know, there's one
4 bucket which are things that are sort of no
5 brainers, if you will.

6 Basic things, like I said, lab
7 results, maybe a diagnosis code at an ICD-9
8 level or ICD-10 level or whatever the current.
9 But just because that's something that you got
10 to do to survive.

11 There's another level of things, and
12 I agree with Paul, you know, that we don't
13 make it easy for providers to capture things.
14 But hey, that's a reality today.

15 So there's a real cost, at whatever
16 level it is, to get things out of the
17 provider's brain into a structured record cost
18 allot.

19 I mean, the example I always use is
20 they send you these stupid surveys in the
21 mail, and there's a \$5 or \$10 bill folded up
22 with a survey.

1 Well, they don't do that because
2 they're nice. They do that because they know
3 it takes your time to get some out of your
4 brain into one of the five checkboxes for
5 those ten questions.

6 And it's hard. You know, we don't
7 have any magic to do that. I think EHRs could
8 be much, much better. But even if they're
9 perfect, it's still a very hard job.

10 So there's things that we have, as
11 providers, captured, if you will, in our
12 brains at some level. But translating them to
13 structured data costs a lot.

14 So automated data, you know, pretty
15 easy, should be. Even blood pressures, you
16 could argue, should be pretty easy. And then
17 there's the stuff that's really, really hard,
18 you know, either because people aren't
19 capturing it today, it's not available in the
20 structure.

21 So it's maybe a different way of
22 thinking about that, because at the end of the

1 day, we're talking about what the measure
2 should be.

3 It seems to me this is a diagnostic
4 test on our health care system. And how do
5 you look at a diagnostic test? It's a
6 screening test, right? We're saying how are
7 our providers doing with X, Y, Z?

8 So when you ask that question with
9 the screening diagnostic test, how do you
10 think about it? Well, you say how sensitive
11 and specific is it? And how much does it cost
12 to do?

13 So at the end of the day, a measure
14 that costs a lot to do, because it uses data
15 elements that are difficult to capture, and
16 I'll talk about today and tomorrow in a
17 minute, is one we may want to think real hard
18 about what's the benefit that we're gaining
19 from that diagnostic test.

20 And just the silly example, but you
21 know, the beta blockers after MI stuff where,
22 you know, how valuable is that going forward

1 given the level of performance? Do we want to
2 keep testing every year for something that we
3 know is stable and good.

4 If you're an internist, you know,
5 like me, you do that. But in general we maybe
6 don't want to do that because it costs
7 something to do.

8 So the other related thought is to
9 Paul's point. In the vein of trying to help
10 people, you know, if I choose a stupid EHR, it
11 costs me a lot. This is a huge point, you
12 know?

13 If I can capture that data from a
14 device or from unstructured data or something,
15 I can be really clever and smart, or I can
16 create a workflow where MA captures data and
17 I validate it.

18 Good for me, it lowered my cost of
19 doing it. And the analogy that came to mind
20 for me was MPG, Miles Per Gallon goals. You
21 know, maybe you have buckets for these
22 different levels of goals.

1 There's stuff that should be free,
2 right? Structured lab tests should be free,
3 and the measure developer shouldn't have to
4 worry about how much that costs.

5 You know, there's a next tier up of
6 things that are, you know, they're \$3 today to
7 capture. And I'm not actually making up that
8 number.

9 That's the number that Kaiser uses
10 for what it costs them to capture a structured
11 data element that they didn't previously, per
12 data element.

13 So it costs, well for 2014, maybe
14 what we're saying is, you know, that's a \$2
15 data element, or \$1.98 data element, or \$1.10.

16 I mean, it sounds silly, but it's
17 sort of like so first, let the provider, you
18 know, once you get sort of a today's
19 assessment, to Howard's point about what is it
20 today and is it a good and valuable thing to
21 do?

22 But let's raise the bar by lowering

1 the price going forward. And then there's
2 stuff that just, do you really want to spend
3 \$100 to capture the stage of labor, I mean,
4 I'm making it up.

5 But you know, some of these things
6 are really, really difficult to capture in a
7 clinical world. Is it worth doing the
8 measure? You know what I mean? You have to
9 ask that question.

10 So I hate to reduce it to dollars
11 and cents, but in some ways, you know, it's
12 like so many things, you need a common
13 currency.

14 What's the value of what we're doing
15 and what does it cost to do? And it makes it
16 a real easy decision. I'm oversimplifying,
17 obviously. Is this a worthwhile measure,
18 worthwhile diagnostic test to do given its
19 cost?

20 And can we simplify this assessment
21 of workflows and things by saying this kind of
22 data ought to be relatively cheap and easy.

1 This kind of data, you know, we could put tags
2 and red, yellow, green in the QDM or whatever.

3 You know, this kind of data more
4 expensive than this kind of data. If you
5 think about it, you better be ready for people
6 to say wait a minute, that's going to be
7 really hard and costly. And you better have
8 a higher tier, or a higher standard for
9 whether that's a good thing to do or not.

10 DR. LIEBERMAN: Ginny?

11 MS. MEADOWS: So I completely agree
12 with those comments. That was actually great
13 descriptions of what I was saying earlier
14 about looking at the costs versus the value.

15 But one thing, if we could kind of
16 go back to Paul's comments about some of the
17 difficulty, I think we have to be careful
18 about mingling the usability of a system with
19 the feasibility of collecting data because as
20 we do know, I mean, EHRs have traditionally
21 been used for very different tasks and reasons
22 than we're now moving into, kind of this new

1 world of what we really want to be able to do
2 with our Electronic Health Records.

3 But the whole usability piece is a
4 whole separate topic that could take us a long
5 time to discuss. But we probably need to
6 separate that out a little bit because I don't
7 think it really impacts feasibility as we're
8 talking about it today.

9 DR. BUTT: So I think, based on all
10 the discussion, it looks like the goal for us
11 should be to have whatever assessment
12 methodology we sort of come up with later on,
13 that it be able to determine not just whether
14 it is feasible or not, but when is it
15 feasible.

16 In other words, is it feasible in
17 the short term, or is it feasible in the post
18 2014 world. And whatever methodology we come
19 up with, whether it's a single score, it needs
20 to be able to be able to discriminate between
21 those two states in a sense because, to me,
22 that's really the critical part of this.

1 So that's sort of something to keep
2 in mind when we have the subsequent discussion
3 later on.

4 MS. MARTINS: I echo Ginny's and
5 Marc's comments in the sense that it's
6 important for us to measure feasibility beyond
7 now. I think it's more than just the timing
8 issue.

9 It's not just timing. It's EHR
10 capability because we're going to have EHRs at
11 different stages at any given time. So it has
12 to be anchored in what the EHRs can do in a
13 set of criteria for what EHRs can do rather
14 than, or not rather than, but in addition to
15 how long a particular EHR may need to get to
16 that state.

17 And then to further echo Ginny's
18 comments on the blurry line between what are
19 issues with EHR adoption versus what are
20 issues with eMeasures in terms of workflow.

21 It's not only that there may be bad
22 workflows out there in EHRs, it's that we're

1 asking providers to start using EHRs and to
2 start collecting data for measures, based on
3 EHR data.

4 So that's a huge barrier, I think,
5 for providers. And it only started when
6 incentives started being provided. So I think
7 that the barrier to EHR adoption was workflow
8 change in a sense.

9 And we're just asking for more
10 workflow change. And I think from a provider
11 perspective, the two may be confused. And
12 there's a lot of change management that needs
13 to be done around this, regardless of the
14 measures.

15 DR. TANG: One comment about the
16 usability, I don't think we ought to put that
17 into the criteria. But I think it's a strong
18 influencer over the workflow costs. That's
19 how it's sneaking in here.

20 So let me go with what Marc was
21 talking about, the dollar. It's a \$3 effort
22 now, it's a \$1 in the future. And it maybe

1 still goes back to maybe there's actually a
2 stage of quality measure.

3 There's a 2012, there's a 2014 and
4 2016. And each of those had different
5 "feasibility," I wish there was a better word,
6 score because, ideally, a measure developer
7 shouldn't have to assess the measure being
8 posted, shouldn't have to assess, know the
9 details of scientific rigor or how to even
10 spell QDM.

11 They would just like to have a score
12 that says somebody who does know all that
13 stuff assigns it this. So in some sense, if
14 we knew what it costs today, if it was \$10 for
15 2012, then let's not make it at Stage 2, 2014
16 measure.

17 If it could be \$1 and it's really
18 important, in 2016 let's do that. I mean,
19 that's the kind of information I would think
20 the measure developer, particularly a consumer
21 like CMS would want to know.

22 So we need to find the different

1 aspects that go into that dollar or \$3 or \$10
2 to really give a good rendition of what it
3 means to CMS.

4 The way I would characterize
5 Howard's definition is that's the easiness
6 factor, and that's a factor. But it's not the
7 whole game. I'm worried about us making it
8 the whole game because I wouldn't want 100
9 percent easy. Well, you know, the free lunch
10 thing.

11 DR. LIEBERMAN: Just one comment.
12 You know, in trying to determine what the cost
13 is in the future, or should be available in
14 the future, I think it's valuable and we need
15 to include it. There's always uncertainty,
16 though.

17 And you have to factor that in, as
18 well. So we can pretty easily say something's
19 available now. We can even look a year ahead
20 and say well, that should be available.

21 When you start looking two, three,
22 four years out, it's very difficult to, I

1 mean, we have some guidelines now with
2 meaningful use criteria about what should be
3 available, so that can help us.

4 But there's still going to be more
5 less certainty about what the costs will be of
6 a data element in the future.

7 DR. TANG: Let me give you an
8 example. In the paper world, a patient
9 reported out, come cost \$100 per phone call.
10 In today's world, it's probably still \$10 or
11 whatever it is, \$10, \$20.

12 We're expecting, we're hoping in
13 2016 that that will be down to 20 cents. So
14 you can probably, if you know enough, figure
15 out about that.

16 So yes, it's uncertain. But CMS and
17 NCQ and PCPI should get some indication of
18 what's reasonable in a sense in 2016.

19 DR. LIEBERMAN: And just the other
20 point about assigning a cost to a data
21 element. I like it a lot, and I think what
22 would be, I don't know who would do that work,

1 but it sounds like Kaiser's already done some
2 of that.

3 But it would also provide some
4 feedback to individual institutions or clinics
5 or vendors to see that there's a data element
6 that is inexpensive. But in your system, it's
7 expensive.

8 And you have to ask the question,
9 why is that? And that's something to look at.
10 Howard?

11 DR. BREGMAN: I just want to respond
12 to Paul's comments. I do think, I'm going to
13 take credit that I think Marc kind of restated
14 my definition in his explanation.

15 Feasibility, in my mind, has nothing
16 to say about value. So that a measure could
17 be, if it has significant effect on quality of
18 health and it's deemed to be important, and it
19 scores a 20 in feasibility, I don't think the
20 EHR vendors are telling you not to do it.

21 For first of all, we shouldn't be
22 giving it a score of 20. I'm saying 100 is

1 perfect and zero is no feasibility. We
2 shouldn't be giving you a score without an
3 explanation of why we gave it that score.

4 We should be very specific, and we
5 are willing to be very specific about why we
6 would give it a certain score. But if it's
7 determined by whatever stakeholders are
8 involved, that that is important enough, then
9 feel free to do it.

10 You know, go right ahead with
11 implementing that measure. I would say that
12 if you're going to pick ten measures, and they
13 all score low, that's probably not a great
14 decision because there's difficulty all
15 around.

16 Now if you have ten measures and
17 nine of them score very high and one of them
18 scores very low, but you think that one is
19 important, you know, this is all getting back
20 to Ginny's original statement.

21 It's just a cost benefit decision.
22 The feasibility and, I think Marc restated

1 this, is a measure of cost. And if something
2 is low feasibility, it's just a statement by
3 us, an assessment of the cost.

4 And believe me, I do not think that
5 we have any interest in understating the
6 feasibility. So I think we really have an
7 interest.

8 And because we're not just in it to
9 get off easy, we're in it because we also have
10 an investment in increasing the quality of
11 care and the quality of outcomes that we
12 really do want to give you an accurate
13 assessment of the feasibility.

14 And if it's in the context, if it's
15 the feasibility today, then that is different
16 from what it could be, you know, in a couple
17 year interval.

18 DR. BUTT: Yes, just to clarify the
19 issue of the sort of milestones of the 2014
20 and beyond. I think just to clarify, I think
21 if the assessment tool or whatever we want to
22 call is designed with the necessary weighting

1 and so forth, because really what we're
2 talking about is data availability along those
3 milestones because there is a certain national
4 program that is pushing that availability
5 along those milestones.

6 So instead of focusing on the
7 milestone dates rather than focus on what is
8 it that would determine the score of that
9 availability that would automatically conform
10 to those milestones would be the way to look
11 at it, as opposed to try to sort of have
12 assessment that's geared towards the dates
13 themselves, but more towards what is
14 underlying those dates that would drive that
15 score is kind of what we need to keep in mind
16 when we develop the scoring.

17 DR. LIEBERMAN: I would assume that,
18 you know, the EHR certification process is
19 going to be ongoing, and will change over
20 times so there will always be a set of
21 criteria to move towards, that you should have
22 some expectation of what should be available

1 within what period of time. Am I correct in
2 that? More knowledgeable people in the room?

3 DR. OVERHAGE: I guess I would not
4 expect the certification process to be that
5 granular because it can't be that responsive.
6 I think the kind of capabilities that we'll
7 see, I agree, they will.

8 But I think for the purposes of our
9 discussion here, I don't think we're going to
10 see functionality specification at a level of
11 say, you must be able to record at a
12 structured level, the gestational age of -- I
13 mean, you know, that's sort of too low a
14 level. And that's where our challenges are,
15 I think.

16 MR. KRAVITZ: That's in there now.
17 Essentially, you have to be able to capture
18 all of the data elements that are in the
19 meaningful use two measures. That is a
20 certification requirement, irrespective of the
21 cost.

22 DR. OVERHAGE: That is sort of true.

1 I mean, it's back to Zahid's point that it
2 doesn't say you have to be able to enter them,
3 or you know, it doesn't specify how you have
4 to be able to capture them.

5 And it doesn't say that that's how
6 you have to use them to generate the measures.
7 It just says, so to Paul's point, the answer
8 is yes, you can stand on your left foot and
9 push with your pinky and you can make it
10 happen. That's certifiable, that's not
11 feasible for our purposes.

12 MR. KRAVITZ: Okay, so that you
13 could be certified, but it doesn't mean that
14 there's any reasonable way that, so using
15 gestational age as the example, you could
16 certify that you could capture and compute off
17 of gestational age, but doesn't mean that
18 there's any meaningful workflow where that
19 data element would be entered into the --

20 DR. OVERHAGE: Well, certainly that.
21 Or it may be difficult, or you know, and
22 again, it's a disconnect. Right? They're not

1 connected in the sense that the certification
2 criteria are, like you say, abstract in the
3 sense of saying capture these data, only we're
4 not saying what they are.

5 And then somebody else is saying,
6 well here's this other data element. So data
7 elements are not data elements are not data
8 elements. It's very different.

9 And so there's this sort of
10 disconnect of saying well, you have to have a
11 way to do it. Well great, I can pop up a
12 form, you know, the answer.

13 So then I'm certified. Now you got
14 to figure out a way to do it realistically.
15 So I mean, I don't see those as connected, or
16 at least, not very well.

17 MR. JENTZSCH: Unless I'm missing
18 something, we're talking about eMeasures in
19 general, not just meaningful use. We keep
20 talking about meaningful use as certification.

21 I don't think certification has
22 anything to do with all the other 13 measures

1 that are not part of the MU, right? It's all
2 eMeasures. Am I wrong?

3 So the feasibility score is going to
4 come in, it may not even be part of the
5 certification process. So I think that's kind
6 of an irrelevant discussion.

7 I think it's important that it be
8 certified, but I just don't think we should be
9 focusing on just that. It's not really the
10 vendor's responsibility to, the roll that I
11 take, we do something called the Big Q.

12 It's a very large, essentially,
13 database that shows all our measures from TGAC
14 to NCQA, to a bunch of measures. And we go
15 through a feasibility process all the time.

16 They may be measures that are
17 specified by other people. We bring them in,
18 we try to figure out what the feasibility is
19 before we actually report it at a national
20 level for that.

21 And that process is very difficult.
22 We may get a very low score on feasibility,

1 but it may be very important. It will show up
2 on our dashboard.

3 And then we track it over time how
4 well we are improving in the implement at the
5 regional levels, different workflows, whatever
6 they have to to improve their scores to do
7 that.

8 DR. LIEBERMAN: I think that I
9 wouldn't say that this is irrelevant in that
10 what we've talked about is giving a baseline
11 to assess feasibility against.

12 And that's where we do have national
13 standards and national specifications about
14 what should be expected, what an EMR or an EHR
15 should be able to do.

16 DR. WINKLER: I actually wanted to
17 ask a question based off of some of the
18 comments here. We were talking about the
19 potential customers for a feasibility
20 assessment tool.

21 Someone said that the developers
22 would benefit from the assessment. And I

1 wanted to ask the developers, the roll you see
2 in this sort of an assessment tool in your
3 development process very early on, because
4 there's been a lot of talk about feasibility
5 considerations have to be moved way up to the
6 front of the whole process, which really
7 starts with the developer creating some idea
8 about a measure, and then you know, figuring
9 out how you're going to do it.

10 So I would ask the developers, do
11 you see this as a tool that you would, you
12 know, would be using in your initial sort of
13 formulative thinking about how this measure
14 could be created, developed, constructed.

15 And then perhaps use it in an
16 iterate fashion as you move through the next
17 stages of development, really trying to figure
18 out your specifications and really figure out
19 how that measure's going to come together and
20 ultimately, as you move into developing the
21 logic phase.

22 So I just was wondering really how

1 the developers were seeing the potential use
2 of this kind of a tool in their development
3 processes.

4 DR. LIEBERMAN: We'll take more
5 comments while you're thinking about it.

6 DR. BUTT: So I think that the
7 certification standards are really very
8 helpful at one level. So for instance, when
9 the certification says that there must be a
10 problem, there's that structured and in
11 SNOMED, or ICD-9, that's very helpful because
12 it's establish a certain floor, which is
13 expected of all these EHRs.

14 Now what it doesn't do is then it
15 has not the granularity that Marc was talking
16 about, that okay so you have a diagnosis in a
17 problem list, which few will smile here
18 including Howard and Rute and Chris.

19 But the measure needs a principle
20 diagnosis, the measure needs a discharge
21 diagnosis, the measure needs all those
22 attributes of a diagnosis, which generally are

1 not part of the certification requirements.

2 So that's kind of where the rub is
3 that those are very important for the measure,
4 but they're not.

5 So I think it's very good to know
6 that in every EHR, there will be a diagnosis,
7 and that it will be specified either in SNOMED
8 or ICD-9. But I think the eMeasures generally
9 need more than that.

10 DR. OVERHAGE: You said something,
11 and I think it's worth, you said that the
12 measure requires. And I think that's one of
13 the places where the rubber hits the road
14 here.

15 The measure doesn't require,
16 frankly, a principal diagnosis. That's a
17 mental model that has existed and we've used.
18 What does it mean to require?

19 You know, are there eight other ways
20 you could get at that? Probably. That's just
21 the way that we have done it in the past
22 because that fit our information model that we

1 had a primary diagnosis on a hospital
2 discharge.

3 That's what we thought about.

4 That's not the only way to get there. And so
5 that's where I think some of the tension comes
6 in.

7 And as you said, moving this process
8 up front so that you're not saying we assume
9 that there's -- well, you don't have to have
10 one. That's just something that we did
11 because it was convenient.

12 DR. BUTT: Could I respond to that?
13 I don't want to open a whole new discussion.
14 But I think that some of it is, I guess, maybe
15 required may be too strong a word, but some of
16 it is quite important and necessary in some
17 ways.

18 And we can have a whole discussion
19 around that. But your point is well taken
20 that we should look at everything that has
21 been done up until now, or has been required
22 to see whether the same intent can be achieved

1 by more sort of EHR based data capture
2 methodologies.

3 But having been in the weeds of this
4 stuff, I can tell you that some of it is
5 necessary. And not all of it is something
6 that can be gotten rid of.

7 MS. MARTINS: So I think that the
8 measure, and to Reva's point, I think that the
9 measure developers really need this
10 feasibility assessment because some
11 feasibility issues may be show stoppers for a
12 measure, depending on how important the
13 concepts are for that measure, how rare the
14 event is for that measure.

15 How is it going to effect the rates
16 in the end and make the measure meaningless?
17 Well, maybe we need to reconsider this. So I
18 think that's really important.

19 The other aspect of it is that
20 traditionally, measure developers are thinking
21 about what's in the record, period, and not at
22 the cost of a particular data element that is

1 not captured in a structured way.

2 You know what? The information may
3 be there in a free text field. It's not e-
4 feasible. It doesn't mean that the measure
5 isn't feasible.

6 So I think there is a gradient in
7 terms of automated data capture from an EHR,
8 and a measure that is fully implementable that
9 way.

10 And then there is a decision that
11 measure developers face which is, is it really
12 cheaper to collect this measure as an
13 abstracted measure?

14 Maybe it is, maybe we should stick
15 with it for some of these measures. Maybe the
16 value of collecting it electronically does not
17 justify the workflow changes. It may not even
18 be meaningful.

19 So if you're looking for a specific
20 care plan with specific information for the
21 patient, how can we get at that electronically
22 right now?

1 So I think there is value for the
2 measure developers to decide. You know, and
3 if this really important, maybe it should stay
4 as a paper based measure for now. Or maybe
5 there is something that we haven't talked
6 about really, which is a sort of a hybrid.

7 What is it that can be collected in
8 an automated fashion, and then complimented by
9 abstracted information in order to retain the
10 validity of the measure and the buy-in from
11 providers that are looking to their
12 measurements and going ah, why are my rates so
13 low?

14 Well, I did deviate from the
15 guideline from this measure, but it was
16 justified. And that's one of the hardest
17 parts of capturing in a structured field, in
18 a reasonable workflow, within an EHR.

19 How can we still account for that
20 information where the providers feel that they
21 need to?

22 MR. KRAVITZ: I think the cost

1 model, or talking about things in terms of
2 cost and value, I think it's really, really
3 helpful because I think, you know, if you look
4 at, and I want to come back to something
5 Shannon said a long time ago which is, you
6 know, one bad data element can kill the
7 feasibility of a measure.

8 When you're trying to translate the
9 science of the clinical quality of the
10 measurement into something that you can
11 actually do without a chart abstracter, you've
12 got to make some trade-offs.

13 You can either have a very expensive
14 measure that no one can implement that's very,
15 very accurate. Or you might have to back off
16 and say I need to drop that \$15 data element.
17 And okay, my population shrinks by 50 percent,
18 but hey, I can actually get everybody to use
19 this.

20 So I think this notion of trading
21 off the cost of the data elements and the size
22 of the population that you can address, or the

1 clinical value that you can bring, I think
2 that's a really good way to think about it.

3 DR. LI: To response to your
4 question, the tool, the feasibility assessment
5 tool, I think if there's a tool, it will be
6 very useful, very helpful for the measure
7 developer to determine what the measure
8 candidate to be developed.

9 So personally, I really like such a
10 tool available. So as of today, all of the
11 eMeasures are developed based upon the QDM.
12 So really, the tool should convert the
13 conceptual QDM into a implementable
14 representation.

15 Then, it's more like a NQF conduct
16 semi-annual survey against all the QDM based
17 implementable artifacts to majority of the EHR
18 vendor. Is this element supported in today's,
19 your EHR system?

20 What is the data format, structured
21 or narrative? What is the vocabulary you are
22 using? If not, what's the cost estimation to

1 support it in the next, you know, 18 months?

2 If we have such a comprehensive
3 survey in front of every measure developer,
4 that this survey results get updated every six
5 months, then we will have a much reliable
6 evidence to assess, to determine, you know,
7 should we retool this eMeasure, this paper
8 measure into eMeasure given the current state
9 of that availability?

10 DR. TINOCO: So thanks for the
11 additional time to think about the question.
12 I don't want to bandy with semantics. I think
13 the term tool can get people, I agree and I
14 know.

15 But what we need are standards of a
16 way of communicating the results of our
17 assessments. I believe that measure
18 developers, there are many of us out there,
19 and growing.

20 And you know, providers themselves
21 are developing measures, right? So with that
22 many players in this space, I think we do need

1 to think about the criteria, the uniform
2 criteria that we should be communicating.

3 And how to communicate it such that
4 the downstream consumers know what they're
5 getting, and they can compare things across
6 people that are actually building these
7 things.

8 DR. SIMS: So one of the things I've
9 been thinking about as we've been talking is
10 I love the idea of costs. I have no idea how
11 we would practically assess that against, you
12 know, 10,000 different data elements.

13 But I'm wondering, something for you
14 to chew on, I looked up a thesaurus.
15 Feasibility, to me, when you say something's
16 feasible, almost anything is feasible in my
17 EMR.

18 So I'm wondering if a semantic word
19 change to something like practical was the
20 best thesaurus entry I could come up with.
21 But maybe that implies incorporation of the
22 workflow issues, the cost issues, the

1 technical feasibility issues.

2 I don't know that that's viable
3 under your contract or whatever. But I do
4 wonder if there's a better semantic choice.
5 And then I want to talk about the use of this
6 score.

7 So my dream scenario, and I used to
8 be a measure developer way, way back in 2009
9 before EMRs actually were really on the scene,
10 or electric quality measurement, I should say.

11 I mean, my dream would be that an
12 organization like CMS would, I'm thinking of
13 kind of a receiver/operator curve model where,
14 you know, there's value and now this new
15 feasibility.

16 And that when they choose measures
17 to be in programs, they're maxing out the area
18 under the curve of those two variables. And
19 in the same way, I think the axes are
20 different for our measure development
21 colleagues.

22 But certainly the available

1 evidence, the need, and then also now this
2 feasibility could be an additional axis for
3 them to chew on.

4 It certainly would be my hope.
5 Based on the number of committees I'm asked to
6 be on, I'm assuming there's not a ton of
7 people with the expertise in this group
8 running around to staff all these various
9 initiatives, and certainly not at the provider
10 institutions.

11 Nobody at my institution speaks any
12 of this language at all, which is, I'm sure,
13 the case in most places. So that would be my
14 hope for the end users.

15 But at the end of the day, if we're
16 able to generate a score that can kind of be
17 the axes for these different permeations and
18 thinking, people in this space, I think that
19 would be incredibly valuable.

20 MS. CHRISTENSEN: I will step back
21 to all those comments from just a moment ago,
22 so we're kind of bouncing back and forth.

1 Sorry.

2 I would also support if we change
3 the word tool to something more like
4 framework, just from the perspective that our
5 measure development activities are often very
6 organic.

7 It would be great to be able to have
8 some data out there to be able to go and show
9 to the workgroup well, that's, to use your
10 word, high cost data element.

11 Is that really the way we want to do
12 this, because oftentimes, they are of
13 differing opinions about the actual
14 feasibility based on their own personal
15 experience.

16 So that would be really good. What
17 we wouldn't want to do is anything too
18 prescriptive that we would have to fill out
19 that would take away from the organic nature
20 of the development.

21 DR. BUTT: Yes, so I was sort of
22 intrigued about JD's sort of suggestion, or at

1 least, comment that potentially one way to try
2 to get a sense of what all the different major
3 EHR vendors are planning to do in the next six
4 to 12 months is through some kind of a regular
5 survey methodology, because I was actually
6 thinking about it myself the other day because
7 the only other thing that you can sort of
8 grasp on is the standards and certification.

9 And that, we know, is not granular
10 enough to know everything that we need to know
11 for eMeasurement.

12 And so my question to the EHR
13 vendors would be that how practical or
14 feasible would such a survey be if it is felt
15 to be an important component of what elements
16 can be expected to be had beyond the
17 certification level of granularity.

18 MS. MARTINS: Zahid, to your point,
19 I think that's a two way conversation. So I
20 think it has to do with the measures that are
21 on the pipeline and concepts that may be
22 important for the measures that we have no

1 idea how feasible they are and then what would
2 be the cost of adding them to a measure.

3 But also, how workflows and EHR
4 documentation evolves as EHR adoption evolves,
5 as well. And even for your specific EHR
6 installation, there may be customers who are
7 asking for, you know what, I think I can
8 document this now in a structured format.

9 And hopefully, that evolution will
10 occur as EHRs become more and more mature and
11 organizations use them more and more for their
12 own internal purposes.

13 So when I say two way conversation,
14 what is it that, on the measurement side,
15 we're looking for and how does that fare
16 against what EHRs do today versus also how are
17 EHRs evolving and how can we leverage what EHR
18 functionality and how it is evolving beyond
19 the certification criteria.

20 DR. BUTT: I understand that this
21 will be an ongoing process and different EHRs
22 will be in different stages of it, as you

1 mentioned earlier.

2 My question is only that is there
3 some way to formalize the process of finding
4 out what elements are reasonably expected to
5 be available.

6 DR. BREGMAN: I'm probably going to
7 support Paul on this issue. I don't think
8 that the measure developers need to be
9 responding to what the EHRs are doing. I
10 think they can drive what the EHRs should do.

11 And I personally would not have a
12 problem if the certification criteria were
13 stricter and more granular, because it would
14 basically say look, in the preference example
15 I gave before, you need to create a tool that
16 allows a structured, accessible, communicable,
17 patient accessible way to record patient
18 preferences and, you know, match to codes.

19 MS. MARTINS: And I agree with you.
20 I'm not saying that we should be driving
21 measure development by how EHRs are developing
22 and evolving.

1 But we certainly can take that into
2 account, given what the priorities are in
3 terms of measure development.

4 DR. BREGMAN: I think that that
5 would be incorporated in the feasibility
6 score.

7 MS. MARTINS: Yes, and --

8 DR. BREGMAN: When we say, you know,
9 yes we're already working on that and yes, two
10 years from now it will be available, that
11 would be baked into the feasibility score from
12 my perspective.

13 MS. MARTINS: What I would like to
14 say in addition to that is in terms of the
15 population, as measure developers, I don't
16 think it would be meaningful enough to just
17 reach out to EHR vendors because there are
18 vendors with multiple systems.

19 So you have the product level in
20 terms of feasibility. And then you have the
21 EHR installation, which is I would guess, the
22 same as provider level.

1 So when choosing a sample of
2 institutions or vendors or organizations to
3 work with in feasibility, besides the
4 provider, or what we typically do in paper
5 based is choosy, try to cover the population
6 of organizations that we see as using these
7 measures for quality improvement.

8 So we're talking, and typically on
9 the inpatient side, you would be talking about
10 hospitals. We want to take into account
11 rural, urban, some of the demographics
12 surrounding the hospitals.

13 In addition to that three measures,
14 we certainly need to take into account
15 different EHR vendors, so market coverage,
16 different EHR vendors, different products
17 within EHR vendors.

18 And then the different
19 installations. And the different
20 installations need to take into account the
21 hospital demographics or the provider
22 demographics. And that brings feasibility to

1 a very unfeasible level for measure
2 developers.

3 So this is what I struggle with as a
4 measure developer is how much do we bring
5 upstream to feasibility so that we can kind of
6 assess where we want to go with the measure
7 and how we're going to move forward versus
8 actually piloting this, which would validate
9 the feasibility assessment and how we moved,
10 how we decided to move after the feasibility
11 assessment.

12 DR. OVERHAGE: This just builds a
13 bit on your comment. You know, the EHR I know
14 best today, you can enter any data element in
15 it today.

16 I can say that categorically,
17 there's no data element that you wanted to
18 record that you can't record. It all gets
19 into it.

20 So in some ways, you know, this sort
21 of going and asking the vendors can they do
22 it, to your point, I don't think helps us very

1 much because yes.

2 The question is how much work, how
3 hard? And the variability, and you know, we
4 talked a little bit before about, well we
5 shouldn't let providers be too variable in
6 their workflow or whatever.

7 And I just don't know how realistic
8 that is. I mean, if you take a very simple,
9 by my standards, anyway, observation like the
10 fractional shortening or the injection
11 fraction from an echocardiogram, there's these
12 incurrent measures.

13 I know of at least 18 different ways
14 that that data element gets captured today in
15 customers I'm intimately familiar with. So I
16 don't know that asking the vendors helps us
17 very much, frankly.

18 I mean, they may be able to be a
19 proxy for their customers, to a degree, but
20 it's so variable. Like you say, urban, rural,
21 size, what other systems they have, if they're
22 legacy, on and on.

1 And that's why I was trying to
2 suggest, I think to some level we're going to
3 have to do some lumping here. I think if you
4 think about at the individual data element
5 level, you die.

6 And you've got to categorize them
7 somehow as this type of data element, this
8 type, this type. And then I think you can
9 more realistically do either through a survey
10 methodology or through other ways, start to
11 assess the difficulty of that kind of data
12 element.

13 So then you get into the issue about
14 well, what is that taxonomy? And in some
15 ways, I think that's what the QDMs sort of
16 gets at, but not quite all the way there.

17 MS. MARTINS: Can I respond? I'm
18 sorry. It's going to be really quick because
19 I guess we go back to assessing what the QDM
20 feasibility is versus what the individual
21 meaning of the data element is.

22 And I do think that's dangerous

1 because a single measure may be built upon the
2 concept of gestational age we're looking at
3 term babies or term mothers.

4 If you don't get at the feasibility
5 of gestational age, you don't know how
6 feasible the measure is. So data element
7 specificity, from a measure development
8 perspective, is critical at the level of
9 specificity that the measure is looking for
10 it.

11 DR. OVERHAGE: Or putting it into
12 the right bucket.

13 DR. SIMS: So I'm the QDM
14 subcommittee, one of the co-chairs. Sorry,
15 that's a disclaimer, but I do think that
16 there's a rational way to do what you're
17 saying, Marc.

18 And the QDM, I realize it's not
19 perfect. And I know I'm mispronouncing your
20 name, pardon me. For doing that within the
21 QDM some lumping ability. And we've already
22 gone down this path with a little bit of the

1 style guide.

2 And the other thing is that the
3 feasibility, this is one of the reasons I'm
4 suggesting we think about a semantic change
5 from feasibility to something like
6 practicality because feasibility, yes, it's
7 feasible. It doesn't mean it's practical or,
8 you know, justifies the cost, et cetera.

9 MS. MAJOR: I just want to kind of
10 echo a couple of the points that Aldo and Keri
11 were making, but also to say, I mean, it's
12 true that there is a lot of variability and
13 you can't just go out and do a survey of one
14 EHR vendors and you have to kind of get the
15 context of all their various products and
16 implementations and whatnot.

17 But I do think that having some
18 level kind of setting of the available data
19 elements and then making that kind of a dance,
20 right, between the development process and
21 what's currently available.

22 So it's not that what's currently

1 available dictates the development process,
2 but that there can be an opportunity for kind
3 of pushing to the next level within that, but
4 having some sort of baseline.

5 And the reason that what you were
6 saying kind of ticked me off on that or kind
7 of pinged it in my brain is that I think in
8 some ways, part of what we answer, or at least
9 in the processes I'm familiar with in
10 feasibility testing now is well gosh, can you
11 find a place that can do it, right?

12 Or can you find a couple of sites
13 that can do it with their vendor and with
14 their implementation and with their current
15 workflows.

16 And so, to Aldo's point, that's not
17 always, like, the best question you want to
18 answer, right? Not just that you have one
19 site that can do it.

20 So just again, to kind of reinforce
21 what Aldo and Keri were saying, that if
22 there's a framework, right, that can be used

1 so that that kind of measure development dance
2 can happen, if that makes sense, and that we
3 have a set of kind of how we're going to
4 describe the outcome in terms of a scoring one
5 through five or however, that is standard and
6 that we all know what the scoring outcome
7 means, we say it's feasible to an extent of
8 three, four, five, whatever, that we all
9 understand what that means.

10 And what you get out of one
11 feasibility testing process is the same that
12 you get out of another. We've all kind of
13 answered the same question.

14 DR. BURSTIN: Yes, it's interesting
15 because I sort of share your concerns about
16 the word feasibility, particularly as it's
17 tied to testing because I think it's when you
18 say feasibility testing that people really get
19 lost, because testing is really about the
20 reliability and the validity of the measure,
21 which is later.

22 But I do think there is something

1 about that very early stage when measure
2 development is happening and it's more
3 iterative where you could almost imagine some
4 sort of virtual marketplace, not the right
5 word, perhaps, but where the vendors and the
6 providers, the end users have some way to
7 provide input on how feasible currently or
8 practical it is to collect these data.

9 And the potential costs and all the
10 gradations we just talked about. And also at
11 the same time, have something that allows for
12 the developers to make the case for the value
13 of that data element.

14 So you begin to triangulate that,
15 and then the vendors get a good sense of this
16 data element's really important. I can't do
17 it now, but boy I had better get this one in
18 place over the next two years.

19 And the developers can kind of take
20 a step back saying you know, this measure's
21 not going to work for a while yet, it's clear
22 it's just not out there.

1 Let's rethink, you know, for
2 example, do I really need to know if somebody,
3 just to use Joint Commission example, you
4 know, do I really need to know that somebody
5 is on NIH protocol?

6 You know, how much of that is really
7 small numbers that we could just move beyond
8 knowing how incredibly difficult it is? But
9 it just seems to me like a logical sort of
10 coming together, of both sides coming together
11 rather than it always being just the vendors
12 here.

13 But it's really what's the value,
14 what's the feasibility and bringing it
15 together in some sort of shared space where
16 people can comment and bring forward their
17 thoughts I think might really add value,
18 perhaps built off the backbone of the QDM.

19 DR. LIEBERMAN: All right, at this
20 point, can we open it up for member and public
21 comment?

22 DR. WINKLER: Arnika, operator?

1 Hello?

2 OPERATOR: At this time, I would
3 like to inform everyone, in order to ask a
4 question, press star then the number one on
5 your telephone keypad. Again, to ask a
6 question, press star, then the number one on
7 your telephone keypad.

8 DR. LIEBERMAN: Okay, we do have a
9 comment from the room.

10 MS. CRAWFORD: Hi. My name is
11 Alyssa Crawford. I'm from Mathematica Policy
12 Research. And I just wanted to make a really
13 quick comment.

14 Something Aldo mentioned before I
15 wanted to reiterate and say that I think it's
16 really important to consider, which is that I
17 think the overall goal of doing these
18 feasibility assessments and testing is to
19 really document what the potential barriers to
20 feasibility are so they're not surprises when
21 we interact with them in implementation, and
22 then to be able to identify potential work-

1 rounds.

2 So I think in some ways we want to
3 encourage measure developers and providers and
4 vendors to consider all of the possible
5 options and to look very broadly.

6 And I think the guidelines should
7 reflect that because yes, we need to have some
8 sort of easy way of saying, you know, how
9 feasible is this on a spectrum.

10 But at the same time, the projects
11 that actually go further and ask more people
12 are going to identify more barriers. So that
13 doesn't necessarily mean that the measures are
14 less feasible. It just means that they've
15 identified more of the potential problems down
16 the line.

17 So I think this guideline is very
18 helpful and the guidance that's going to come
19 out of this project is very helpful, but it's
20 about really helping measure developers and
21 vendors and providers and all of the other
22 stakeholders to start continuing to think

1 along the line and not encouraging them to
2 think restrictively within a certain number of
3 sites. It's really about thinking farther.

4 DR. WINKLER: Operator, are there
5 any other questions?

6 OPERATOR: At this time, there are
7 no further questions.

8 DR. WINKLER: Okay, thank you.

9 DR. LIEBERMAN: Okay. So it looks
10 like lunch is here. So I think we will break,
11 is it for a half an hour? Half an hour, and
12 then we'll get back together and, I think,
13 start trying to actually come up with what
14 this framework looks like.

15 And again, just to kind of quickly
16 reiterate, I think what we heard was that this
17 framework should be used as a communication
18 vehicle amongst the various stakeholders, and
19 using the generic stakeholder term there.

20 But I think it's useful there. So
21 it gives people a way of talking about
22 feasibility or of the measure. And for that

1 last comment, I think it's very important as
2 well.

3 It exposes where the cost is in the
4 measure to further that discussion about, you
5 know, how to best do the measure. So we'll
6 think about that over lunch. And then get
7 back together at 1 o'clock.

8 (Whereupon, the foregoing matter
9 went off the record at 12:34 p.m. and went
10 back on the record at 1:14 p.m.)

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A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:14 p.m.)

DR. LIEBERMAN: All right, so welcome back from lunch. So we have a couple more hours, and I know that some people are going to have to start leaving to catch flights before the scheduled adjournment time of 4 o'clock, myself included. So we'll kind of get as far as we can in the time we have.

I foresee us coming up, again the task was to come up with a set of criteria around this feasibility report or feasibility framework or feasibility assessment. And as we heard right before the break, I mean I think the idea behind this is a communication device amongst stakeholders, a way of succinctly summarizing some of the feasibility of the measure and identifying issues with the measure and what might be impacting that feasibility.

So we're kind of tasked with coming up with what should be included in that

1 document or in that report. And just to give
2 a little context, you know, I think it was
3 Aldo mentioned this isn't a vacuum, work has
4 been done here before.

5 But we're going to start with, I'm
6 going over some ideas that have been bouncing
7 around the NQF over the last couple weeks and
8 months, and then we'll also, I think there's
9 a slide in here on the HITEP criteria on the
10 data element part, and then we'll go from
11 there. So I'll let Reva talk through this.

12 DR. WINKLER: Okay. We put this up
13 a little earlier. Again, with the report
14 we're envisioning having, you know, you always
15 need the picture or a schematic or something
16 to keep it from looking totally boring, and
17 trying to capture the who and what over the
18 timeline, all these sort of multifactorial
19 elements of the matrix.

20 And so we're interested in seeing
21 your reaction to this. I can honestly say
22 that right up front I noticed that the first

1 green box should have "developers" in it, at
2 least, if not the first two green boxes.

3 But again we've been working on, you
4 know, trying to figure out how do we
5 pictorially present sort of way of
6 conceptualizing all of these various elements
7 to assist stakeholders in understanding what
8 it is we're trying to accomplish here. So I'd
9 appreciate any of your thoughts or feedback.

10 DR. LIEBERMAN: Yes, Paul?

11 DR. TANG: We've all been struggling
12 with this word feasibility. I wonder when I
13 look at this timeline it looks like it's the
14 same thing happening in all phases. And I
15 wonder if there is something that we do
16 prospectively as you're even starting the
17 measure concepts, we do something, the agile
18 development, and then we do a feasibility
19 testing or something test.

20 Do you see what I'm saying? There's
21 different kinds of activities, and maybe that
22 helps us, one, in describing what we would see

1 as the normative process to coming up with
2 developing new eMeasures. I don't know
3 whether I've said that right, but right now
4 they're undifferentiated and we might be
5 losing a little bit of what should happen.

6 Another analogy I'll use is user
7 interface usability. If it's usability
8 testing at the end then it's too late. And
9 there have been a number of, in the
10 environmental scan they mentioned this. If we
11 do the design and if the users and the user
12 interface experts are there at the design side
13 that's a critical role. We're trying to say
14 the same thing for feasibility.

15 DR. WINKLER: Any other thoughts?

16 DR. BREGMAN: Can you explain again
17 what the difference is between the two rows?

18 DR. WINKLER: Well, the first one
19 was talking about, you know, the data element.
20 What about the measure, what characteristic of
21 the measure is being addressed?

22 And the second is more about who's

1 working on it or involved in that part of the
 2 assessment because, you know, the sense of
 3 everybody is going to be involved at some
 4 point but maybe not everybody at all points,
 5 and the collaborative nature of it.

6 But again --

7 DR. BREGMAN: So does that mean the
 8 --

9 (Off microphone comments)

10 DR. WINKLER: Oh. Okay. In the
 11 first, the data level.

12 (Off microphone comments)

13 DR. WINKLER: Okay, underneath the
 14 Data Element, Workflow Processes, EHR Vendor
 15 and System Level, and it's obvious to me that
 16 that should also include Developer. Under
 17 Measure Logic it's EHR Vendor or Local
 18 Provider, and the question is that maybe
 19 Developer in that box as well. And then
 20 Measure Score is more at a Local Provider
 21 assessment.

22 DR. BREGMAN: I don't understand

1 that part.

2 DR. WINKLER: Well, I think that
3 that's sort of the end of the road, being able
4 to pull out a fully, you know, the measure
5 result.

6 DR. LIEBERMAN: I think that's more
7 under the reliability, validity, kind of
8 feasibility assessment, tails off in that
9 stage but that's in measuring those other
10 properties of the measure.

11 DR. RADFORD: But then you also have
12 the people that are using the score for
13 accountability. They want that score too. So
14 that's a product really.

15 DR. BUTT: So are they implying in
16 Measure Score, the performance?

17 DR. WINKLER: That's the performance
18 score.

19 DR. BUTT: Okay, so maybe if we,
20 because we're talking about score in this
21 context, perhaps if we could clarify that it
22 might help.

1 DR. WINKLER: Sure.

2 MS. MARTINS: I think certainly the
3 subject of what we're trying to assess in a
4 feasibility assessment and in a reliability
5 and validity assessment is largely
6 overlapping. The way we go about and do that
7 and the level of statistical validity of our
8 conclusions are certainly different.

9 So I think the feasibility
10 assessment is, and we've talked about this,
11 more of a qualitative, may have some
12 quantitative aspects, but to kind of steer us
13 in the right direction where we're going with
14 this measure and make sure that we're not
15 creating a measure that in the end we've
16 invested all of this time and effort and it's
17 useless.

18 But then there is the assumptions
19 that we work upon given the feasibility
20 assessment need to be validated either both in
21 the larger population of sites and how
22 comparable the data may be across a larger

1 sample of sites, and also at the very specific
2 level of patient data from EHRs that are in
3 the real working world.

4 DR. WINKLER: As the conversation
5 goes on we'll keep tinkering with it and any,
6 you know, get your feedback as just a way of
7 schematically trying to describe this fairly
8 complicated and intricate process.

9 DR. LIEBERMAN: This is from ONC
10 trying to get a framework about thinking about
11 data elements as well, and really, you know,
12 hoping to find, upper right, all this in the
13 upper right box with high value.

14 So again, essential to quality of
15 care and that are structured and present in
16 the EHR, that would be a data element that
17 would score very well. And then on the other
18 end is the low value, elements not very
19 significant and that are unstructured are ones
20 that you would not find as much value in. Go
21 ahead to the next one.

22 So this is back to the work from

1 HITEP-I, where we started to look at trying to
2 assess data elements, and these were the
3 criteria that were used in that group. And
4 you can see there's both, the scale is one to
5 five for each of them, but they were weighted
6 somewhat differently.

7 And I can read through them, but
8 there was, you know, Authoritative/Accurate
9 Source. Is the entry in the EHR from an
10 authoritative data source? What is the
11 accuracy of the data element in EHRs? And
12 then Data Standards. So again is it using a
13 nationally accepted terminology standard in a
14 structured format?

15 And then Workflow Fit. This gets
16 to, you know, a lot of the discussion this
17 morning. So is it captured in a typical EHR
18 workflow? And again we could look forward and
19 say, will it be captured in a typical EHR
20 workflow as well?

21 And then Availability in the EHR.
22 So that one was just, is it currently there?

1 And then Auditable, can we look back and see
2 whether or not it was accurate?

3 Paul, how many data elements did we
4 score using this method? Do you have a --

5 (Off microphone comments)

6 DR. LIEBERMAN: Hundreds, yes.

7 Okay, and that was at the data element level
8 for kind of what we felt were high value
9 measures at that time. Okay, go ahead to the
10 next one.

11 And then this is, again this is for
12 more kind of from some thinking over the last
13 couple of months about this as well. Really,
14 and these were things that were called out.
15 And you can see there's a good amount of
16 overlap sometimes from them.

17 So again it's the, captured during
18 the course of patient care, and I would say
19 kind of routine course of patient care. Data
20 found in structured data fields. Data element
21 definition is precise and unambiguous with
22 appropriate granularity to represent the

1 quality concept.

2 Data element and associated value
3 set use standardized vocabulary. And then the
4 last one, interoperability complexity, that's
5 the one in reading through I wasn't as sure
6 exactly what that was getting at. I think it
7 was, how is that different than some of these
8 other areas? Do you know, Reva?

9 DR. WINKLER: Yes. I mean we were
10 having a hard time characterizing the concept
11 that, Shannon, you bring up all the time is,
12 certain things are easy and don't require a
13 lot of interoperability, and sometimes the
14 interoperability is so challenging that make
15 it very, very difficult.

16 We didn't know how to characterize
17 that concept, but the concept was if the data
18 element typically is going to be challenging
19 because of constraints around
20 interoperability and data exchange that has
21 impacts on feasibility. I don't know what to
22 call it. This is the best we could come up.

1 We're open to any suggestion.

2 DR. SIMS: Well, I think what I was
3 alluding to was that I think in the coming
4 stages of meaningful use, not that that's the
5 only reference point for how EHRs might grow,
6 but I mean I think we'd all agree that we'd
7 all like to get to the point where we can use,
8 or we can develop and use quality measures
9 that, you know, rely on exchange of valid data
10 between institutions.

11 But that simply is not extant right
12 now. It just doesn't exist. We don't have an
13 HIE in Chicago, for example. Well, we do but
14 nobody uses it. So I think that that's got to
15 be a characteristic.

16 Now I think what I was alluding to
17 is that, and maybe this is what Paul and I
18 have been chatting about was, I think it's
19 clearly going to be a future state but I don't
20 know if it's two years or ten years, hopefully
21 not ten. But I think that's got to be a
22 realistic consideration when we think about

1 the feasibility of these data elements is,
2 what can we do right now or in the next couple
3 of years?

4 So I would say not so much
5 interoperability but data exchange, I guess,
6 is probably a better word.

7 DR. LIEBERMAN: So I would submit
8 that when we are looking at this there are,
9 data elements are definitely a key component
10 of feasibility, but it's probably not all of
11 the feasibility for measuring. It has to do
12 with, you know, you can have each individual
13 data element being available and feasible but
14 they could exist in different systems, so it
15 makes it a little more difficult or, I'm not
16 sure of workflow, but there may be additional
17 criteria beyond data elements and so we should
18 discuss that and whether that's the case.

19 But I think we could start with
20 talking about characteristics of data elements
21 both in kind of current EHRs and in some
22 future state to try to come up with a scoring

1 algorithm for that and a way of analyzing that
2 information, and then move on to additional
3 characteristics beyond data elements. And I'm
4 open to other suggestions as well.

5 DR. BUTT: So I think that the issue
6 of structured versus codified/standardized, I
7 think that, you know, things could be
8 structured but they're often not standardized
9 or codified.

10 For eMeasures, really feasibility.
11 That's the more important one, so perhaps we
12 should incorporate that. Because even in that
13 two-by-two that you showed for ONC, it only
14 talks about structured being high value for
15 quality. But if all of that structured data
16 is based on nonstandard elements then it's not
17 of as high quality.

18 DR. SIMS: Can I react to that? I'm
19 sorry. So I totally agree with what you're
20 saying. The problem is that, you know, just
21 because something has a SNOMED code attached
22 behind it doesn't mean anything, right?

1 I mean ultimately what you want to
2 do to standardize data is ensure reliability,
3 generalizability, external validity, right?
4 But if I'm doing a local mapping at my
5 institution, which is going to be invariable
6 here about what constitutes a blood pressure
7 measurement and so forth given how
8 customizable EMRs are, I'm not sure that
9 necessarily having a standardized code behind
10 it necessarily makes it more or less feasible
11 or potentially reliable down the road. That's
12 my --

13 DR. BUTT: I think the point I was
14 making is that the more structured it is the
15 more likely that it will be codified.
16 However, you know, if, and I agree, Shannon,
17 that there will be a lot of mapping, but that
18 is the point. That mapping is necessary
19 because the structured data is not codified.

20 So the mapping is to the code and
21 that's what the eMeasure looks for. It's
22 looking for the code sets or value sets,

1 however you specified them, whatever code
2 system you want to use, RxNorm, et cetera, et
3 cetera.

4 But at the end of the day it's going
5 to require that in some fashion, whether it
6 gets mapped or whether it gets structured,
7 whether it gets captured in unstructured, but
8 some mechanism to extract it with natural
9 language processing or whatever, but at the
10 end of the day the eMeasure is going to look
11 for some codified value set. So that's the
12 one thing.

13 And the other is that in terms of
14 the HITEP-I slide where there was a scoring
15 for the workflow part, how did they actually
16 get to the score for the workflow? Because
17 I'm interested in learning more about that.

18 (Off microphone comments)

19 DR. LIEBERMAN: People sitting
20 around saying, oh, I think it's about a four.

21 DR. RADFORD: I'd like to respond to
22 this issue of standardization.

1 I cannot believe I'm saying this
2 having been on multiple data standardization
3 workgroups, but I would argue to take data
4 standardization, which is standardized
5 definitions that everybody agrees to and
6 adheres to, off the table for this document.
7 Because it's really, in my view, kind of a
8 medical provider issue that we really haven't
9 dealt with optimally as a group.

10 I mean when you think about
11 different entities that have developed
12 standardized measures, I'm going to contrast
13 medicine with banking, I mean it's kind of
14 easy to codify what 1.00, meaning \$1 that's
15 pretty easy.

16 But we really, in medicine, have a
17 lot of concepts that have a vocabulary around
18 them and nobody really knows whether what
19 heart failure really is and all that so I
20 really think that that's not something that we
21 should get at here.

22 We assume that it's correct or not.

1 We acknowledge that this is an issue. We
2 acknowledge that the fact that data
3 standardization doesn't really exist can lead
4 to all kinds of interesting things to happen
5 including gaming measures, but that this is
6 really about automating measures such as they
7 are.

8 DR. BUTT: So can I ask a follow-up
9 question then? So maybe the measure
10 developers can comment on that. Can you
11 develop eMeasures that can use noncodified
12 data but structured data and make it work?

13 DR. RADFORD: No. So let me just
14 say --

15 DR. BUTT: Can we say, it depends?

16 DR. RADFORD: Yes. I mean I think
17 that let's look to the future a little bit.
18 When you talk about noncodified data you're
19 not talking about nondiscrete fields, right,
20 text fields?

21 DR. BUTT: Well, I'm saying that it
22 needs to conform to some codification system,

1 and not necessarily but it's captured only as
2 structured fields, because it'll not always be
3 captured as structured data. Because if you
4 get hung up on structured data only, we're
5 going to miss the bigger point that is that we
6 need codified data and accurate codified data
7 however it gets to us in whatever form.

8 MS. MARTINS: The one comment I
9 would make is that in order to, if you want to
10 use a measure outside of a provider, a single
11 provider, and even within a single provider if
12 you want to compare different clinicians, for
13 instance, if you want any level of
14 comparability there certainly need to be
15 standard definitions.

16 And I completely agree with you,
17 Martha, that this is bigger issue than just
18 the definitions that exist in the realm of a
19 measure and that societies need to agree on
20 what they mean by gestational age, for
21 instance.

22 And I'm bringing it again, but that

1 work needs to happen with the clinicians, and
2 the clinicians need to agree on what they're
3 calling what, completely. We can't go there
4 with eMeasures. All we can hope for is that
5 the codes that are being used to define,
6 because that's part of the problem is that in
7 paper-based measures you could actually attach
8 a definition to what your data element was or
9 is, and in eMeasures you kind of have to, you
10 move away from that.

11 And incidentally, vendors are trying
12 to reverse engineer value sets to kind of try
13 to understand what we mean. So I wonder if we
14 don't need definitions with value sets as
15 well. But that the codes are the only source
16 for the meaning that we're trying to convey.

17 And so in that sense, I think we
18 can't disassociate the representation of
19 certain concepts using standard vocabularies
20 for measure feasibility particularly.

21 And I'm not saying that they need to
22 be, in order for a measure to be feasible that

1 the vocabulary needs to be used at the point
2 of care and that it is consistently used at
3 the point of care. I think that's more of a
4 role of ongoing reliability, to be very frank,
5 because we don't have the data yet to be able
6 to assess that kind of reliability and
7 validity.

8 But for instance, in eMeasure
9 representation you may even have a situation
10 where you don't have the codes to represent
11 your concept, and this is due to the level of
12 maturity and real-world experimentation with
13 these standard vocabularies. They're not in
14 widespread use, and so they need their own
15 maturation or evolution I would say.

16 So there are issues in multiple
17 fronts. But I do agree with you that just
18 because we have a code it doesn't mean that
19 the code is used in a standardized fashion,
20 and that needs to be taken into account in
21 validity and reliability testing and ongoing
22 assessment.

1 DR. TINOCO: So I don't have a
2 definitive answer and so I kind of agree, but
3 I think it depends. So not all terminologies
4 or nomenclatures are created alike.

5 Give me a LOINC code, I understand
6 what you mean. Give me a SNOMED CT term, I
7 don't really know what the definition is. I
8 have to look up the definition in a medical
9 dictionary to say, oh, that's what that
10 diagnosis means. RxNorm also, I can navigate
11 the hierarchy and I have an understanding of
12 what it means.

13 So just to say that we should or
14 should not use standard terminologies and make
15 that a requirement, you definitely need
16 measure specifications, maybe not a
17 requirement of the EHR database itself. It's
18 just not clear to me yet because it varies by
19 subject domain.

20 And secondly, within some of our
21 measures, and we're getting better, we do have
22 to call out explicit definitions for our data

1 elements because of a couple things. Either
2 they're somewhat complex or we learn through
3 experience that when you say one thing like
4 cumulative medication duration, and Saul will
5 remember this one, it seems as if different
6 measure developers might have a different
7 understanding of what cumulative medication
8 duration is and how it should be computed by
9 an EHR system. So it's sticky.

10 DR. BREGMAN: I just want to return
11 to the question you asked that prompted this
12 discussion which I think you made the point
13 that, well, you asked whether how much, how
14 important the data elements and what else is
15 there other than data elements?

16 And I would make the case that
17 almost all the money is in the data elements.
18 When we sweat these measures out, from our
19 point of view it's always an issue of, where
20 are we going to get this data and where are we
21 going to find a structured format, is it valid
22 where we find it? What's the variability from

1 one place to another? Everything is just
2 minor compared to that.

3 So I think when we talk about
4 feasibility, you know, I love the HITEP
5 paradigm, the HITEP-I paradigm. That really
6 captures all of the issues with data elements
7 and that's most of feasibility.

8 (Off microphone comments)

9 DR. BREGMAN: Well, it was a very
10 good paradigm to start with.

11 DR. BUTT: So I just again want to
12 make sure that I'm very clear in what I said.
13 I wasn't implying that codification means to
14 select one of the existing code sets.

15 What it means is that even in all
16 those definition, if they have to lock down a
17 definition then that becomes their code
18 system. A system needs to be in place that
19 everybody can follow and the eMeasures can
20 sort of understand what the data element is.
21 And my comment was really only limited to what
22 the eMeasure consumes, not what should be

1 captured and how it should be captured in the
2 bigger EHR.

3 So from the standpoint of making it
4 unambiguous, because there's not a human being
5 for interpretation in the middle, it's got to
6 have some kind of codification system be it
7 the existing systems or some new system. But
8 that's what's going to have to be done to
9 actually make it work.

10 DR. LIEBERMAN: So now I propose
11 that we spend some more time perhaps starting
12 with HITEP-I and look at those and determine
13 if we feel those are sufficient criteria by
14 which to evaluate individual data elements.
15 And we should also think about how we would do
16 that forward-looking.

17 So we've talked a lot about how
18 would we apply these criteria to what we
19 expect the state to be in 2014, or 2016, and
20 how would we work with that in our system. So
21 comments on these? Does anybody have
22 suggestions for how we might change these and

1 whether we want to get rid of any of these or
2 whether we want to add additional criteria
3 around data elements?

4 MR. KRAVITZ: This may be beating a
5 dead horse, but the kind of availability, I
6 think it needs to be qualified somehow based
7 on some combination of the maturity of the EHR
8 and the kind of the IHE ecosystem that this
9 provider lives in.

10 So my favorite example would be
11 outpatient measures that reference previous
12 inpatient encounters that the patient had. If
13 you're in an integrated delivery network where
14 the EHRs are integrated you might see it, but
15 from my understanding most providers today
16 wouldn't have visibility to that. And if they
17 did have visibility it may be stored as a PDF
18 attachment to the patient's record as opposed
19 to something you could query against.

20 So again, some of the data elements
21 that are in the measures, you can't score them
22 in an absolute sense. You really need to

1 score them in some context. It's going to be
2 a more nuanced scoring than just yes,
3 inpatient encounters are available.

4 DR. BREGMAN: I think you're right,
5 but I would assume that that's part of the
6 evaluation of that part is considering that.
7 I mean when we are to provide this kind of
8 feedback from Epic we would have to think
9 about our entire user base, all the different
10 situations they were in, and we would have to
11 come up with an answer, a score, a composite
12 score.

13 And we would say for this, for
14 example, we would say, generally yes, because
15 most of our hospitals are integrated and they
16 have our system both in inpatient and
17 outpatient. However, in the case where they
18 didn't this would be a tougher issue and then
19 we would put that in the score.

20 MR. KRAVITZ: Sorry if I missed it,
21 but is this the questionnaire scale or is this
22 the final results scale? Because you're

1 saying if this is the questionnaire scale,
2 everybody who got the questionnaire has a
3 different perspective and some people might
4 grade that element a one if they're in a --

5 DR. BREGMAN: Well, sure.

6 MR. KRAVITZ: And some people might
7 grade it a five, and someone's got to roll
8 that up to a final score. So is this for
9 both?

10 DR. LIEBERMAN: I would say it's for
11 both in that I mean, I think, eventually we
12 want this to be a document associated with a
13 measure. So this would be, I would say we're
14 talking now about kind of a final score.

15 You could have different ways of
16 getting to that final score and part of that
17 could be surveys sent to EHR vendors or to
18 providers or something else on those measures,
19 or it could be, you know, discussion of an
20 expert panel, whatever that might be. So
21 there could be different inputs to it, but I
22 think we are talking about looking for that

1 final value.

2 (Simultaneous speaking)

3 DR. SIMS: I was going to say,
4 you'll be surprised when I have opinions. But
5 I think the first two again, to me, are more
6 value based judgments. I mean the assumption
7 for number one is that there's bad data in the
8 EMR, and if that's the case then I don't know.

9 I mean thus far in my experience
10 doing core measures and PQRS and meaningful
11 use and then internal efforts, I mean we
12 consider most data points to be fairly equal.

13 Clearly we know that if a med
14 student writes down a diagnosis and it gets
15 copied and pasted it's probably crap, or
16 potentially crap, but at a certain point, I
17 don't know, that feels like unnecessarily
18 complex.

19 And on the data standard piece, I
20 don't feel like that should be part of a
21 feasibility assessment. And the reason that
22 I say that is because actually in meaningful

1 use there were times when the value sets
2 actually excluded appropriate population.

3 So I think, I don't know, I just
4 feel like that mapping, the reason to have a
5 good data standard is obviously the measures
6 have to be calculated using that but currently
7 the way we do things is we map the data
8 standards if necessary.

9 And I think that there are bigger
10 issues about, I think, that the real value of
11 a standardized data vocabulary behind these
12 measures is that it improves comparability
13 between institutions and providers, which it
14 feels like outside the scope of this
15 committee. But I recognize a lot of really
16 thoughtful people put this together so I don't
17 want to speak out of turn.

18 DR. LIEBERMAN: Go ahead.

19 MS. MEADOWS: I was going to comment
20 to what Shannon just said. For the second
21 thing for data standards I do think that
22 that's something we should be thinking about,

1 because there are cases when we've seen things
2 introduced that don't truly have any kind of
3 standards behind them whether they're codified
4 or could be mapped or not.

5 So we do have to think about whether
6 there is a way to get some kind of codified
7 standard even if it's through mapping or other
8 capabilities. And there are some things I
9 know that we've evaluated that don't actually
10 have any kind of standard whatsoever. It
11 could be anybody's list of things they think
12 are important.

13 MS. MARTINS: And I would add on to
14 that that from a measure developer's
15 perspective, again comparability is an
16 important part of assessing whether a measure
17 is feasible or not. If we can't compare rates
18 across institutions how is the measure even
19 worth it? It may in some situations but it
20 may not.

21 The other aspect of the data
22 standards, and I do agree that we shouldn't

1 try to force data standards into EHRs, are
2 they even going to get there? How? I don't
3 know.

4 I think that from a measure
5 developer's perspective I would want at least
6 to gauge the field in terms of how the
7 national standards are being used so that we
8 can kind of start thinking about the potential
9 issues in terms of reliability and all of
10 these just different mappings that are
11 happening and how do they impact the measure
12 rates. So I agree it's important. Maybe it
13 shouldn't have such a high weight.

14 DR. OVERHAGE: In some ways though
15 this gets back to the whole reason for
16 bringing this process upstream though, is just
17 sort of fix, I mean to recognize and fix these
18 issues, right. So as a provider or, you know,
19 EHR implementer, so if there isn't a code for
20 it don't put it in the measure because, you
21 know, we've got to work back upstream and fix
22 those things, otherwise it is going to break.

1 So part of me would say, yes, this
2 ought to stay really high, because if it's not
3 then it's not very implementable and we better
4 go fix it.

5 DR. BREGMAN: I'm just going to
6 propose a sixth criteria, and then that would
7 be, I'm not sure of the right term but it
8 would be likelihood of accuracy or validity,
9 or someone can suggest a better way to
10 describe it.

11 So an example I will give you is
12 let's consider the sex of the patient. In
13 these categories you would say, comes from an
14 authoritative source. It's mappable to a
15 terminology. It fits the workflow to enter
16 the sex. It's certainly available in the
17 EHRs. It's auditable, and it's very likely to
18 be accurate, right.

19 Another example would be, when a
20 physician receives an alert that says there's
21 a drug interaction they have to consider and
22 then they have a response. In Epic you have

1 a choice of responses. One common choice
2 would be benefit outweighs risk. Another one
3 would be, not relevant to the situation.

4 And there may be other choices the
5 physician's supposed to choose, which one
6 applies to the situation? And you would say,
7 does it come from an authoritative source?
8 Yes, it's coming from the physician. Is it
9 mappable to a data standard? Yes. Does it
10 fit the workflow? Yes.

11 A drug alert after ordering a drug,
12 is it a standard part of the workflow? Is it
13 available? Certainly. Is it auditable? Yes,
14 as, you know, we can debate that one. And
15 then is it likely to be accurate?

16 Well, the answer to that is I would
17 say, no. It's very unlikely to be accurate
18 because the physician is unlikely to be
19 thoughtfully choosing the answer that really
20 applies to the situation. So that would be an
21 example of something you would mark low on,
22 likelihood of accuracy.

1 DR. LIEBERMAN: I wonder if that
2 could be included in Authoritative/Accurate
3 because it's authoritative and accurate
4 source, or maybe they are two different
5 things.

6 (Off microphone comments)

7 DR. LIEBERMAN: Yes.

8 DR. TANG: What is the accuracy of
9 the data element in EHR? I think that's the
10 question we're asking, right? The second
11 question, under description, first row --

12 DR. BREGMAN: Okay, well, I'm
13 reading that to mean the source is likely.
14 Well, I thought that was a comment on source,
15 but yes, if that applies to that then that
16 would be included in that.

17 But I think those are two separate
18 issues. One is whether it's the right source,
19 which in that case the physician was the right
20 source, but even so it's unlikely to be
21 accurate. So those kind of conflict.

22 DR. LIEBERMAN: And would

1 Authoritative Source, where would that score
2 low? I mean --

3 DR. SIMS: I agree with that. An
4 example of, you know, they're bantering around
5 the notion of gender identity and sexual
6 orientation and that's going to be collected,
7 at least at our shop, by front desk staff
8 which I want to be a fly on the wall for those
9 conversations.

10 But I mean I don't know. I think if
11 it's in the EHR it's certainly a legally
12 discoverable element, and from our perspective
13 legally at our institution we consider it to
14 be true, knowing that.

15 DR. TANG: So that's an example of
16 where that may not a score a five, that
17 example? A back office lab would be an
18 example because it's not the same thing as
19 spitting out from an automated lab instrument.
20 So that's where those are things that might,
21 would not score a five, as examples.

22 DEBBIE: Another example could be a

1 result of a diagnostic test that is in a
2 separate system that had to be then the
3 results transferred into the EHR. So every
4 time another human touches something, you
5 know, there's more chance for error so that
6 could --

7 DR. TANG: So let me give a
8 counterexample to Shannon. So if the patient
9 was entering their gender identity that would
10 be called authoritative and accurate. So I
11 mean that's how that would work.

12 DR. SIMS: I agree with all that. I
13 just think we're losing the, I mean the issue
14 that we have in a quality measurement is not
15 these fields which we could clearly have some
16 issues with accuracy. There are keystroke
17 errors. At our house that's 20 or 30 percent
18 error rate we've learned.

19 But it's more of the things like,
20 was an asthma action plan created? Was the
21 smoking cessation counseling provided? It's
22 not stuff that's already mostly structured.

1 That's the problem. And that's where I think
2 the measure developers need more feedback.

3 So those are the examples I think we
4 should be focusing on perhaps more than some
5 of the stuff that's already highly structured
6 to begin with.

7 DR. TANG: I'll respond to that too,
8 directly, like a smoking counseling checkbox.
9 I would rate that pretty darn low which is a
10 message to the measure developers saying,
11 well, why should we do that? In the first
12 place how useful is it in the scientific
13 validity and how good is the data? How
14 accurate is the data in the EHR?

15 So those are examples, actually, of
16 where this should show up and influence your
17 decision on including those.

18 DR. BURSTIN: Sorry to jump in, but
19 I'm not convinced that's feasibility as
20 opposed to validity. I don't know that you
21 can, I don't want to confuse the data versus
22 the validity of it. That's just the fact

1 that's just a nonvalid representation of
2 smoking cessation. It has nothing to do
3 whether it's a checkbox checked by a nurse, a
4 medical assistant or anybody else.

5 DR. SIMS: I agree with that. I
6 mean feasibility you're talking about a priori
7 development of measures. Reliability you're
8 talking about sticking those into the real
9 world and seeing what comes out, comparing
10 that to human chart review or to patient
11 reported outcomes or whatever.

12 I guess you're really going to have
13 to clarify what you guys want. Because
14 everything Paul said is absolutely valid and
15 I agree with, but if we're talking strictly
16 feasibility you've got to disentangle things
17 a bit.

18 DR. TANG: Well, I guess I would,
19 okay. If I really wanted to know whether
20 counseling was done then I would use the audio
21 recording. If I wanted to figure out is there
22 a better source, I'd look and say, hmm, is the

1 EHR a better source? Probably not. Go beyond
2 that, you know, go next. Is the patient,
3 asking the patient a better source? Probably
4 better than the EHR. And that's how I would
5 use this, quote, "score."

6 So I think those are some of the
7 issues we're trying to get at. There's a lot,
8 in some sense there's some anti-gaming. And
9 you want to figure the merit of, hey, should
10 I use the EHR to get this information, and
11 this is how that would flow it into.

12 You won't see it under scientific
13 validity or impact. You'll have to see, yes,
14 this is where I, probably not going to get it
15 from the EHR is, I mean that's the logical
16 conclusion, getting a low score here.

17 MS. MARTINS: I wonder how that
18 overlaps with availability in the EHR. So as
19 I look at these two criteria I think we really
20 need to clearly define. And I don't know that
21 we need to do that today, but we want to make
22 sure that they're at least mutually exclusive

1 in what we're trying to evaluate, although I
2 think that's hard but the least overlapping
3 possible. Let's just say that.

4 And that we're not evaluating the
5 same twice, so that there can be an
6 understanding from different measure
7 developers and different respondents to these
8 type of questionnaires on what the
9 understanding is of what we're trying to get
10 at.

11 DR. SIMS: I guess just in general
12 I'm a fan of simplification and this feels
13 like an awfully elaborate scale to apply to
14 potentially thousands of data elements in a
15 short course of time.

16 But I mean I think from a staff
17 perspective I think you guys have got to tell
18 us what you want. I mean everything that's
19 being said is true, there's just so much
20 opportunity to move the bar forward with good
21 as opposed to perfect. I'd love to see that
22 happen, that's all.

1 DR. WINKLER: In response I would
2 say we've got different representation from
3 the different stakeholders who are likely to
4 be customers of this kind of a framework.

5 So I'm going to ask you, what is it
6 that's going to be useful to you? How is this
7 going to, you know, influence your work as a
8 developer, as a vendor? What are the elements
9 that are going to give you the most useful
10 information that will help solve the problem
11 that we've all been discussing going forward?

12 DR. BUTT: So I think that in the
13 second section, the data standards, are we
14 sort of saying that unless it's structured
15 format that it's not going to score high?
16 That's number one. So we should probably
17 discuss that.

18 And then also, is it locking down
19 terminology specifically as the only standard
20 here? Because one could potentially be
21 getting codified data from classification
22 systems and so forth, and I'm not an expert in

1 that to say whether that falls under
2 terminology or not, but that may be another
3 thing to make sure that we're not
4 inadvertently locking down into something that
5 is very, you know, sort of narrow for codified
6 and standardized data.

7 DR. LIEBERMAN: Well, I think for
8 data standards with the QDM, I mean all the
9 data that's being used in electronic measures
10 is going to be structured. I mean the
11 measure's going to be evaluated.

12 Well, I guess it also depends on at
13 what stage we do this feasibility assessment,
14 because I would assume that if you're looking
15 at a QDM data element it's a piece of
16 structured data at that point. And the only
17 issue here is whether there's a terminology
18 standard associated with it or not.

19 If it's some type of information
20 that you're trying to get at that hasn't yet
21 been associated with a specific terminology
22 standard, would that score lower?

1 DR. BUTT: So, you know, when
2 structured is used I assume it to mean that it
3 is conforming to a certain structured form of
4 data capture, right, or is basically, for
5 example, just as a quick example, a diagnosis
6 code, let's say it's SNOMED CT.

7 Could be in a problem list which is
8 structured or could it be embedded in a note
9 that is then pulled by whatever method, would
10 that same diagnosis that's part of a note
11 electronically extracted not be valid because
12 it's not captured structure?

13 DR. OVERHAGE: No, I think I hear
14 your question. Like I said, you clearly have
15 to get to a point where you have a structured
16 coded element to execute whatever kind of
17 logic you're going to execute on it. I think
18 we all kind of agree.

19 And I think your question, I think I
20 got it, is what does it mean for that when we
21 score this, let's say that you could extract
22 the gender of the patient from the brain waves

1 of the person at the front desk and get it
2 available to do the measure, does that still
3 count? I mean that's sort of the extreme
4 example.

5 So in other words, how do you get to
6 the diagnosis that the patient has diabetes?
7 One way to get there is you require somebody
8 to enter the problem list or dictate into, or
9 I'm sorry, enter into a problem list as they
10 have diabetes.

11 But you could just as well extract
12 it from a note that they had written and turn
13 it into a structured coded element or have a
14 predictive model that takes into account the
15 patient's glycoside hemoglobins and their
16 pattern of care and their medication usage and
17 determine that they're diabetic, and that
18 should be just as valid.

19 DR. BUTT: I guess we can specify
20 exactly. Because my only concern is that in
21 general sort of usage the word "structured" is
22 interpreted in that context that it's got to

1 be captured in a certain sort of structured
2 fashion, and it kind of limits it to how it
3 has to be captured. And that's all --

4 DR. LIEBERMAN: Now potentially
5 would that then end up in the workflow part?
6 I mean if it's information that is captured
7 somewhere in an EHR system it's not coded at
8 that point. It's not in structured data
9 element and you have to get it there. That's
10 going to take a hit on the workflow part.

11 DR. BUTT: See, but I make a
12 distinction being coded and structured, right.
13 So it has to be coded. So that's what I'm
14 saying that perhaps the emphasis should be on
15 codified data. It could come from a
16 structured capture source or non-structured
17 capture source.

18 So like the example I give, that
19 structured data capture is typically, for
20 example, in a problem list. There's a certain
21 way to capture that information, right, in a
22 sort of a list fashion or in a pre-coordinated

1 fashion. But if the same data element were
2 part of a progress note or something that was
3 within the system, look, it would be codified.

4 Let's say if somebody has a, when
5 they're making a note they have mapped their
6 local term of diabetes to a code and the
7 physician, and this is actually in practice in
8 the EHRs where a note is being written and the
9 selection of that code is being made within
10 the note where there is a section of let's say
11 diagnosis. Now it ends up from there into the
12 problem list as well, but I'm just saying that
13 maybe it's splitting hair, I don't know.

14 But that's one of the things that I
15 think if it implies that it can be only
16 captured in a structured fashion that's the
17 part that a lot of physicians have the most
18 trouble with when everything is structure,
19 structure, structure, you have a checkbox or
20 selections.

21 But there are some examples where in
22 most cases -- you are correct, Helen. In most

1 cases the two are the same. That for it to be
2 codified generally it's captured in a
3 structured format.

4 But I'm just giving ourselves some
5 wiggle room in terms of the whole issue of
6 natural language processing and so forth where
7 data is extracted from notes and then some
8 algorithm converts it into a codified thing.

9 Is that going to be not possible to
10 be evaluated, that scenario, if we say that
11 that's not structured data capture, or would
12 that still be structured data capture if it's
13 converted into a structured? I guess it would
14 take unstructured data and convert it into
15 structure so maybe it would be okay.

16 DR. TANG: Correct. Because if you
17 read the, it says, is the data element coded
18 in a structured format? It doesn't say how
19 it's captured. It's just, does it exist in
20 the EHR in a structured format?

21 DR. LIEBERMAN: Aldo?

22 DR. TINOCO: So many reactions to

1 this. It's very interesting, because in my
2 mind, in response to the prompt I'm trying to
3 use this tool to assess a measure in my mind
4 that we're working on right now.

5 First of all, I think it's very
6 difficult unless we know how to assess data
7 quality over the content of an EHR system as
8 a measure developer. We know that that is an
9 issue onto itself that affects feasibility but
10 that's way over here. That's data provenance.

11 Assessing the accuracy of the
12 problem list content, we know the reality of
13 what's in the problem list, but we still refer
14 to the problem list in some of our
15 specifications, or at least diagnoses. So I'm
16 a little wary of asking in the measure
17 development process to assess data quality.

18 I'm not saying we shouldn't do it,
19 but I think it could really distract us from
20 identifying feasible data elements and then
21 moving on to some of the harder work to say
22 reliability and validity testing. Granted,

1 data quality issues will make their ugly heads
2 known during reliability and validity testing,
3 so there is this interplay we have to figure
4 out. I just don't know if it's here.

5 And Shannon said, let's make it
6 simpler. I agree. Scale of one to five,
7 maybe. Scale of one to three, ah, now I know
8 what we're talking about, you know, a little
9 simpler. That's going to be helpful.

10 To be concrete for the data
11 standards item, if something is available and
12 coded using a nationally identified
13 standardized terminology I'll give it a three.
14 That's what I want in a structured field.

15 If it's structured but it doesn't
16 use a LOINC or a SNOMED or an RxNorm but it's
17 consistent, okay, that's a two. If it's in
18 free text only that's a one. So that's how I
19 would try and operationalize this tool as a
20 measure developer making these decisions. And
21 let me stop there, because I could go on.

22 DR. TANG: I was going to answer

1 Reva's question, but I'd love to hear the
2 developers, whether this works.

3 So if you sat at your committee or
4 this measure authoring tool and you were
5 looking for a data element to fit in your
6 definition and up popped this score, and you
7 know that whether it's three or five, you
8 know, whether it's 100 or 30 that this was a
9 very high score, and you knew if I picked this
10 to put in my definition the data in the EHR
11 came from an authoritative source, it was very
12 highly accurate because it got threes in your
13 scoring, that it was coded in a nationally
14 standardized format, that it generally fits
15 the workflow of the provider so the burden was
16 low, available today, which means you can use
17 it today versus 2016, and you could audit it
18 when you come in, would that be a use to you?

19 DR. TINOCO: Yes. It's a very
20 important piece of the puzzle.

21 DR. TANG: I'm trying to answer
22 Reva's question.

1 MS. MARTINS: That's nirvana. When
2 we actually go out there and all of our data
3 elements fit what you've just said, then our
4 measure is completely feasible. It's easy.
5 It's doable. It's perfect. It won't upset
6 anyone downstream.

7 DR. BREGMAN: Well, that's great.
8 But then Shannon said it was too complex, and
9 then, Aldo, you made a reference that we
10 should leave the accuracy of the validity
11 testing at the end. Are you suggesting we
12 take that out?

13 And Shannon, what would you take out
14 if you wanted to simplify it?

15 DR. TINOCO: So if the information
16 is available at accuracy or if we make an
17 assumption about accuracy, I'll take it.

18 DR. BREGMAN: If we know, you know,
19 that example I gave about the drug alert, we
20 just know from experience that it's not going
21 to be reliable information, I wouldn't want to
22 not tell you that if knew it.

1 Now you could still want it to go
2 through validity testing to confirm that but
3 I certainly would want to let you know if we
4 had concerns about its accuracy from the
5 start.

6 DR. TANG: I can tell you an EHR's
7 drug alert would not score anywhere close to
8 a five or three.

9 DR. BUTT: So did the HITEP have the
10 type of definitions for the scoring as Aldo
11 was implying or suggesting? Because I think
12 that may be a very important part of this to
13 define what a one is and what a two is and
14 what a three is for each one of these
15 components.

16 DR. TANG: One to five was easier to
17 get people to score. I don't think there's
18 anything wrong with thinking about the three
19 because that could also work.

20 DR. BURSTIN: Except we didn't
21 define what a one, two, three, four or five
22 meant, I think is what he's saying. Instead,

1 attach definitions to what a one is, a two is
2 and a three is. I like threes better --

3 DR. TANG: It was easy for him to
4 use in that example of standard. Try one of
5 these others but it won't be as easy. But yet
6 there was fairly good agreement in terms of in
7 people's minds. You sort of looked across the
8 room and you could tell, because actually the
9 consensus process was very quick, which is a
10 signal to say people understood what the
11 difference between a five and three were. But
12 that was a good definition for --

13 DR. LIEBERMAN: I'll just make one
14 comment. If we're looking at trying to
15 develop a score for a data element I think
16 that we, just from the previous discussions
17 here, workflow fit should be much more heavily
18 weighted.

19 It sounds like that's what people
20 are really interested in knowing and that's
21 where a lot of the cost of the element comes
22 from. So right now, you know, it scores a

1 little bit. We kind of get lost. A low score
2 in workflow should be very apparent.

3 DR. SIMS: So Howard, if I can,
4 sorry. I guess from my perspective, and I
5 know I'm a reductionist but I mean to me, data
6 standards, workflow fit and availability are
7 all kind of, they're related things.

8 I mean I think availability within
9 the EHR is heavily contingent on if it's part
10 of the workflow or not already. And when we
11 say availability, what we really mean is
12 structured data availability. So those would
13 be the kinds of things that I might
14 consolidate down. I mean if it's available in
15 a free text, no. Not very many of us have
16 natural language understanding and processing
17 ability to translate that.

18 So I think for me at least we
19 probably need to focus on things that are
20 captured structurally, although certainly they
21 would count if that's the way they had handled
22 it.

1 So I like accuracy, I think that
2 needs to be retained. But I think you could
3 get down to, personally, I would think three,
4 and they would be workflow fit, structured
5 availability and accuracy.

6 DR. LIEBERMAN: Sounds like
7 Shannon's making a motion to remove auditable.

8 DR. SIMS: How can we have a
9 structured data element that's not auditable?
10 I don't understand. Is there an example that
11 comes to mind?

12 DR. TANG: There's replacing.
13 Instead of tracking adversion there's non-
14 version, so you have no idea what they saw at
15 the time. That's a killer from a --

16 MS. MARTINS: Gestational age. You
17 documented once, it keeps getting replaced and
18 added. Who knows when it'll stop and how do
19 you know at the point in time where you needed
20 to know what the gestational age was, whether
21 a specific course of treatment was appropriate
22 or not? You lose that.

1 DR. TANG: And just a note on the
2 fourth one, availability in EHRs. That was the
3 proxy for whether it could be done today. So
4 that was a different, that's an orthogonal, it
5 was put in there because it was to assess
6 today's work.

7 So in what we discussed today we
8 could have categories. In fact, I still like
9 the stages because it'd just give you sense of
10 when it could be ready. But that's what
11 that's for and so that could be a different
12 dimension to this.

13 DR. BREGMAN: I liked Shannon's
14 suggestion about getting rid of or combining
15 availability and workflow, or getting rid of
16 availability. And, you know, Rute's point
17 about auditability is accurate. And, you
18 know, certainly we're going to keep data
19 standards and we're going to keep accuracy
20 measure whether it, you know, accuracy is
21 really, I guess, part and parcel of accurate
22 source, so really the first one is about

1 accuracy.

2 MS. MARTINS: And I would say that
3 availability is actually partially
4 authoritative source and partially workflow
5 fit. And so it's kind of assessing the two
6 pieces at the same time.

7 DR. TANG: Well, try to dismiss
8 availability because that was basically a
9 timing. So pretend that wasn't there.

10 MS. MARTINS: Well, if availability
11 wasn't there I would still think that workflow
12 fit and authoritative source would still cover
13 what we're trying to do against, and again I
14 think that's important, against what are we
15 scoring this? Is it the average EHR? Is it
16 the certified EHR? Is it, what is it that
17 we're scoring against?

18 DR. TINOCO: Just one more comment.
19 What's helpful is, what's the process by which
20 I actually determine if the answer in the EHR
21 from an authoritative data source is a true
22 state or non-true state? How do I do these

1 things? How do I ask someone else like a
2 vendor or a provider to answer these
3 questions? So as I'm trying to figure out,
4 well, how would I do it? And it's not that
5 clear.

6 DR. LIEBERMAN: Well, I mean I think
7 that's a good question. So the last time that
8 we did it is as a consensus process with an
9 expert panel. Now how it's going to be done
10 in the future, I think, is something that we
11 can make recommendations about.

12 DR. BUTT: So I think along those
13 same lines, I think that certainly the data
14 standards part of it is probably the easiest
15 one for expert panels to determine.

16 But I think that with the workflow
17 or availability, that's where you really need
18 a larger sample size, much larger sample size
19 whether it's done through the vendor or
20 directly. Because for it to be valid it can't
21 be an expert panel, I think.

22 And then I think the only other

1 issue is that if there's no weighting assigned
2 to availability then how do we sort of
3 determine the whole discussion we had whether
4 something is available today, whether
5 something will be available in 2014, whether
6 something will be available as an aspirational
7 goal in 2016 and beyond? How would we
8 incorporate that into the scoring?

9 DR. BREGMAN: The answer to that is
10 you create a feasibility score for now and you
11 create a feasibility score for later.

12 (Off microphone comments)

13 DR. BUTT: So it would score high if
14 it's available today and it would score low if
15 it was available in the future? Is that kind
16 of what you're saying?

17 DR. LIEBERMAN: Availability today
18 and availability at, you know, some
19 predetermined two years out, three years out,
20 whatever that might be. So a measure
21 developer may be very interested, may be
22 thinking three years in advance. They don't

1 really care if it's available today.

2 (Simultaneous speaking)

3 DR. BUTT: So you would have a score
4 for today and then another score for future.

5 DR. BURSTIN: Wouldn't workflow
6 potentially change as well? I mean workflow's
7 not statically helping EHRs. Isn't that, I
8 mean it just seems odd to make it only
9 availability that's time-dependent.

10 DR. LIEBERMAN: Yes, I think you're
11 right. It could be data, the whole score
12 probably, yes.

13 DR. BREGMAN: It would be the whole
14 score for now and a whole score, and it's all
15 an educated guess. You would say, yes, we
16 think that it's this much more feasible if we
17 had a three-year timeline.

18 DR. LI: So I wonder, during the
19 actual scoring is there ever a scenario that
20 the data is, the availability in EHR the
21 answer is no, then if the answer is no, how to
22 score the rest of four criterias?

1 DR. BREGMAN: I can answer that. I
2 think the essential answer is, everything is
3 potentially available in an EHR, anything. I
4 could write anything and I could codify it and
5 it could be awkward but it could be anything.

6 So, you know, anything is
7 potentially available, so therefore it's just
8 a matter of how difficult a workflow is it.
9 Is it in anybody's workflow? Could you kludge
10 it into somebody's workflow and get it and
11 that would basically come out in the workflow
12 score?

13 So there really isn't anything
14 that's not available in the EHR. You could
15 put the weather in the EHR. All you have to
16 do is find somebody to do it and a field to
17 put it in.

18 DR. LIEBERMAN: Well, you should be
19 able to get an interface at least to do the
20 current weather.

21 DR. BREGMAN: No, you just need a
22 window.

1 DR. BURSTIN: A great definition
2 says, when a device or situation is of great
3 complexity and either cannot be explained
4 easily or leaves the respondent dumbfounded or
5 perplexed --

6 MS. MARTINS: I guess I'm struggling
7 with the availability in EHRs being a criteria
8 that you would, and again we've talked about
9 different scores. So then what I wonder is,
10 if availability in EHRs is not a criteria at
11 the level of which the other criteria are and
12 simply the staged approach, so all the other
13 criteria are assessed against a certain EHR
14 stage and then there's going to be another
15 overall score for all of these other criteria
16 for another stage. So it's another dimension
17 of evaluation rather than a criteria in
18 itself, correct?

19 DR. BURSTIN: JD's question was more
20 so, how can you rate any other criteria if
21 it's not there, if it's zero? Workflow, it
22 doesn't make sense. It's not there. But I

1 think that goes back to Howard's point. It's
2 never going to be rated as zero, presumably
3 it's a one, two or three. So it's gradations
4 of it, I guess.

5 DR. BUTT: But that's where that
6 gated concept might come in that you first go
7 through the first gate. If you can't get
8 through that until 2016, well, I guess you
9 still do it and say that this is a score for
10 that time period, yes.

11 DR. LIEBERMAN: So it seems to me
12 though the data availability in EHRs still
13 probably needs a score in that even, you know,
14 couldn't you look at something that's not
15 available today or that scores low today and
16 you think is going to score better in two
17 years but it still may not score a three, I
18 mean you still need some differentiation about
19 how available it will be at the next stage.

20 And that could be another kind of
21 expert opinion type of thing where your system
22 will not allow it to be captured but you don't

1 really feel like it's going to be that
2 accessible at that point.

3 MS. MEADOWS: Well, and that's a
4 good point, but I think that brings us back to
5 the whole cost versus benefit discussion too.
6 And I don't really see that as a score here.
7 So as Howard said, anything can be built. We
8 said that earlier. Anything can be built in
9 any EHR, but at what cost versus the value of
10 that?

11 DR. LIEBERMAN: But I think workflow
12 is cost at this point. I mean I would equate
13 those two, cost with workflow, really, at this
14 point.

15 DR. BREGMAN: Well, accuracy also
16 feeds into cost. I could have a great
17 workflow. It's very easy to do. It's very
18 unlikely to be accurate and it's costly to get
19 the right data. So it's not just, not quite
20 workflow.

21 You know, my point about the weather
22 was when you talk about feasibility and now

1 feasibility in the future, if I were to grade
2 weather in this scale I would say low
3 feasibility today and unlikely we're going to
4 build a weather module in the next three
5 years, and so low feasibility in three years
6 from now.

7 And if it was another more
8 clinically relevant example then I would say,
9 yes, I could imagine that we probably are
10 going to have some tool like this in three
11 years and then that would have an increasing
12 feasibility in the future.

13 MS. MARTINS: And also what's the
14 difference between availability in EHR and is
15 there an entry? If the data isn't there it's
16 not going to be available and there's not
17 going to be an entry. So again part of the
18 availability is captured by the source and
19 part of it is captured by the workflow.

20 And what I'm struggling with, and
21 I'm sorry, it will be the very last time I say
22 this, but is that availability in EHR seems to

1 me the set of EHR functionalities where
2 answering this question are against.

3 So is the entry in the EHR from an
4 authoritative data source against what, what
5 EHR, what, right? And then the combination of
6 all of those responses was all of those EHR
7 installations would yield the score, the
8 overall feasibility score which I would think
9 is the availability in EHRs.

10 So maybe I'm confusing myself here,
11 but it doesn't make sense to me as a criteria
12 in tandem with all the others.

13 DR. LIEBERMAN: You know, I think
14 that availability in the EHRs to me is if you
15 kind of strike out the currently, but do you
16 expect the data to be available? So it's
17 subjective. It's subjective.

18 It's kind of looking at it and
19 saying, yes, providers -- well, I don't know
20 if this is a good example -- but you can
21 document a foot exam in structured data but
22 nobody's really doing it because it's hard,

1 but maybe we think that it will be, so I would
2 say available in the EHR, not really, workflow
3 would be high.

4 But down the road, three years down
5 the road if we have, for whatever reason,
6 either a new workflow or better reason to do
7 that maybe we can expect for some reason to
8 have it more readily available so we could
9 give it a higher score then. And that's not
10 a great example but that's how I would think
11 about it.

12 And it probably is, an expert
13 opinion is, or perhaps it could be the
14 currently available. You could look at EHR
15 data and say, yes, it's actually available in
16 most EHRs. It's being recorded as opposed to
17 just can it be.

18 DR. TINOCO: Two comments. So I
19 like that. I mean I think what we do need is
20 a slideshow or benchmarks. So an idealized
21 simulation environment that we can all come up
22 with, for example, a perfect state system.

1 How does a given data element compare to that
2 perfect state system? How does it compare to
3 a system that's built on the rules put forth
4 by the meaningful use certification
5 objectives? That's another benchmark.

6 And another one would be, what does
7 the EHR vendor say based on its user base?
8 Another scale would be, what's the perfect
9 health care organization that actually has
10 been doing this for the past five years in
11 their own QA program?

12 So the way to interpret these
13 different results is by comparing them to
14 different settings or different examples, and
15 that gives us an idea of, well, when we say
16 feasible, this is feasible. Well, what's the
17 context of that assessment of feasibility?

18 The second one, availability, I mean I'm not
19 sure if it's a criteria in and of itself for
20 me, but I would have a time one versus time
21 two. And then I'd have to ask people, well,
22 what's the level of effort? What's the cost?

1 And I would operationalize that on a
2 tool, a grid like this by getting, it's not a
3 row in my mind, it's a column. Current state,
4 future state, and then another column, how can
5 you get me there and is it worth getting me
6 there? And that's how I would plaster it onto
7 this grid.

8 DR. BUTT: So the authoritative
9 source obviously would depend upon the data
10 element or the type of data element. So would
11 you have to then, in order to operationalize
12 this, define for each data element what the
13 authoritative source or sources would be
14 before you can assign a score?

15 DR. SIMS: I don't think so. I'll
16 say no.

17 DR. BREGMAN: I think the proposal
18 was to roll authoritative source into accuracy
19 and we just call it accuracy. It includes
20 that as a consideration. But that's the term
21 we use.

22 DR. BUTT: How would you define that

1 then? For example, in that blood pressure
2 example would an authoritative source have to
3 be a doctor, a nurse, MA? Who would be the
4 authoritative source?

5 DR. SIMS: I think that's a judgment
6 call. I mean again I think we're focusing on,
7 to me what we're trying to avoid is instances
8 where in meaningful use stage when we had a
9 quality measure where we had to assess whether
10 a patient was sexually active or not. That's
11 a bear of a thing that nobody actually
12 collects at least at our house.

13 Whether or not the blood pressure is
14 accurate or not is a good problem to have
15 because at least you have the data to chew on.
16 Things like, when I'm thinking about
17 feasibility, I mean I'm trying to keep the end
18 game in mind here, and when we wanted to do
19 the composite measure about smoking assessment
20 and cessation, it was easy to do smoking
21 assessment because it's already captured in
22 social history.

1 But we had to create a kludge where
2 we put in some pull-down menu in our template
3 that most everybody in our house uses, but we
4 don't actually use it because despite
5 battering on them for weeks and weeks and
6 weeks on how to do it, nobody does it because
7 it doesn't fit into their workflow.

8 So I think that, you know, focusing
9 on the kinds of issues that, like keeping that
10 in mind, the accuracy of the blood pressure,
11 yes, probably, you know, humans are rounding
12 up. If you get data interfaced in it's
13 actually going to not be 140, it's going to be
14 138 or whatever. That's good problems to have
15 in that you look at the reliability of it.

16 A lot of this stuff we don't even
17 have that option for, and I think that's the
18 stuff we're trying to prevent and so we should
19 more focus on that kind of stuff, I think, the
20 accuracy of blood pressure and gender.

21 DR. BUTT: So actually I think it's
22 not as much the accuracy of the data itself,

1 which is more in the reliability side, but it
2 is more of the source of the data, right, that
3 is implied in that first authoritative source.

4 So the question is that if it's not
5 going to be defined and it's sort of this
6 elusive thing, and most of them are, and I
7 think this was addressed earlier that how is
8 it going to then discriminate between a five
9 and a one or a three and a one? Because if
10 most of these are going to be, well, kind of,
11 sort of, yes, whoever does it is okay, then
12 why have it?

13 DR. LIEBERMAN: Well, I think that
14 brings up a good question that Reva's going to
15 ask me to ask which is, who's going to do
16 this? So, you know, and that has a lot to go
17 with, you know, how we define it.

18 Are we expecting this to be expert
19 panel? Are we expecting it to be measure
20 developers? Are we expecting it to be the NQF
21 just in general?

22 DR. RADFORD: The providers are

1 going to do it. And I think that that's
2 something that really isn't acknowledged that
3 much. That since quality data is getting
4 collected on us, we actually have a very
5 vested interest in knowing what all of these
6 concepts are.

7 And there's a lot of measure level,
8 element level testing going on at the provider
9 level that we know nothing about at the
10 national level. And I've thought for a long
11 time that we should have some sort of
12 clearinghouse about these issues because the
13 providers, believe me, are checking.

14 Now you have to take the provider
15 information with a grain of salt because, you
16 know, they want themselves to look good. And
17 you have to sort these things out as to
18 whether this is a real measurement issue or
19 whether it's, you know, something else. But
20 we don't do that.

21 DEBBIE: I think we're going to have
22 a host of folks using this, to answer your

1 question, Michael. Besides the developers,
2 you're also going to have the TEPs because
3 we're going to be using this for de novo
4 measure development and we're going to assess
5 feasibility of what we're trying to create,
6 can we capture this? So you're going to have
7 the TEPs.

8 You're going to have the
9 organizations that may take quality measures
10 and massage them and call them something a
11 little bit different for their own
12 organizations. You're going to have other
13 people that create, so measure stewards,
14 they're going to be looking at this.

15 And so I think what, I have a number
16 of different thoughts that I won't talk about
17 now, but one thing that I think is important,
18 whatever scale we propose is that you provide
19 clear definitions for the terminology, because
20 every time somebody says something they bring
21 a little different twist to it. And so
22 authoritative and accurate source, you know,

1 brings a whole lot of different connotations.
2 So that's something I think that's important
3 that we need to include, whatever we finally
4 decide on.

5 MS. MAJOR: I don't mean to take the
6 conversation in a different direction so I
7 hope this question doesn't. It's just kind of
8 an honest question, because I'm kind of trying
9 to think this through down to what the end
10 result is.

11 And what I'm sort of picturing is
12 we've got this big old database that says,
13 here are all the data elements that we care
14 about and here are their scores on our three
15 main criteria and our weights for each of
16 those criteria.

17 And then as, you know, we develop a
18 measure or think about measures at a technical
19 expert panel level we kind of go in and take
20 a look at this database and say, here's kind
21 of what would be feasible and then kind of
22 build measures based on that.

1 And then do we kind of take that
2 result of, we've built a measure based off of
3 our understanding of feasibility based on the
4 scores and the weights, and then we say it's
5 feasible, and that's it? Or is there another
6 step that's going to go along with this?

7 And then we have to maintain that
8 database, right, over time? Is that kind of
9 how people are picturing this happening or am
10 I missing a piece? Okay, I just want to make
11 sure I was --

12 MS. CHRISTENSEN: So if I can just
13 remind everybody, we listed a lot of
14 stakeholders and I think all of those people
15 play a part. If we let all the stakeholders
16 play by themselves we'll get lots of different
17 answers for the same thing which is not a
18 desired outcome.

19 And then the other thing is that
20 this stuff makes sense to everybody in this
21 room, but from our work having actual provider
22 organizations assess feasibility of real

1 measures most of them are not able to do this
2 work, even folks that, you know, have had an
3 EHR for a long time. This is very confusing
4 for them and they don't necessarily all have
5 the expertise that's necessary to do it.
6 Folks like Shannon who have done it are a
7 little bit different because they're well
8 versed in the clinical aspect, in the IT
9 aspect, in the national policy aspect, but
10 that is not the case at most organizations
11 that you've got folks that are able to play in
12 all those fields. So I just think we might
13 need to think very carefully about who's
14 qualified to make the assessment.

15 MR. JENTZSCH: I think we did one of
16 those assessments before. But if I was going
17 to say how we would implement this as a
18 consumer, I would hope that we'd get some kind
19 of score from the developer, some kind of an
20 overall score by data element.

21 I would also like to be able to see
22 our vendor have their score based on that as

1 well. So it's not just who developed it but
2 the actual vendor that we work with. We would
3 probably take the same thing internally and
4 have somebody internally go through and do
5 their own scoring based on what they know, and
6 it would be a useful tool if we could get all
7 three of those things going.

8 We probably would not be as
9 interested how well other people are
10 implementing it because they don't implement
11 their product the same way we implement our
12 product, right, they don't have the same
13 workflows. So it's probably not as useful for
14 us.

15 DR. TANG: So I was going to try to
16 answer your question and Catherine's. I think
17 it was imagined, not that the individual
18 measure developers would calculate this but
19 you would get to score in this imaginary
20 system, that nirvana, and it just was 80 or
21 100 or 50, and you would know, in fact, that's
22 how those were scored in the original QDM.

1 And so that's all you would use, and
2 then if you had 100, it would say those things
3 that I said to Rute and she said would be
4 nirvana.

5 Your question as far as who would do
6 that, I mean I'm just trying to imagine one
7 possibility is AMIA. It's sort of a clinician
8 informaticist that would know how to score
9 these things, and so potentially it's, well,
10 NQF has to first get the money and then
11 contract with like an AMIA or some group that
12 goes and does this. It's sort of an expert
13 panel, it's consensus development process for
14 these scores.

15 But hopefully the end user, the
16 developers would not have to get into the
17 nitty-gritty and just would use this overall
18 score to say, hey, of these things to choose
19 from, hmm, this one looks better, and go with
20 that.

21 And then it would be NQF in this
22 case would be the maintainer, would make sure

1 that each new, and then clearly, new data
2 elements you come up with would be submitted,
3 get scored, and then it goes back out in the
4 QDM and you'd have access to it in the, for
5 example, the MAT.

6 DR. LI: I'm not sure my comment is
7 directly relative to the L-score criteria, but
8 in my mind I think these common data types are
9 wrong for a long time. We just, you know,
10 take another look from a quality scoring
11 perspective. And also most of the common data
12 types may already very well specify that by
13 other, amino one, amino two, specifications.

14 So I think we need to find that they
15 also leverage the precedent results. So for
16 example, the CDA. There's a lot of data
17 already exchanged in the CD format. We know
18 these data are structured data with standard
19 terminology. So for this data, I'm not sure
20 we need to reevaluate or reassess the quality
21 scores. Just a thought. It's more like a
22 cross-checking the other standards.

1 MS. MARTINS: So two comments. One
2 of them is, so it seems that we are talking
3 about not only about a framework to assess
4 feasibility but that all developers would work
5 on the same set of data to assess feasibility,
6 the same sample of data elements, the same
7 sample of providers and vendors, and that
8 strikes me as extremely biased.

9 Because if we have a single source
10 for all the measure developers as opposed to
11 conducting a feasibility assessment that
12 actually focuses on the providers on which the
13 measure is focused and has a potentially
14 different market coverage, we could definitely
15 get to different feasibility assessment
16 results and they may be better or worse than
17 the central database. And I'm not saying that
18 the central database shouldn't exist, but is
19 it the end-all of feasibility assessment?

20 And then to JD's point, and forgive
21 me because I know not what I speak of, but I'm
22 under the impression that CDA only requires

1 narrative descriptions of the data elements
2 that are being exchanged, and that just
3 because you're exchanging a CDA document it
4 doesn't mean that that information is
5 structured and coded.

6 DR. LI: The CDA is coded, so it
7 contains both narrative and coded data entry.

8 MS. MARTINS: But it has to contain
9 also a coded, or can you exchange a CDA with
10 just the narrative?

11 DR. LI: No. No, according to the
12 MU specification you must exchange both, the
13 narrative plus coded data.

14 DR. BURSTIN: It just seems to me
15 we're talking about two different things. No
16 one is saying this replaces the feasibility
17 testing you would do in the course of normal
18 measure development. That I think would still
19 happen. I think what we want to have is at
20 least some centralized way to at least say of
21 these data elements, can we pull in all the
22 right information from the different

1 stakeholders to say to inform your process.

2 Don't even go down the, like don't
3 even bother testing a measure that's got a 20
4 on this because it's just a recipe for
5 failure. Go back to your committee in the
6 way, at least we've heard, you know, Yale does
7 it, and say, you know, this is so unlikely to
8 feasible, do you really need this data element
9 or could we live without it? So making it
10 more of an iterative process.

11 I see it as sort of a way to feed in
12 information to the development process. But
13 you're still going to test your measure. No
14 one else is going to test your measure for
15 you. But I think we at least need some
16 centralized source of where we think the state
17 of the art is.

18 MS. MARTINS: But how is that
19 different from feasibility testing? I
20 understand that's different from pilot testing
21 the measures and doing validity and
22 reliability testing, but can you get to a

1 point where a developer will just rely on this
2 database and say, you know what, anything
3 that's outside of here is out of scope and
4 that's a developer decision whether, you know,
5 how do you want to dwell in less feasible
6 measures or not.

7 But I think the process of
8 collaborating directly with vendors and
9 providers cannot be understated, and maybe
10 that's in addition. And again I'm not arguing
11 against this, I'm just saying that it may not
12 be it for feasibility.

13 DR. LIEBERMAN: I think one of the
14 key parts about this would be that just if you
15 see a score of 40 it doesn't necessarily need
16 to be a showstopper. You should look at that,
17 right, and then think about it, and say, well,
18 is this something that we need to address
19 through Meaningful Use Stage 4, or is this
20 something, you know, that maybe I take
21 exception with the --

22 (Off microphone comments)

1 DR. LIEBERMAN: -- exactly, you
2 know, whatever's down the road is what I was
3 trying to say. Don't want to scare anybody.

4 But you can also, I don't know, we
5 can have some sort of method of reevaluating
6 something, because it could be that it's
7 scored once and then we're finding that
8 actually it's not correct.

9 So again I think that we shouldn't
10 focus so much on a specific score but look at
11 this again as a way of identifying issues with
12 a measure and bringing up at that exact
13 discussion you were talking about between
14 people.

15 And I guess one other thing that you
16 mentioned which I think is useful. So we
17 talked about data elements being kind of the
18 key component, but you keep coming back to
19 context. And so it could be that for a
20 specific measure all the data elements look
21 pretty good but only in a certain context. So
22 you would want to identify that and have this

1 in that current document.

2 You made a point where with the
3 sexual activity, are you sexually active.
4 You say that's not a reliable field in yours,
5 but in an OB-GYN office it's probably very
6 reliable. So it could be that, you know, and
7 you could put that sort of comment in this
8 analysis so, you know, it's not a good measure
9 for primary care but it might be a very good
10 measure for somewhere else where you might
11 have different, you know, this is the data
12 field that's causing it to score low but we
13 think that, whatever.

14 MS. MEADOWS: I was going to comment
15 to the same thing that you were talking about
16 that Rute brought up. I think this data
17 element kind of repository of feasibility of
18 data elements is a place to start, but I think
19 you really need to understand per measure the
20 overall measure intent before you can really,
21 truly evaluate the complete feasibility of
22 that measure.

1 And I was talking earlier to JD
2 about a conversation last week along those
3 same lines as far as the data element catalog
4 that we received for Meaningful Use Stage 2.
5 Very helpful. We've all been heads-down as
6 vendors making sure that we could collect
7 those data elements.

8 But once we got the measure
9 specifications and understood some of the
10 measure intent and the logic behind it we
11 realized that it was only part of the whole
12 picture, and there were a couple of measures
13 that were very problematic.

14 For example, I was using the example
15 of exclusive breast feeding. That always
16 comes up. Because sure, we looked at the data
17 elements, said, oh yes, we collect whether the
18 mom's are breast feeding. But when you looked
19 at how you had to collect it and what was
20 expected, the granularity of the data, right,
21 nobody does that in a newborn nursery. It's
22 just not collected today.

1 MR. JENTZSCH: You can go back to
2 what I was saying before. If this is not done
3 on a per measure basis it would be really of
4 no value to us. It has to be on a per measure
5 basis, not just globally this data element,
6 for the exact same reason everybody's saying.
7 It would be absolutely no value to us if it's
8 not on a per measure basis.

9 I mean it would be good to say in
10 general this particular data element would
11 have this score, that's okay if we're looking
12 at it. But we're not measure developers. We
13 don't think in those terms. We have to
14 actually implement the measure and execute on
15 it. If you were to create a measure for us
16 and we don't have that, it would be of no
17 value to us.

18 MS. MARTINS: And that's why I'm
19 struggling with the concept of a central
20 database as, you know, it may be a good
21 starting point but it may be of very, very
22 little value depending on the measure that

1 you're evaluating.

2 DR. SIMS: Doesn't that get to the
3 audience? I mean, you know, if you've already
4 built a measure and you're looking for a
5 scoring methodology about how feasible it is,
6 I mean at that point you've already probably
7 wasted what, 12, 18, 24 months convening an
8 expert panel.

9 I mean I think we do need a roll up,
10 but I think you should be thinking about,
11 measure developers I would suggest should be
12 thinking about this as they're developing
13 measures and thinking about, okay, here's the
14 evidence available to us. Here are the
15 guidelines. Here's what our experts feel is
16 important and here's the gap, the opportunity
17 to improve care, can we do it?

18 I mean if you're not doing it during
19 that expert panel process then I don't think
20 that this work is that great, honestly. I
21 mean I think that's the opportunity and that's
22 where it should be injected in the process.

1 Am I wrong? I don't know.

2 DEBBIE: We definitely, I think I
3 mentioned if we do incorporate this
4 feasibility in the development process,
5 absolutely, before we've completely defined
6 the numerator when we're just talking about
7 the concept, is it a concept that should be
8 developed into a measure? And we have all
9 that discussion, but then we look at exactly
10 what we want to capture at a high level and do
11 this discussion.

12 So again I think the importance of
13 classifying the feasibility testing on the de
14 novo measures versus retooled measures.

15 DR. SIMS: And there might be some
16 value in creating, I mean I think you do need
17 to roll it up but there would be value in
18 evaluating existing measures, so CMS and other
19 providers can think about, or payors and
20 providers could think about whether it makes
21 sense to incorporate.

22 But I think the real value will be

1 moving forward and creating measures that take
2 better advantage of the EMR. Because the
3 existing measures are mostly developed in the
4 claims world so we know that they're not going
5 to score very well on a feasibility scale.

6 DR. OVERHAGE: I'm sitting here
7 struggling. I guess maybe I'm getting too far
8 in the weeds, but I'm just trying to think
9 about the, I understand that there situations
10 in which there may be measure-specific issues
11 for developers, but I'm also struggling with
12 the scale and scope of the work that a measure
13 developer would have to undertake to do that.

14 I'm just trying to imagine going out
15 and saying, well, gee, we're thinking about
16 these 120 data elements and we've got to go
17 out and somehow assess the feasibility/cost of
18 gathering these. How could you even do that?

19 So I guess I keep coming back, and
20 not to say it's the be-all and end-all but it
21 seems like the collective effort somehow has
22 got to go into this because it's going to be

1 very hard.

2 MS. MARTINS: And I think it
3 includes this framework. I'm not sure if it's
4 readily available information. It doesn't
5 mean that we can't crowdsource it for a
6 specific, but for the specific questions that
7 we ask may not have a readily available
8 answer. That may need to be provided in the
9 context in which they're being asked.

10 And taking the example of a paper
11 based world, we typically go, I think, to five
12 sites to do what we call alpha testing
13 actually, which is equivalent, I guess, to
14 feasibility testing. And we try to get the
15 gamut of providers that are going, so it's
16 kind of, it's a guesstimate. It's not
17 validity and reliability.

18 DR. OVERHAGE: Sure, and I guess
19 that's where I'm going. And so if you want to
20 assess, and probably I guess I'm getting
21 tangled up in the every provider implements,
22 every EMR, you know, I mean it's probably to

1 your point, uniquely, going to five isn't
2 going to help. I mean it's going to be very
3 hard to get a reasonable sample. You're
4 probably talking about 40 or 50, especially in
5 the ambulatory setting, maybe hundreds to
6 begin to get a handle that means anything.

7 MS. MARTINS: I agree with you and I
8 struggle with, and this is something that I
9 actually brought up earlier. I don't know if
10 you were here yet or not, is what we're
11 bringing up to feasibility given the impact
12 that after you do feasibility you put specs
13 out there and you want to test them, and so
14 you're kind of at the point where vendors are
15 going to be incorporating these data elements
16 in their EHRs and there better be a good
17 reason for it.

18 So I agree with you that feasibility
19 is probably going to be more expensive and
20 more burdensome. And I do think that there
21 needs to be a stop in terms of, you know, we
22 can't go to 100 organizations or maybe not

1 even 40.

2 But I would argue that on the paper
3 based side, five is also not very meaningful
4 in terms of feasibility, but again it's a
5 qualitative assessment that I think we're, are
6 we going in the right direction overall?

7 The fact that each EHR
8 implementation is a single EHR implementation
9 certainly brings a lot of complexity to this,
10 and I doubt it that even with that kind of
11 sample we would get at all the EHRs. The
12 final measure is not going to get at all EHRs.
13 Some are going to have to make changes in
14 order to accommodate it because we can't
15 evaluate the whole population.

16 But I think that that's a good point
17 in terms of where, how many organizations do
18 need to be involved in this so that
19 feasibility testing means something in the
20 context of a particular measure?

21 DR. OVERHAGE: Maybe that's a key
22 step here though is figuring that out, you

1 know, what is the scale that you have to get
2 to to get a reasonable idea? And that's
3 obviously a studiable or answerable question.

4 MS. MARTINS: And that's also a
5 cost-benefit analysis from the developer's
6 point of view, as it is for you to implement
7 these --

8 DR. BREGMAN: Rute, I'd like to ask
9 you, this committee, I believe, we have to
10 come up with a recommendation or conclusion,
11 what do you think that should be? At the end
12 of the day here, what should we be
13 recommending?

14 MS. MARTINS: You mean in terms of
15 the framework, in terms of the population?

16 DR. BREGMAN: In terms of whatever
17 the goal is of this what we're trying to
18 accomplish. What recommendation should we
19 produce at the end of this process?

20 MS. MARTINS: What I would like to
21 see is a framework that we can use as measure
22 developers to get out on the field and

1 evaluate given, you know, a feasibility on our
2 end on the number of providers or vendors that
3 we could include. And let's not forget that
4 this will probably be voluntary based, so
5 there's that aspect there. We can only use
6 the responses that get to us.

7 And then produce an overall
8 assessment that would congregate these views
9 of the reached out providers, and whether that
10 takes into account a central database that
11 already includes valuable information, I think
12 it could. And then when we have the final
13 scoring we can make decisions on, is it worth
14 it to proceed with developing this measure
15 right now? Do we develop it right now or can
16 we develop it right now and say --

17 DR. BREGMAN: If the product of this
18 committee is what, is the assessment, right,
19 what do you think the assessment should be?

20 MS. MARTINS: I think this
21 assessment makes sense. I mean we've
22 discussed it extensively in terms of what

1 should be columns and rows and all of that.

2 I think what we are talking about, and that's
3 a good question in terms of whether this
4 committee is going to decide on that is how
5 this should be applied.

6 DR. BREGMAN: Right. Well, I think
7 we're just trying to come up with a tool.

8 MS. MARTINS: That's fine with me.

9 DR. BREGMAN: And then we can figure
10 out how to, where it can go. I was going to
11 say that I don't think we just agreed to go
12 with this tool. I was kind of following what
13 Shannon said, to simplify it. I would like to
14 see it in three categories, accuracy,
15 standard, codify or, I don't know the term,
16 structured is the word I'm looking for.
17 Accuracy, structured, workflow. Those are the
18 three areas that we're evaluating, and then we
19 have a scale.

20 And we can weight them but, you
21 know, I think that basically those weights are
22 going to be pretty comparable. And structure

1 is essentially a boolean, right, or maybe it's
2 a variant because there's a distribution of
3 whether it could be structured or not but
4 it's, you know, sort of a boolean. And then
5 those would be the three realms that we're
6 going to score on.

7 DEBBIE: And can we ask the
8 question, the same question, current and then
9 future.

10 DR. BREGMAN: Right, and then it
11 could be based on whatever time scale we're
12 looking at.

13 DEBBIE: Right.

14 DR. OVERHAGE: So I may be missing
15 it, but how in the framework do you get at how
16 hard it is to get it there? I mean you may be
17 able to get a highly accurate structured
18 result there, but is it okay if it costs \$2
19 million to that?

20 DR. BREGMAN: Well, that's workflow.
21 Workflow includes the cost of, workflow is
22 essentially, in real life what is the cost to

1 an organization to get the data.

2 DR. OVERHAGE: Okay. And on
3 accuracy, so you look at what's out, blood
4 pressure is a great example. You look at
5 what's out there in blood pressures in the EHR
6 structured data fields today and the accuracy
7 is horrid.

8 If your standard is what was the
9 patient's blood pressure when they walked into
10 be assessed, it's horrible across the board.
11 So what do you do with that as a measure
12 developer so that the, you know, the accuracy
13 of that is ten percent?

14 DR. BREGMAN: Well, my response to
15 that would be everything's relative, one. And
16 secondly, I think that's really a question for
17 the experts, the measure, the experts that are
18 proposing the measures, they are the ones who
19 know in general what is the accuracy of blood
20 pressure taken at --

21 DR. OVERHAGE: But that's the point.
22 It's not the accuracy of the blood pressure,

1 it's the accuracy of how it gets recorded in
2 the system in real life in the workflow as a
3 structured data element. And that's what
4 we're hearing that the measure developers
5 don't know.

6 DR. BREGMAN: Well, if that's the
7 case then we would score it low based on our
8 knowledge of that.

9 DR. OVERHAGE: Well, I guess where I
10 was going is, so we look at that, so we do
11 that, does that mean you, what do you do with
12 the measure for which the data element, and I
13 guess I'm just trying to understand how that
14 gets --

15 DR. BREGMAN: What do we do or what
16 does the measure developer do with our
17 evaluation?

18 DR. BURSTIN: I think part of this
19 gets to the timing issue of where we are in
20 the process. So my sense of this is, my hope
21 would be this whatever we want to call it,
22 tool, et cetera, would have these data

1 crowdsource-collected across many EHRs, many
2 implementers, have a central source, so that
3 as you're sitting down with your TEP, you're
4 sitting down with your workgroup, in the words
5 of the other developers, you've got some basis
6 on which to guide how feasible this measure
7 will likely be.

8 Does that replace what you're
9 talking about, Rute? No, of course you're
10 still going to do your alpha and beta testing,
11 whatever you call it. But at the beginning of
12 the day, particularly for the sake of CMS or
13 ONC or those that are funding it, they want to
14 know that what they're actually putting
15 forward there is going to likely result in a
16 measure that's doable today or in the future.

17 So it still seems to me like it
18 would be really useful. If I was a developer
19 I would really like to be able to sit with my
20 committee and say, I know you really think
21 it's important to have that data element. Do
22 you have any idea how hard it is and how

1 unlikely that's going to be in the next five
2 years? How much do you really need it?
3 Should we move to the next?

4 I mean I think this is what they're
5 trying to do is, how do you build this into
6 the development process so it's not something
7 that you're doing at the end of the day after
8 you've already got it built, but it's
9 literally helping you build your measures?

10 So I'd love to hear from the
11 developers. I mean that's, again I haven't
12 done that in years.

13 MS. CHRISTENSEN: Hey, it worked
14 that time. I agree. I think that would be
15 really useful. We definitely get a lot of
16 pushback from folks who are passionate about
17 a particular measure. And it's not a bad
18 measure, per se, it's just, you know, it's not
19 going to happen in the next five years so why
20 bother to spend your time on it? Now the
21 evidence could change in five years.

22 But the concern I have, and I know

1 I've said it before so I will take one of your
2 lines and I won't say it again after this, I'm
3 not sure that we can get good people to do
4 this right now when we are offering to pay
5 them.

6 So crowdsourcing, though a great
7 idea, there's got to be an incentive. And I
8 think if we walk out of here without
9 understanding what the incentive is besides
10 just we all love this stuff and want to do it,
11 we're going to get a crowdsource with no
12 information.

13 DR. BURSTIN: I guess I'm thinking
14 more along the lines of, again I don't know if
15 they would even fund this, but if there's a
16 way to get, you know, the group of
17 informaticists and informaticians, my AMIA
18 friends tell me on the board, I'm sorry,
19 informaticians and vendors and end users
20 together, and it may just be 20 people, I'm
21 not convinced it's that difficult to do this
22 on an annual basis the way we're updating the

1 QDM.

2 You then, as part of this then you
3 have an update of the data element feasibility
4 scores that this get provided to all to use.

5 MS. CHRISTENSEN: So not really
6 crowdsourcing then --

7 (Simultaneous speaking)

8 DR. BURSTIN: I didn't mean to be
9 quite that ad hoc, yes. Sorry.

10 DR. LIEBERMAN: So would a system
11 with three categories and three scores to each
12 category create enough information that we can
13 do what you're talking about doing? Would a
14 score, so that would be, what a nine-point
15 system? So if you see a measure, a data
16 element that's less than seven is that a red
17 flag and then you go in and look at it or what
18 would the --

19 DR. SIMS: I think we have to
20 develop that empirically. I think we have to
21 look through a bunch of data elements and see
22 how they're applied in existing measures, but

1 I think that's a rational way to proceed.

2 I would say as you form that 20-
3 person committee, and I know that's
4 aspirational but it would be heavy on vendors
5 and providers. That clearly all stakeholders
6 are invited and should participate, but that's
7 where the rubber meets the road on
8 feasibility.

9 And then your vendor products,
10 you've got to get as many different vendors
11 obviously.

12 MR. KRAVITZ: One thing that that
13 would force, which I think would probably be
14 a good thing, is that when the TEPs are
15 working they would have to thinking in QDM.

16 So you have to get out of thinking
17 in terms of English, you know, the doctor's
18 assessment to the patient's mental state or
19 something, and they would have to actually
20 boil down the measures to, I'm looking for a
21 depression assessment tool in order to do the
22 assessments. And that would really push the

1 thinking way back up into the TEPs.

2 DEBBIE: And just one other point
3 besides my plea for definitions in the
4 document is, I think it's important that we
5 clearly state that this is a tool to be used
6 at the appropriate steps in the process of
7 measure development.

8 Meaning that here's your first line
9 of information with a score, we mean for you
10 to discuss this further to reach out for a
11 public comment to use it in the whole measure
12 development cycle testing cycle, whatever
13 cycles.

14 This is sort of, you're now at first
15 base. You have some evaluation, and before
16 you move forward consider these points. So I
17 think that's important so that we don't have
18 anybody say, oh, this has a score of six, we
19 can't use it. We can't continue to
20 discussion, or throw it out the door, or, you
21 know, even at the lower end of the scale, this
22 is meant for consideration, points to consider

1 and discuss.

2 DR. BURSTIN: The value of the
3 element still has to be considered, and value
4 of the element is nowhere here. That's the
5 other half of it.

6 DR. BUTT: So I'm trying to sort of
7 operationalize this. So we have three
8 categories and then within each category we
9 have a one, two, three scale, right? And so
10 will each, all those scale items be clearly
11 defined what they actually mean? And then
12 will all of these be equally weighted or will
13 there be a weighting attached?

14 DR. SIMS: I would say no weighting
15 to keep it simple, personally.

16 DR. BUTT: Because if we keep the
17 weighting equal I can see the structured
18 data/coded standards as in a relative scale,
19 easier of the three categories to get your
20 arms around in terms of what you come with,
21 workflow perhaps less so. But the accuracy,
22 I'm still not sure I understand how will we

1 determine the accuracy of data in this
2 context.

3 DR. WINKLER: Might it help sort it
4 out if you could offer examples of what one,
5 two and three might look like for accuracy?

6 DR. SIMS: I mean accuracy could
7 vary at, you know, in my institution across,
8 it could vary from provider to provider in the
9 same clinic. I mean, you know, is one using
10 a PA and one using an MA? So all of this is
11 highly subjective.

12 But I think, you know, it allows us
13 to put some guardrails on the road to keep the
14 car on the road as opposed to, you know, we're
15 not the steering wheel, we're not the
16 speedometer, we're just trying to keep the car
17 going in the right direction in terms of
18 measure development. So, you know, I think we
19 can live with that subjectivity. I would
20 postulate.

21 DR. LIEBERMAN: I'd make one
22 recommendation and maybe we can get a show of

1 hands or something. I would say that, I still
2 think workflow should be weighted more heavily
3 than the others.

4 And maybe it doesn't make it quite
5 at simple, but when people talk about
6 feasibility it seems to me that they're asking
7 about how hard is it to get this information
8 and how hard is really workflow, so I would
9 suggest maybe doubling it and having
10 everything else single-weighted or something
11 of that nature.

12 DR. BREGMAN: I would second that.
13 I also, you're probably going to shoot this
14 one down as a group, but I would vote for a
15 five-point scale just because you want to
16 reflect a little bit of nuance and the
17 distribution among, you know, there's so many
18 factors that it would be nice to be able to
19 say, you know, four is yes but five is really
20 yes.

21 And it doesn't have to be we have to
22 define all five points. You can just say one,

1 three and five have a definition and four is
2 halfway between three and five. And for the
3 record, Marc was nodding when I said five-
4 point scale.

5 (Laughter)

6 DR. LIEBERMAN: Can we see a show of
7 hands? Who agrees with doubling workflow?

8 (Off microphone comments)

9 DR. RADFORD: I'm not sure that we
10 need to obsess about the weights of the
11 different domains, because I think the
12 different domains are going to be treated
13 slightly differently by the measure
14 developers.

15 So for example, if there's a
16 workflow issue that's rated low, then
17 depending on what it's all about someone may
18 want to work on that and say, okay, we're
19 going to work on what the workflow is so that
20 it, you know, it's going to be easier. I
21 think that's the point. And the other domain
22 similarly. So I'm not sure we really need to

1 obsess about a weight.

2 DR. TINOCO: I agree. And as long
3 as we have the option of seeing the individual
4 subcriteria and the result of those and a
5 current state versus the level we have to get
6 to the future state, that's meaningful for me
7 as opposed to rolling everything up into a
8 single composite value that hides the nuances
9 of each subcriteria.

10 DR. LIEBERMAN: So I would think
11 that eventually we would, I mean we're going
12 to have how many data elements in a measure?
13 And does somebody want to throw something out?
14 I don't know, is it --

15 (Off microphone comments)

16 DR. LIEBERMAN: -- lots and lots,
17 right. So you can come up with an, maybe when
18 you're looking at an overall measure you're
19 going to do something like look at the overall
20 score, I mean look at the average for all of
21 the data elements and maybe you're looking at
22 the outliers, you know, which ones are high,

1 which ones are low.

2 And I think what you're going to
3 want to do is, I think you want the ones that
4 have difficult workflows to stand out more
5 than the ones that have difficult data
6 standards. I mean that's my assumption, and
7 again --

8 DR. SIMS: Well, I think you have to
9 be careful because one bad data element can
10 ruin, you know, one bad egg screws the whole
11 thing up. So I think at the very least we
12 need to publish the minimum score of the data
13 elements, and then from there we can mean
14 maybe a mode, whatever, that's fine. But the
15 minimum value is an important factor, I think.

16 DR. LIEBERMAN: Right. But if you
17 score perfect on accuracy and data standards
18 and poorly on workflow it might not stand out
19 is what I'm afraid of.

20 DR. BREGMAN: Just as a reality
21 check, which measure has 200 data on it?

22 DEBBIE: You know, I was thinking of

1 the whole feasibility report that we had on
2 200 data elements.

3 DR. BREGMAN: Because even the SCIP
4 measures have, I don't know, 30 or something
5 like that.

6 (Off microphone comments)

7 MS. CHRISTENSEN: I think something
8 just to throw out there, and it's probably
9 obvious but sometimes I like to just say them
10 out loud. Some data elements matter more than
11 other data elements, so I think that that's
12 something that as measure developers we have
13 to take into account. If it's something
14 that's essential to my denominator, you know,
15 a two out of three may not be enough. That
16 might be a no-go if I can't get the
17 denominator.

18 But if it's something that's going
19 to affect one percent of patients some of the
20 time about why they're not going to meet a
21 measure, maybe one out of three isn't that big
22 of a deal.

1 DR. BURSTIN: And maybe you just
2 won't include that data element in your
3 measure.

4 MS. CHRISTENSEN: Yes, exactly.

5 DR. BURSTIN: Strip it down to
6 what's really needed.

7 DR. TINOCO: So I hope this is, I
8 love building tools. This is fun. But I sure
9 hope that during this process we actually
10 exercise the tool that we build and challenge
11 ourselves to use the information that we
12 generate, and make the decisions as if we were
13 either a sponsor or payor that's going to
14 implement this thing.

15 DR. BURSTIN: Actually in HITEP-I,
16 since I may be only one of the people who was
17 here for HITEP-I, we actually went through and
18 we rated -- well, you were there too, Marc,
19 weren't you? We went through and rated, what,
20 40 measures or something as a group.

21 So I think some of this might be, if
22 we can come up with the anchors around these

1 one to five and some definitions here, we'll
2 go ahead and we'll just pull up some measures
3 and send it along. I think I heard some
4 support for five.

5 DR. LIEBERMAN: Maybe we should have
6 a quick vote on three versus five. Who's in
7 favor of five, a scale of one to five?

8 DR. TINOCO: I mean it will be on us
9 to actually define what each one means.

10 DR. LIEBERMAN: Howard, your
11 proposal for one to five got voted down while
12 you were out. I'm actually going to have to
13 go pretty soon, but some of the things that we
14 can do is work on the definitions of putting
15 some words around one, two and three for each
16 of three categories. I think we have, we've
17 got three categories there. We probably will
18 take a break in a few minutes. So that's one
19 thing to do.

20 The other thing is, you know we
21 talked briefly. Do we want to explore anymore
22 about how we want to aggregate the information

1 that we're collecting on all these various
2 data elements or is that something that can be
3 saved as later as well?

4 So we can look at kind of things
5 like average scores for the overall measure.
6 We can look at, you know, high score or low
7 score. What comes to me is, when we talk
8 about cost this will identify individual data
9 elements, but there is something to be said
10 for if you're, you know, if you have a lot of
11 medium cost data elements maybe it's not so
12 good either.

13 And so with the scoring system we've
14 put in place that might be hard information to
15 find. I'm not sure, because you might want to
16 invert the one through three, so one is good
17 and three is bad, and then you can add up all
18 of the workflow scores or something to get an
19 overall idea. But I don't know. I mean do we
20 want to spend some time on that or not?

21 DR. SIMS: I have some quick
22 thoughts. I mean I think as Keri alluded to,

1 if it's a denominator or a numerator element
2 then that's going to take precedence. It's
3 going to have a higher weight than if it's an
4 exclusion criteria which are more rarely used
5 and which, frankly, if you're using a
6 threshold based approach to measurement
7 accountability may not matter in the end
8 anyway.

9 So if we're going to go down that
10 road that would be the road that I would
11 propose. And I don't know that you can
12 discriminate with denominator and numerator
13 being more important. They're both pretty
14 important. But exclusions and exceptions you
15 might be able to navigate around a little bit.

16 DR. LIEBERMAN: Reva, were you going
17 to say something?

18 DR. WINKLER: Just something some of
19 you were talking about earlier, the idea that
20 a score for each data element somehow
21 aggregated and make some assessment about what
22 the aggregate looks like so that's moving

1 towards the score.

2 What other characteristics of
3 feasibility of the score beyond the individual
4 data elements are important? The actual
5 measure should be part of a feasibility
6 assessment that would be useful for
7 developers, and then anyone else along the
8 line.

9 DR. BUTT: So I think maybe not
10 exactly answering your question, but I think
11 that one of the things in addition to maybe
12 the average score would be important to have
13 the frequency of a certain category.

14 Because, you know, I'm still
15 concerned that we'll get a lot of threes in
16 accuracy because it's going to be so
17 subjective that, you know, as was being
18 mentioned that accuracy is so sometimes even
19 provider dependent that how do you sort of
20 generalize it in a scale that you're trying to
21 put at this level with 20 people sitting
22 around the room and trying to say whether this

1 element is going to be accurate or not? I'm
2 just concerned.

3 So if the frequency of these
4 elements through different either surveys or
5 expert panels is showing very high or low then
6 we need to revisit and see whether it's truly
7 getting us what we need.

8 DR. LIEBERMAN: Shannon?

9 DR. SIMS: I think, Keri, didn't we
10 joke about this on one call? That the, I
11 might have put it out as, putatively, the Sims
12 scale that the more data elements there are in
13 a measure the less likely I am to implement it
14 or the less likely.

15 So, you know, we might look at some
16 metadata like the number of data elements.
17 That is correlated with how many institutions
18 like Mike and myself and other providers will
19 do because it makes a huge build effort. I
20 mean we can spend several FTEs for a month or
21 two building one metric. I'm not kidding. So
22 the sexual activity one, for example, took us

1 forever and actually we just abandoned it, to
2 be frank.

3 So there might be those kinds of
4 opportunities there, and the logic itself. So
5 that probably the more data elements there are
6 is not an independent variable from the
7 complexity of the logic, but the complexity of
8 the logic also, as a provider organization,
9 not so much the computational aspect but our
10 ability to explain it to our providers.

11 So this is why your population is
12 only half of what you expect. It's because
13 they're excluded for XYZ reasons is another
14 factor, and feasibility, in a sense how likely
15 we are to both implement it and then to use it
16 for substantive quality improvement.

17 DR. OVERHAGE: That's one of those
18 that, to me, falls into the category of, in
19 God we trust and all others bring data.

20 I mean I think that's one that
21 you've got to measure because the assumption
22 about what it will be, you know, and so maybe

1 people like Kaiser or somebody may have 99,
2 but I think we have some data on that when
3 you're really going to be in trouble. Because
4 it's so easy to assume that that obvious thing
5 would, and gender is actually a great example.

6 At Partners Healthcare we were doing
7 a research study, and not to beat up on
8 Partners because I don't think they're any
9 worse than anybody else, 45 percent of the
10 people didn't have race, okay. And something
11 simple and obvious, not there, so I think you
12 have to be really careful about the accuracy
13 one.

14 MR. KRAVITZ: I just want to come
15 down to the breakdown by populations that I
16 think Shannon mentioned. I think it's really
17 important to report the roll-ups by
18 denominator, numerator exceptions and
19 exclusions.

20 And I think the number of data
21 elements is an important measure to report
22 both from the ability to explain it but also

1 the testing. If you look at the testability
2 of some of the measures that have a zillion
3 data inputs, it's clear that no one has ever
4 tested them computationally because to
5 actually test them in a software perspective
6 would be prohibitively expensive.

7 So we also have, just as an aside,
8 we have a research project to try and look at
9 the QDM expressed measures and computed
10 measure of complexity, your algorithm and
11 complexity of them to report that since that
12 also makes it harder to explain.

13 DR. BUTT: Another thing might be
14 for us to consider the average score
15 interpretation. So perhaps, you know, from
16 here to here it means this, from here to here
17 it means this. Because then the measure
18 developers actually can use that sort of to
19 determine that for a denominator that is a
20 critical data element they would only use a
21 score above a certain number versus perhaps
22 some exclusions they could select a slightly

1 lower score.

2 So we don't have to get into that
3 part of it how they use it, because that will
4 be up to them to determine how important it is
5 in their measure to use a certain data element
6 based on the score.

7 DR. LIEBERMAN: And then you can
8 also see that if you start collecting this
9 data you can start doing a lot of different
10 analysis on it, so we could look and see which
11 measures people are choosing to report for
12 meaningful use, and then we could look at
13 average scores for data elements on those
14 measures and you can compare your new measure
15 against those or, you know, it would open up
16 a world of possibilities and lots of good work
17 to be done.

18 Aldo?

19 DR. TINOCO: Forgive me, I'm going
20 to try and sneak in four thoughts. With
21 regards to Reva's question about the score of
22 the measure itself, it's kind of hard to

1 disentangle that from the logic. I mean these
2 are computers. This is software.

3 And if we can generate values for
4 each data element then it's just a matter of
5 programming in what type of calculation we
6 want, even if it's a complex weighted
7 composite that we have planned for, you know,
8 future iterations of meaningful use. So
9 that's one thing about, I can't really answer
10 your question directly at this time.

11 Secondly, Shannon, the quantity of
12 data elements being rolled into this, should
13 I implement, should I not or the cost of
14 implementation, let's think about whether or
15 not those data elements already exist in our
16 systems -- I'm sorry, are already used for
17 existing quality measures.

18 So if I assemble components from
19 different Meaningful Use Stage 2 measures and
20 they're already out there in deploy and
21 successful, that's going to be like ten, for
22 argument sake, but they're all existing so I

1 wonder whether or not we can make sure that we
2 know that there's a different level of effort
3 for brand-new, brand-new versus reused data
4 elements.

5 Third, we haven't really talked
6 about data elements that are derived from
7 other data elements. So there's some special
8 cases here like we're talking about change
9 over time measures and that is subtraction in
10 many cases of two existing numeric values, but
11 we have to keep those special cases in mind.

12 And lastly, we haven't really said
13 much about attributes of data elements. So as
14 measure developers using the QDM, we have this
15 ability to say oh, I want a patient reported
16 outcome result from use of a tool and I want
17 to assert that the source information is the
18 patient not the provider.

19 So as we flesh out these different
20 rules of engagement with feasibility it's not
21 just, sometimes a measure concept or component
22 is not just a single data element, it's a post

1 coordinated collection of separate data
2 elements.

3 DR. LIEBERMAN: Along those lines of
4 this issue of using data elements that have
5 been used in measures before, actually I think
6 that's a really interesting idea. And it
7 doesn't get at this issue of building for the
8 future but it does give you, should we use
9 that in our scoring system?

10 So if we've been collecting a data
11 element, it's been used, it's been reported,
12 the overall measure has been found to be
13 accurate and useful, should you get more
14 credit for choosing that data element than one
15 that scores well but is untested?

16 DR. OVERHAGE: So I would suggest
17 that that's independent. I think it's a huge
18 value, right, that's our aspiration here is
19 that I record the blood pressure once, use it
20 for 900 measures and for patient care and for
21 research, actually nine measures. So that's
22 aspiration.

1 But to me that comes in sort of at
2 the back end of the thinking. So A,
3 presumably that will be a pretty accurate if
4 it's been used it will score well as a
5 measure. And then there is some level of, and
6 as you said it's sort of a mixture of, yes,
7 that's been used before. That's something
8 that signals providers and EHR developers this
9 is something that gets used a lot.

10 But I can also imagine sort of the
11 wishlist need as you said for the future.
12 Well, I don't see the measure there. It's
13 going to be a tough one to collect, but let me
14 at least tick the box and say to the world
15 that this is something that we thought about
16 and would like to have if we could, even
17 though it scored too low that we couldn't,
18 we'd like to have it, and that that's what
19 helps drive the future development.

20 So capturing the fact that a measure
21 developer thought about an element and
22 abandoned it or whatever would be very

1 valuable, I think.

2 DR. SIMS: I would agree with that.
3 There are a lot of data elements in use right
4 now that aren't very feasible, so I think it
5 needs to be an independent evaluation.

6 MS. MARTINS: Just a quick comment
7 based on Aldo's comment on what is a concept
8 that we would feed here in what we're calling
9 data elements.

10 I think everything that whether
11 that's a QDM element or an attribute of QDM
12 element that has a value set attached to it
13 would qualify as an individual concept to be
14 evaluated as a unit of meaning, so a single
15 atomic data element, if you will.

16 And then there may be others that
17 don't actually have value sets attached to it,
18 so admission date, for instance, those are
19 attributes of an encounter within the QDM. So
20 again, to me, a QDM element is the highest
21 level of specificity defined within it.

22 DR. SIMS: Can we do it empirically?

1 I mean can we look at the measure authoring
2 tool, pull out sort of most frequently used
3 state, the combinations of QDM designations
4 and sort of start with those?

5 Is that a rational starting point
6 for the group assuming that that might be the
7 most frequently used types of data elements
8 moving forward? Because this is going to be
9 a long list of potential data elements and
10 that might help us as we work through the
11 rubric that makes sure that we're identifying
12 the needs of the measure development
13 community.

14 MR. KRAVITZ: I would suggest we
15 start with the data elements that are used in
16 the Meaningful Use 2 measures as a sanity
17 check.

18 DR. SIMS: But I mean the cat's kind
19 of out of the bag on those, right, I mean
20 those are writ. I mean I think --

21 MR. KRAVITZ: But we don't know
22 whether they're feasible.

1 DR. SIMS: That's true. That's a
2 good point.

3 DEBBIE: Right. They're not proven
4 yet.

5 DR. SIMS: Okay, but then all right,
6 so that's a good point.

7 DR. KENNEDY: But it may be a good
8 data set to start with to assess feasibility.

9 DR. BURSTIN: I just wanted to go
10 back to the, I'm the measurement geek, so I
11 wanted to go back to the issue of data element
12 versus measure, because I think we sort of
13 glossed over it a tiny bit. So I guess one
14 question is, if there's this level of rigor on
15 the data element side, does anybody feel like
16 you need to really do additional feasibility
17 analyses for the overall measure?

18 Is that something we would require,
19 or are we feeling pretty good that if you have
20 the data elements and you're putting those
21 forward and you think they're fairly reliable
22 -- let me just finish the last part of this --

1 you think the rest of the concerns would
2 likely come up because they are still going to
3 have to be tested for reliability and
4 validity.

5 So it's hard to imagine that a
6 measure will turn out to be valid if it's not
7 feasible. So I just wanted to try to
8 disentangle that for a moment with you.

9 MS. CHRISTENSEN: I'm going to go
10 back to Aldo's point about the data around the
11 data element, because a lot of times that's
12 where we're seeing people run into trouble, if
13 they're not capturing all the information
14 about the actual piece of information then you
15 can't compare one piece of information to the
16 next one or do the linkages between them that
17 you need. So --

18 DR. BURSTIN: And how do you assess
19 that? Is that the complexity of the logic?
20 Is that the completeness of the logic? What
21 is it?

22 MS. CHRISTENSEN: I don't know. I

1 mean I don't want to say that each of those
2 pieces of information that you gave is
3 actually a data element because it's not in
4 the sense that it's not a new data concept
5 it's a related bunch of data concepts, but it
6 almost is.

7 There is almost a feasibility for
8 each of those individual pieces of it and then
9 how they link together, and that's hard to get
10 at. Yes, it's the measure. Short answer.

11 DEBBIE: I would agree with Keri,
12 and I think although I know vendors can
13 program anything logic-wise, I think there's
14 a complexity related to implementation and
15 understanding, understanding to the providers
16 and sort of a whole picture there with the
17 complexity of the context and related to the
18 logic. So I think we should call out some
19 things to consider and for discussion and
20 that.

21 MS. MARTINS: And I would agree that
22 there is a dimension that is about the measure

1 that exceeds the data element by data element
2 evaluation. I think that data element by data
3 element evaluation -- and again to me I've
4 already explained what that means to me,
5 whether that's the pieces around a specific
6 measure or concept, I think it is -- I think
7 the aspects of eMeasure representation, so the
8 challenges of eMeasure representation which
9 are not necessarily here.

10 So for instance, a limitation in the
11 QDM. Whether we need to do that data element
12 by data element, I don't know, but we
13 definitely want to have some measure of those
14 limitations as well in order to create an
15 overall score of how we feel that the measure
16 is going to fare. I would say though that I
17 think it will be really hard to come up with
18 a scale for that.

19 DR. RADFORD: Yes, so I would agree
20 that we should at least say something about
21 the measure itself beyond the individual data
22 elements. I mean as you know I couldn't make

1 the phone call because of Sandy, and I had a
2 remedial phone call after that. And I was
3 very worried about this, actually, because,
4 you know, we've had two EHR vendors. We just
5 dumped one and had another, and both of them
6 are telling us, gee, that's a great idea about
7 measure construction and we'll get back to you
8 on that, and they never do.

9 So, you know, this issue of how you
10 take the data elements and aggregate them and
11 put the logic behind them and, you know, give
12 back either, in my view, decision support or
13 a post care measure, it is a very real one and
14 I think we need to acknowledge it.

15 DR. LI: Just one comment on the
16 data element assessment. So we can suggest
17 that we do the overall but to put more focus
18 on the measure specific, that element
19 assessment, because that basically fall into
20 the scenario that Keri just mentioned.

21 For some complete, complex eMeasure
22 you have all the data element defined

1 available but it's still hard to perform
2 measure calculation. Why? Because overall
3 these data elements are available but fall
4 into that measure required a specific context.
5 You may find out that some attributes required
6 of that measure are not available for these
7 data elements.

8 Another finding, we do the MU2
9 measure, the development and the testing, it's
10 that sometimes for the very large, complex
11 measure the logic, what's the most efficient
12 way to represent a measure logic, make it easy
13 calculated, easy understandable could be a
14 issue, but that's kind of a separate issue
15 from the data element assessment.

16 So there's always room to improve
17 measure logic representation itself, but doing
18 validity testing the logic compare reason on
19 the later on phases.

20 DR. BUTT: So I think one of the
21 things might be important to, you know, in
22 this context again define what we mean by a

1 data element. Because, you know, the quality
2 data element has a certain definition and
3 often the granularity is different when you
4 come in at a data type level versus when you
5 put the attribute next to it. And even in
6 EHRs the data sometimes at the element level
7 is stored almost at the attribute level.

8 So the EHRs generally don't follow
9 the QDM model, if you will, of data, so I
10 think it might be very important to define
11 exactly what we mean by data element. Does it
12 sort of include the attribute itself, or how
13 do we define so we can bridge this gap if part
14 of the analysis will be based on QDM, and then
15 we're dealing with the real actual data.

16 MS. MARTINS: I think I've proposed
17 a definition for that, I think, from the
18 perspective of applying this framework to a
19 concept. Particularly because EHRs do not
20 necessarily follow the QDM model, it may not
21 make a lot of sense to evaluate an encounter
22 as a data element, but the admission date has

1 meaning within an EHR or doesn't. I mean this
2 is part of why we're doing the assessment.

3 But I think it goes all the way to
4 the highest level of granularity with which
5 the QDM element is defined, including any
6 attributes and value sets associated with
7 those attributes, and I would say that that's
8 the most granular that you'll ever get.

9 And if it's just an attribute
10 without a value set then that's another level.
11 That's another concept that we want to test
12 against this framework that the element itself
13 with no attributes and a value set that's
14 another concept. All of these are unitary,
15 atomic concepts that we need to test against
16 this and this is my proposal.

17 DR. LIEBERMAN: That sounds like a
18 lot more data elements though. I mean if
19 we're talking about doing this as a, so I can
20 see doing that individual measure to thinking
21 it through that way, but if we're thinking
22 about a repository of data elements that have

1 been evaluated and are available for kind of
2 review I think that's a lot more difficult.

3 MS. MARTINS: I agree, but I would
4 say that again because of this disconnect of
5 how, and it's not necessarily a bad one, the
6 QDM is an information model so it surrounds,
7 it's about meaning. It's about the meaning of
8 the information.

9 And the problem is that a QDM data
10 type might not give you the meaning that
11 you're looking for in a measure. So a QDM
12 data type feasibility assessment may not mean
13 anything as the concept you're looking for.

14 So for instance, an inpatient
15 episode of care. That may have meaning for
16 the measure, but if you are selecting patients
17 based on the admission date and the admission
18 date is an attribute and isn't in that pool of
19 data elements or feasibility or concepts then
20 you won't be able to do anything.

21 So I guess what I'm saying is that
22 the most important concepts for a measure

1 might not necessarily be QDM data types
2 coupled with a value set.

3 MR. KRAVITZ: Can I ask just a
4 clarification question? So you're saying, is
5 your proposal that if I'm proposing a data
6 element, let's say inpatient encounter, so any
7 attributes of that data type that are required
8 by the measure should also be scored?

9 MS. MARTINS: Yes.

10 MR. KRAVITZ: Okay.

11 MS. MARTINS: Because again, the
12 importance of the concept and the measure does
13 not necessarily tie to just the QDM data type.

14 MR. KRAVITZ: The type as opposed to
15 the attributes. I agree with that. Because
16 a lot of the trouble we had during the rework
17 of the Stage 2 measures had to do with
18 attributes not the types.

19 DR. WINKLER: Marc's looking at me
20 because it looks like he's packing up his
21 stuff and getting ready to go. And we are
22 getting to the close of our agenda.

1 I think a couple things we need to
2 decide is what we need to be able to move into
3 starting to put this together into a document
4 that makes some sense and be able to tell our
5 story in a rational fashion.

6 I think it sounds like everybody's
7 reasonably comfortable with the three-part
8 framework that we have here using a three-part
9 scale as certainly a starting point without
10 any weights at least initially.

11 The thing I think that's missing
12 that's critical is going to be what does a
13 one, two and three mean under each of those
14 categories? We don't have time to really do
15 that now, but I would really like to have some
16 volunteers propose some of those, if not I'll
17 assign them. Because I really need your input
18 to help us really understand what you're
19 thinking about.

20 So what is a one, two and three for
21 accuracy? You know, Aldo did a pretty good
22 job of maybe representing what a one, two and

1 three under data standards might be, but maybe
2 it needs to be a little bit more robust or
3 fleshed out a little bit more, and similarly
4 for workflow fit.

5 So I'm right now soliciting, you
6 know, volunteers to try and, you know, pick
7 one and try and do it for one. It would be
8 great if everybody would kind of pick one.

9 (Off microphone comments)

10 DR. WINKLER: Well, it sounds like
11 the accuracy one is the one that people are
12 feeling the least comfort with, so who are the
13 real brave volunteers on that one? Go for it,
14 Marc.

15 Okay, that sounds great. If you
16 guys --

17 (Off microphone comments)

18 DR. WINKLER: And data standards?
19 Zahid was down there on data standards.
20 Martha, JD. Okay, that sounds great. You
21 know, that's really the sort of the missing
22 blank spots right now on this framework.

1 Essentially, I mean through the course you've
2 made some recommendations that you may not
3 have realized that that, but we can formulate
4 them in terms of how this should be used,
5 could be used, might be used, whatever
6 terminology we ultimately agree with that
7 we'll try and formulate.

8 But as after the last call, for a
9 couple days there was this nice little email
10 thing, exchange of ideas.

11 And I would really like to encourage
12 you to think about some of these things and
13 continue those sorts of discussions, because
14 some good thoughts, especially as you ruminate
15 today's discussion, you know, over the weekend
16 or whatever else you may be doing the rest of
17 the next couple days might give you some way
18 of formulating it that may help communicate.
19 Because that's the essence of the challenge
20 for us is communicating all these ideas on a
21 two-dimensional piece of paper, and so your
22 help.

1 Also we started looking at the
2 principles and guidance that we drafted, and
3 we see that as an important part of the end
4 report. If you haven't had a chance to look
5 at those I'd really appreciate if you would,
6 and then any feedback, certainly, if you think
7 they're wrong, need to know.

8 If you think they are not quite on
9 target and can be better formulated to get the
10 concept across, need to know. If you think
11 it's irrelevant or something like that, those
12 sorts of things would be really, really
13 helpful.

14 The next couple of weeks we're going
15 to be trying to pull these pieces together.
16 We do not envision this to be a lengthy tome.
17 We really do see this as a relatively concise,
18 focused document, but nonetheless it's a
19 document about what you all think.

20 And so we want to be sure we've got
21 your thinking accurately, and so we really
22 want to continue getting your feedback and

1 getting your input in terms of how we're going
2 to put this together.

3 So essentially the document's going
4 to look like, you know, there'll be an intro
5 section. There'll be a section on guidance
6 and principles, section on recommendations,
7 section on the framework, and a section on
8 things that should happen afterwards. You
9 know, the parking lot issues, the
10 recommendations that come from of actions and
11 activities that should follow from these sets
12 of recommendations going forward.

13 We do have a very short timeline to
14 accomplish all this so I don't think we can do
15 much more than that, but actually I think
16 that's a fairly significant bit of work to
17 accomplish.

18 Marc, you look puzzled. Do you have
19 a question? Okay, just checking.

20 DR. SIMS: Can I request that these
21 groups give an example, just one example for
22 each of their categorical descriptions?

1 DR. WINKLER: I'd echo that.

2 Because I think that again in explaining and
3 describing the framework those examples will
4 be very helpful in audiences getting it. So
5 thank you, excellent suggestion.

6 Any other of those brilliant
7 suggestions, please?

8 DR. RADFORD: If you could just send
9 an email with this homework assignment in it,
10 whatever you just said, so that we can kind of
11 do that. Thanks.

12 DR. WINKLER: We can do that.
13 Debbie?

14 DEBBIE: I have a question. How
15 will this feasibility testing be used as part
16 of future measure endorsement or maintenance
17 review?

18 DR. WINKLER: Well, I think that's
19 one of the things we're hoping to be able to
20 pull out of this. You know, we've kind of run
21 out of a time to really talk about directly,
22 but as you know feasibility is one of NQF's

1 evaluation criteria. And so just as we did
2 under scientific acceptability with
3 reliability and validity, they called out
4 specific applications of that for EHRs.

5 So I think what we envision is at
6 some point being able to call out things that
7 might be specific to EHRs pertaining to
8 feasibility, but I don't think we're there
9 yet.

10 DR. BURSTIN: For those of you that
11 have been around for awhile, after HITEP-I we
12 went ahead and put these criteria in
13 feasibility very prematurely. This seemed
14 really cool. This is feasibility, we put that
15 in there. It was premature.

16 So I think ultimately it would be
17 logical that these would reside under our
18 feasibility criteria. Did you assess? Was
19 this assessed? Can that be provided? But I
20 think that's something we'll continue to work
21 through with you as we get some definitions
22 and meat on the bones.

1 MS. MARTINS: Can I just make a
2 comment on that? I think it has to do with
3 the source or the information source for a
4 measure. If we're talking about an eMeasure
5 versus a paper based measure they're not the
6 same measure.

7 They may have the same intent. They
8 have different levels of feasibility, of
9 validity and reliability, and I don't think
10 they're, there's no understating this. You
11 may have a very feasible paper based measure
12 that is very reliable, and as you retool it,
13 it suddenly becomes something else. It's a
14 different animal and it needs to be treated as
15 such.

16 DR. WINKLER: I think another thing
17 Helen has brought up is feeling confined to
18 respecify an existing measure on a real
19 identical basis rather than pulling back and
20 saying, what was that measure all about? What
21 was it trying to measure? And then say, okay,
22 how would we measure it in an EHR, not being

1 confined to how it was being done in the paper
2 world because the worlds are very different.

3 I think that's another thing that we
4 want to begin to encourage, and I think it
5 speaks to the fact that they're not the same
6 measure. They may be measuring the same idea
7 but they are not going to be the same measure.

8 MS. MARTINS: Yes.

9 DR. BUTT: I think that also, maybe
10 this is not the time for that discussion, but
11 it also begs the question that from the NQF
12 standpoint is every tool measure considered
13 the same as the original endorsed measure,
14 because currently it gets the same number.
15 And I know the joint commission internally has
16 already moved to assigning a different letter
17 to distinguish it from the paper based
18 measure, and the question there is that does
19 it then have to go through endorsement again
20 because it's a different number? At least
21 internally it's a different number, but I
22 think there are lots of angles to that

1 question in terms of going forward if we're
2 not going to treat them the exact same.

3 DR. BURSTIN: This is part of what
4 kicked off this whole project in the first
5 place is we posted our guidance for what was
6 required for eMeasure testing and very
7 explicitly said what testing was required when
8 you're back for maintenance the first time.
9 And that's when people said, well, what about
10 feasibility? So we're going to have to as we
11 get through this process revisit that and
12 figure out exactly what that means, because it
13 was very clear.

14 And I'll tell you, the majority of
15 those comments came from the provider side who
16 said, I can't use these measures unless
17 anybody's shown they're actually feasible.
18 And especially if CMS has any desire to use
19 them for accountability it's going to be
20 really important we demonstrate that they
21 work.

22 MS. MARTINS: And feasible is not

1 enough.

2 (Simultaneous speaking)

3 MS. MARTINS: -- measures are valid.

4 DR. WINKLER: One last thing we need
5 to do is be sure that, or at least ask any of
6 our audience members here if they'd like to
7 offer any comments.

8 And Operator, would you ask if
9 anyone on the line has any comments or
10 questions to offer?

11 OPERATOR: As a reminder, if you
12 would like to ask a question or make a
13 comment, please press star 1 on your telephone
14 keypad at this time.

15 MS. CRAWFORD: So just a quick
16 comment. I think it might be helpful, if
17 there's a technical capacity to do so after
18 these initial assessments of feasibility for
19 different categories are available, to give
20 measure developers an opportunity to provide
21 their results from actual feasibility testing
22 into a nice database or some sort of resource

1 or clearinghouse where people can see for
2 different settings, for different specialties
3 what are the actual feasibility results,
4 because I think that kind of information is
5 going to be crucial down the line.

6 DR. WINKLER: Last thoughts from the
7 audience?

8 Well, from everybody here at NQF,
9 thank you very, very much for helping us out
10 today. This is just the beginning. We're
11 going to be working together over the holidays
12 and into the new year as we try and pull all
13 this together.

14 We'll be reaching out to you all at
15 various points along the line as we run up
16 against questions or not quite sure which way
17 to go as we're drafting the report and trying
18 to figure out where we need to characterize
19 what it is you all really want to convey and
20 communicate with everyone.

21 But I think it's been a very
22 valuable discussion today. I can envision at

1 least, you know, how I'm going to start with
2 it. I don't know at what point I'm going to
3 run into major roadblocks and yell help, but
4 I won't hesitate to do so.

5 So I've really enjoyed meeting all
6 of you in person, and look forward to working
7 with you as we go forward.

8 Helen, any last words from you
9 before --

10 DR. BURSTIN: No. Thank you, thank
11 you.

12 DR. WINKLER: Please travel safely.
13 Take care.

14 (Whereupon, the foregoing matter
15 went off the record at 3:45 p.m.)

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C E R T I F I C A T E

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In the matter of: eMeasures Feasibility Assessment
Expert Panel Meeting

Before: NQG

Date: 12-07-12

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