NATIONAL QUALITY FORUM

Moderator: Interoperability Project
February 28, 2017
12:30 p.m. ET

OPERATOR: This is Conference #82861883.

Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please stand by.

Jason Goldwater: Good afternoon, everyone, and thank you very much for joining this afternoon's webinar on Interoperability, our fourth webinar and the last one before we all meet together in March for our in-person meeting. We're looking forward seeing all of you and having what we hope will be a robust and productive discussion as we begin to put together the Interoperability measure framework.

My name is Jason Goldwater. I'm a Senior Director here at NQF. And I do want to take a moment to have members of the team introduce themselves. And we do have a new member that has joined our team, and I'd like for him to introduce himself as well. So I'll start with Hiral, introduce yourself.

Hiral Dudhwala: Good afternoon. My name is Hiral Dudhwala. I am the project manager on this team.

Poonam Bal: My name is Poonam Bal and I'm the senior project manager.

Vanessa Moy: Hello, everyone. My name is Vanessa Moy and I'm a project analyst.

Jason Goldwater: And John?

John Bernot: Good afternoon, everyone. As Jason mentioned, my name is John Bernot. I'm one of the newer senior directors here with the NQF. I'm a family physician by training and have some prior experience in health care IT and just recently joining the project just to add another set of clinical eyes to everything we're working on.

Jason Goldwater: John's been an enormous help, and we're very fortunate to have him not just for the Interoperability project but also with NQF as well.

Next slide. So, the agenda for today, we're just going to do a brief summary on the project goals, and then we're just going to take a few minutes to talk about updates that have been made to the Environmental Scan report since our last discussion. And then we'll turn it over to Poonam who will talk about the Key Informant Interview update. Hiral will provide a background and discussion on measures review.

We'll then have a committee discussion for about 20 minutes that Rainu Kaushal, who is on the phone and one of our co-chairs, will be leading. And then Vanessa Moy will talk about next steps, which will include our in-person meeting in March 20th to the 21st. And then we will go ahead and adjourn. Sorry, 21st to the 22nd, my apologies.

All right, so just quickly to review the project goals. So, since the last discussion that we've all had and are going through a lot of the comments that we received on the environmental scan report internally and with the government, we have reframed to the work a bit in order to hopefully make us a little bit more clear about what the overall objectives are going to be and specifically what measures and measure concepts we need to be identifying.

So we reframed the work based on the ONC Interoperability Roadmap because there is a significant section that really outlines core aspects to successfully measuring interoperability. And so, we took the key domains of the environmental scan and reframed those so that they aligned with those core aspects and became four very distinctive but (interconnecting areas) in how to effectively measure interoperability.

And so those four domains are looking at the exchange of data across district systems, the availability of data to facilitate interoperability, the use of interoperability to facilitate decision-making, and the impact of interoperability on health-related outcomes. So we refocused the results of the environmental scan on those four domains, screening information where appropriate, and highlighting measure concepts that related to each one of these domains and mention those in the environmental scan report as many of you have seen.

Our discussions going forward both in environmental scan report, the key (informant) interview summary report, and our discussions going into the in-person meeting will all be focused around these four domains. And these have been promulgated by ONC as being steps they believe are necessary to hopefully successfully measure interoperability.

So, we – this webinar is not intended to have a discussion on this but rather to just talk about how we went about reframing it and we have discussed this at length with the government in order to try to make this a little easier to sell up the project, develop the framework, and synthesize the result.

When we have our in-person meeting, we can discuss this at more length, which we think will be more productive, and decide if these are domains we continue to want to go with, if there are additional (areas) perhaps we need to continue to cover or if these to be readjusted or reframed slightly.

Next slide. Can you please put your phone on mute so that we're not interrupted while we're speaking? So now we want to go to the environmental scan report update. As you all know, we did have a public comment period of 14 days once the environmental scan was completed. We only received very minimal comments while the report was out. We did receive a couple of comments from committee members. We did receive one set of comments from the public, and then there were couple of discussions that we had with respect to the report. But there were not enough comments to where we would have a traditional post-comment call because there was really not enough that we needed to be synthesizing and discussing with you as to whether the report needed to be updated or not.

So, we went ahead and made some additional updates recommended by the government, some updates that were recommended internally by NQF staff, and we took into account some of the comments that were received by the committee members that wrote to us about comments or ideas that they may have had for the environmental scan. We have – and then, of course, John Bernot, who is our newest team member also took a look at it, which is extremely helpful because he's fresh pair of eyes that just got on to this project, and also happens to have clinical and health IT training. And he offered his own thoughts and comments as well.

We've incorporated those comments and have finalized the report. The report is now going through senior review here at NQF and it's almost finalized. And then we will be sending it directly to you so that you will have it to review prior to our in-person meeting. We are hoping that we will be able to send our report out this week. If there are going to be any delays, we will let you know. But we will be hopefully sending this out, again, to serve as a foundation of information for you to use as we move forward into the in-person meeting.

Next slide. So now I'm going to turn it over to …

Mark Savage: Jason, just so you know, it's Mark Savage on the phone …

(Crosstalk)

Jason Goldwater: Hi, Mark.

Mark Savage: Hi.

Jason Goldwater: All right. So, I am now going to turn it over to Poonam who will be talking about the Key Informant Interview update. Poonam?

Poonam Bal: So we met last time and we talked about the key informants and really went through the major themes that came out. We have produced a report now based on those findings. We're putting the finishing touches on that and then also we'll be going through internal review and we hope to have that to you

relatively soon with all the update information. Of course, it's been reframed with the new reframing work that we've been doing with this project. So, it will be very similar to the presentation that we presented to you previously and to just dive a little deeper and to that be a little be more organized based on the new system. But we'll have to you shortly as well to prepare yourself for the in-person.

Jason Goldwater: OK. Thank you very much, Poonam. And, again, we're going to try to have that report to you all within the week. And, again, that will serve, hopefully, as a basis along with the environmental scan to provide a solid foundation of information and go over the issue that we will be discussing.

All right, so now we're going to turn to the measures review, which we have been doing in earnest since we've finalized the latest version of the environmental scan. So I'm going to turn it over to Hiral who will be discussing that. Hiral?

Hiral Dudhwala: Good afternoon, everyone. So as Jason mentioned, another significant part of our project is to determine interoperability sensitive measures. You know, looking at the quality of care metrics that are designed for reporting from an electronic health record and could capture any potential effects of EHR. You know, we're looking to drive and look at improved outcomes in clinical performance, looking at the measures (to) review. This is going to be a very collaborative process where both our NQF clinical staff and the multi-stakeholder committee, yourselves, will be determining the degree of interoperability sensitivity of the selected measures.

So, one of the steps that our internal staff initiated was to define the methodology to review the existing measures. And, again, back what Jason said, we really work to hear this process to align with the ONC Interoperability Roadmap and the domains that we're focusing in on.

We looked at multiple sources when we were pulling measures, these electronic outcome process and structural measures. It was a review of existing ambulatory and hospital-based quality e-measures that were identified

using systems such as the NQF Quality Positioning System and the National Quality Measures Clearinghouse, which is maintained by AHRQ.

So, next slide, please. So, moving on, rating the measures. The conceptual model for rating the measures will make the following assumptions for both of our NQF clinical staff that looked at the measures as well as the multi-stakeholder committee, looking at the data needed to fill measures, measures residing outside of the medical entity, as well as the entity has access to health electronic exchange and the data can be delivered electronically.

The three domains will be used to rate each interoperability metrics. And you will see below, again, aligning with our domains that were mentioned, but looking at electronic health information availability, does the measure require electronic health information to be available from outside sources? Second, electronic health information usage. Does the measure require electronic health information from outside sources to be routinely used for decision-making and managing care? Thirdly, electronic health information impact. If electronic health information was present from outside sources, how likely if it have an impact on health and healthcare outcomes and processes? So each of these domains using a standardized measure scorecard is rated on the scale of one through three; three representing the highest score a measure could receive.

Next slide, please. So gathering those 243 measures that I mentioned, you know, which was the first step, these were the – there was a variety of clinical toxic areas that the measures fell in. So you can kind of see right here, you know, there was a wide variety ranging from cardiology to oncology, to screening, to patient safety. So, you know, you can see the (wide lines) linked in clinical area that the measures could fall into.

Next slide. OK, so this is kind of where we are at this point. You know, from the 243 measures that were gathered, again, using the NQF Quality Positioning System and the AHRQ, we had initiated with a clinical team here at NQF, which was a team combined of an MD and RN, who are reviewing the 243 measures. There was a team reviewing each of those measures and using a measure scorecard, which had focused, again, on what we had just

discussed with the three domains and giving a rating for those three domains based on availability, usage, and impact the MD and RN scored each measure. Again, the highest score being three and the lowest score being one.

Using the findings of their scoring, NQF was able to narrow the measures down to what we would say would be interoperable sensitive measures for further review about 68 measures. They were the ones had the highest scoring based on the measure scorecard. So we were able to narrow that down, that number down, because obviously 243 measures is a wide range of measures to review. So, that's where we are now as far as, you know, our internal staff, our clinical staff. We're able to take a look at – closer look at these measures.

And so, now, it's moving forward to have our committee members take a look. Next slide, please. So what we're looking for now is to get inputs from our multi-stakeholder committee. So the next steps for the measures review really would be for you to be able to look at the measures. We plan to divide the committee into three groups. Each group will be assigned approximately 20 to 30 measures. Again, the total measures that we had come up with were about 68 to 70 measures. So we will be dividing those measures amongst to you, and, again, providing you with the same measure scorecard that we had used internal clinical staff here at NQF so that you will have the opportunity to also rate these measures.

Again, looking at – you know, lining with the roadmap, looking at usage, availability, and impact, and then provide those forward back to our team so that we can compile all the results from your findings and be able to present that as we are approaching our in-person meeting in March. And our plan is to, you know, provide that information to you by the end of this week. You will have the – you know, you'll have an Excel scorecard which will define the scores. It's pretty straightforward. So we don't anticipate that it would take very much time for you to review about 20 measures. But, you know, please set aside some time to look at that and we would ask that you send that back to us in a week, which would be March 10th, and that will be defined in our next steps as well. But those are the next steps that we are preparing for our in-person meeting.

Female: Can you clarify the sort of the availability usage? So, to me, right, if something is not used, how could it ever impact an outcome? I guess I'm just struggling with when you would rate some thing as like, yes for availability but no for use.

(Off-Mic)

Jason Goldwater: So the answer is that – the question is, you know, are we looking at the availability of data? You know, that sort of the first thing, which is the – does the measure require electronic health information be available for multiple sources. So, is it able to gather, will it be able to access and will it be able to collect data from not a singular data source but from multiple data sources, which would then in turn, make that more usable or sensitive to interoperability. Then we move into usage, which is, does it require health information from outside sources to be – actually, I can't read. Can we get back to the slides? We go back to the slides.

Female: Sure.

(Off-Mic)

Jason Goldwater: So, does it require – so the availability is can it get data from outside sources. The next one is does it require information with the outside sources to be routinely use for decision-making and managing care? So, can it collect it? And then is that outside information then required in order for it to be used for decision-making and managing care.

Female: All right. I guess I'm still …

Jason Goldwater: So …

Female: … conceptually struggling with how to think about these because to me they're sort of all on the same puzzle pathway.

Male: Yes, might not be a bad idea to take one of the 67 measures and just use it as an example. I think many of us who actually are in measurements would be

interested to see how these three criteria or plans. So maybe help all of us if you just take one measure and run through those three criteria.

John Blair: Before we do that, one quick question. This is John Blair. When you talk about availability, you keep saying available from an outside source. What about if it is from an outside source but now it's available in your current system?

Jason Goldwater: So you're able to …

(Crosstalk)

John Blair: It came from – well, it came from – I mean so you keep talking about this is as if you're pulling data. There could be data that was available from an outside source that was pushed to you, that's no different.

Jason Goldwater: Well, John, I think that would be acceptable if you're taking data from an outside system and pulling that into the system you currently have it and using that for a measure. I think that would be acceptable because then in turn that measure then has data available that originally initiated from a source that wasn't yours or it was initiated from an outside source. So I think that's fine.

John Blair: OK. Yes, but again, you stated as pulling. So, a hospital discharge, if the data came from the hospital, it was pushed to the ambulatory system, that should no be different then if it was available at the hospital and you pull it in.

Jason Goldwater: That's correct, John, right.

John Blair: OK, OK.

Jason Goldwater: I'm just pulling (them) in a more general (context).

(Off-Mic)

Jason Goldwater: Yes. That's correct. If it's pulled or pushed into a system that you have that originally came from an outside system and it can be used in that measure, that's fine.

John Blair: OK.

Jason Goldwater: I think in terms of an example – do we have an example we want to give here or do we want to send them an example we put on the sheet? Or do you want to do it now?

Hiral Dudhwala: I can read one of the examples.

Jason Goldwater: All right, why don't you read this one? Sure.

Hiral Dudhwala: Sure. OK. Here is one. Here's a percentage members, 12 and older, with a diagnosis of major depression or dysthymia who are covered by an electronic clinical data system who have either PHQ-9 or (PHQ-a4) present in their record. So that's one example of a measure, mental health and substance abuse measure. So you would go through these three domains. Again, looking at that measure, you know, does that measure require electronic health information to be available from outside sources?

You know, again, this would be, you know, we – everyone is going to have their perspective, but you know, looking at it from our clinical perspective, you know, we provide a rating knowing if it's information that we would need to gather from an outside source being first availability looking at that measure, scoring it one to three.

Female: Sorry, can you just clarify – I'm sorry that I'm struggling with this so much. But, you know, I mean let's just in reality, right, like you are seeing a patient who had this diagnosis and the question, does another provider know about that diagnosis? Or am I not able to diagnose it myself? I guess I'm just really struggling with how to think about.

Jason Goldwater: So, this is not reflective of the encounter. This is reflective of a quality measure. So it's a measure itself. There's three different ways of looking at

the measure to determine whether or not it would need a criteria of being what we would consider interoperability sensitive. Or if we're going to look at it in terms of the domain and how we reframed the framework today, you know, what's the impact that that measure would have on interop? You know, what interop – what impact would interoperability have on this particular measure?

So, for the measure itself, the data that is needed to populate and report out on the measure is information available from outside sources that would then help in the reporting of that measure. Does that measure require information from those outside sources to be routinely used for decision-making and managing care? And then if that information was present from outside sources, what would be the impact on health or healthcare outcomes and processes.

I think where the confusion is we're not talking about singular encounter between a patient and a provider. We're talking about quality measure. And so, quality measures generally and the way they've always been done is that it represents a singular encounter at times between the patient and the provider, with the measure being reported from one data source, usually it's single EHR or at times with registry; it just depends.

So what we're asking then is if you look at this measure, think about it in terms of what information from outside sources be on just a single EHR be available to be used in this measure, would, if that information was available, would it help that measure in terms of routinely you be helping it with decision-making and managing care? And then what would be in the impact of it if that information was available on healthcare outcomes and processes?

So, if data was available from sources beyond just single a EHR or if information was pulled into it or pushed into a system, one way or the other, and you were able to access a more expanded data pull and just a recorded encounter in EHR, then it is actually – does the measure require that or was the measure, you know, would the measure require using information from outside sources, would it be taking that information from those sources to be routinely used for decision-making and managing care? And then what would be the impact be on healthcare outcomes and processes?

And just (using) …

Female: So are we saying would the measure be more accurate if we drew on a broader set of information to create it? Is that the right way to think about this?

Jason Goldwater: I think in some ways, yes. I don't know if it's necessarily being more accurate or would it be more thorough? Would it be more comprehensive? Would it be – would it represent, what we, I guess, what somebody once referred to as the whole patient level, like you're looking everything that could conceivably be associated or attributed to this patient with respect to that particular care, that particular measure. So, yes, to some extent that's correct.

David Kaelber: This is David Kaelber. Again, this is really helpful conversation. So I guess I'm trying to put it in the clinical context from my healthcare system. So, you know, in that example that you just gave, you know, I might be the primary care provider for a patient, but their mental health needs if they're depressed might be taking care of by community mental health because we don't have a lot of mental pediatric mental health providers. In this example, are we saying that, you know, it maybe that I'll have the diagnosis of depression in my EHR. For some of those children, I may have a PHQ-8 or PHQ-9 in my system. But for some of those children if the depression is managed by that outside psychiatrist or psychologist, that system would have the PHQ-9. And so, then, you know, presumably there would be – you're trying to measure that added interoperability, if I have, you know, that information from the outside PHQ-9. Is that the type of example?

Jason Goldwater: That's exactly correct, David. That's absolutely right. So you have information. That information is either pushed or pulled into the system in which the patient is receiving mental health and behavioral care.

David Kaelber: Yes.

Jason Goldwater: And then by grabbing that and for – getting that information from your system, adding it to the data in their system, they're enhancing the measure as a result of that. So, that measure then would require the data from the outside

source; so there maybe data your system has that theirs is not. That (by being) able to gather that information from your system and with the system and routinely making decisions and managing care, and then we would be able to better assess the impact on healthcare outcomes and processes because rather than that singular record in the community health system, they're taking that record of information and adding data from your system; either pull or push. You know, I don't know how it would work (inaudible) exchange. But, yes, that's exactly correct.

Male: So just picking up on that and sharpening a little bit. What David was saying is that sometimes it might be within the EHR, sometimes it comes from the outside source. Is this a binary question? Does it always have to be from an outside source? Can it – do we answer yes if it's sometimes available from an outside source?

Jason Goldwater: Yes, that's correct.

Male: So yes if it's sometimes. It doesn't have to be always.

Jason Goldwater: That's correct. But you'll see that it's graded one through three.

Male: Very good.

Jason Goldwater: So, you know, three would be it's always available, two would be sometimes available.

Male: OK.

Jason Goldwater: So, that's how you would score it. It's not a yes or no. It's the one through three because we realized there are – we realized there are circumstances where the data will be always be available and accessible. And then it's going to be times when it's not going to be at all, and then there's going to be times where it is episodically not routinely.

Alan Swenson: So that's for each of the individual domains. You've got the three domains and each one is rated one through three individually?

Jason Goldwater: That's correct. That's correct.

William Rich: Yes, this is Bill Rich. You know, I think that you have – looking at three domains you actually are dealing with the higher level of interoperability. I think it might be a good idea to have a couple of measures. We are really only looking at one data source because what happens if it disrupts interoperability is variability from electronic records for the same measure or the same specified measure.

So sometimes if we have a higher level of this and we look at the complex interoperability issue like you're using – you're going to miss if it fails. You're going to miss some of the basic problems that people have in transmitting data because the variability of data even will establish measures that are electronically specified. So I'd encourage the staff to think about a couple of measures. But you really only have one data source. It's not high level but it may be the cause of poor interoperability when you're trying to look at the hierarchy or the overlay of three domains. Just a thought.

Jason Goldwater: Bill, I really appreciate that, and I think we're all in concurrence. And I will assure you that it's going to be a major topic of discussion when we are in person because I think that's a very valuable component we all do. What these measures are – you know, we went over sort of the four new domains of how we're sort of shaping the framework. This is really dealing with just the impact of interoperability on the healthcare outcomes and processes, and that's it.

The other issues that you're talking about, that also fall in to sort of the use, availability, exchange domain. You know, those deserve a significant amount of attention, and we really want to leverage all of your expertise and knowledge about, sort of how's the best way – what's the best way of tackling that. What would be the best way of developing measure concepts around that to really start assessing that appropriately.

For this, since we already have measures that are already out there, this is just an exercise that they deserve from the standard measures that are already there and potentially endorsed by NQF or certainly have been used, you know,

based on this criteria, do you all feel based on all of your knowledge that some of these would be sensitive to interoperability across those domains with the understanding that the very important issues you brought up are ones that we're going to continue to discuss and shape the framework around. So I appreciate the question.

(Crosstalk)

Jason Shapiro: This is Jason Shapiro. The examples you give were very helpful. But I am still struggling trying to think of an example, for instance, where a measure would require outside resources to be available, but then they wouldn't be used. And conversely if they're not available then they could not be used.

So, you know, I don't know that it's a problem but they're really – the domains are not independent. So the (square one) is going to potentially, significantly affect the score in another domain. And I guess I'm just not sure how I'll handle that one when scoring.

Jason Goldwater: Well, I mean, one example, Jason, that I can give you and it was actually an example that was given during our interviews was, you know, individuals that have multiple chronic conditions and there are plenty of quality measures around those. And the individual that we talked to said it's very uncommon in their opinion, that someone with multiple chronic conditions just see it a singular provider, they see multiple providers. And as the sicker they are, the more providers are going to see and the more treatment they're going to need.

So that information may be in several different systems. But there are maybe a measure that represents multiple chronic condition. That measure has very limited utility or value if you only pulling from a single record. This – and, again, I'm not – this is not our opinion of the Interoperability team. This is the information we were given during the interview.

So, if then there was data available from of all those sources that the patient touched and treatment other multiple chronic condition, if that data could be then used to supplement the record with, I guess, the primary care provider and that would help facilitate decision-making, and then we could then use all

of that data to better assess health outcome or processes, you know, that's where the impact of that measure would be greatly felt, greatly affected by interoperability. And so, that's sort of what we're asking you to look out. If, you know, given the singular measure that you're looking at, what would the impacted interoperability be.

And in order to assess that appropriately, you really have to look at does it require data from more one source, would that data from multiple sources be used in decision-making and what would the impact be. And, again, I think we all realized to some extent this is going to be a little subjective. It's not necessarily going to be that there are some very strict scientific way of doing this.

But, again, you know, you all are on the committee because of your extensive knowledge and experience in interoperability, and many of you are clinicians. So, that would be very helpful to get these numerous perspectives on how you feel this measures would be effective. Understanding, again, that it's subjective we fully expect to get a number of diverse force, and we will be comparing them to ours just to sort of see, you know, what was the difference and then we'll have a final set of measures for you to be considering (what this all means) together.

Female: OK. Then can you give us an example of the case where it would be available but would not be – I think that's one that I'm just struggling with the most, like when would the availability criteria be hit but then you would say, oh no, that wouldn't be used.

Jason Goldwater: Well, I'm not a clinician. So, I'm making an educated guess here. But, you know, in certain cases with measures that might require the use of standardized instrument to assess patient status, you know, not all systems record that information; many of the major ones do but not all of them do. So there may be a case there where that information is not necessarily available and can't be used or there is information that might be available but isn't used because the systems, you know, the two systems are unable to exchange the information successfully. Maybe they are, you know, coming from a qualified clinical data registry and an electronic health record, and the formatting is

different and subsequently the information cannot be moved which would then prohibit the ability for us to be used even if the data is available.

If you feel – and, again, I can't look at all these measures and determine when and if that is possible. But if you – when you're reviewing this thing. Based on all of your expertise that the information maybe available but it's going to be unable to be used because of a variety of reasons that it will never – at this point, it cannot be – it's not interoperable, it can't exchange successfully, the information will not retain its (cemented structure) or whatever it maybe. You know, they need (to be) scored appropriately.

Female: Got it. OK, so …

(Crosstalk)

Alan Swenson: So this is Alan. I guess my question – my thought on that one is if it can't be exchanged, then I would argue that it's not available, right? The other system may know it, but if it can't be exchanged for whatever reason then is it really available?

Jason Goldwater: Right, Alan. I guess we're going to have to determine how we're defining availability. And, again, I'm not going to argue with your definition of it. I think our definition is that the data is available and there to be used in the measure then it's available. If the information cannot be exchanged to be used effectively then it's not going to be used. But if …

(Crosstalk)

Alan Swenson: So for the first domain then, you would be – I guess I'm just trying to understand how to – so does the measure require electronic health information be available from outside sources? So we would be saying, yes, it requires that'd be available. That doesn't necessarily mean I can actually get it. They just know it. They know the information.

Jason Goldwater: That's correct.

Alan Swenson: I require that someone knows the information I want. I may not be able to actually receive it, though.

Jason Goldwater: That's correct. If your opinion is the information is there but you can't get it and score it appropriately. Again …

(Crosstalk)

Jason Goldwater: Go ahead.

Male: Perhaps existence would be like the data exist is …

Alan Swenson: Right.

Male: … the better way of thinking, you know, that it's available. So, that, I was having the same problem. If can't get it, then it's not available to me, but it might exist.

John Bernot: And, Jason, this is John. And I can say since I was one of the clinicians that went through the AD measures or so that we did for the NQF side, and to the points there have made, largely the availability in usage did go hand and hand. I will say that on most of my scores. The vast majority they were the same.

There were a couple examples and this again was my interpretation. But one example measure I can give you where I scored those differently with availably potentially being at a different score than usage, we have an oncology measure that asks for the percentage of patients with the diagnosis of cancer who have some undergone radiation therapy to have a treatment summer report in the chart that was communicated to the physician providing care to the patient within one month.

So the availability of that summary report I scored whether that was available outside, but whether that summary report was useful to me, I gave a different score on the decision-making and managing care score for that one. So that was one example. But I will agree with the other comments that have been said that largely these have gone in line with if it's available, I do need to use it for that particular measure. I'm not sure if that helps or if that muddies the water.

Alan Swenson: That definitely helps from my perspective. The other question, I guess, that I have related to some of the comments that have been made is it seems like we need to have some sort of defined underlying assumptions to start from looking at these because a lot of this, you know, does the measure require electronic health information be available from the outside sources? That's only yes if I don't already cover everything needed for the measure in-house. You know, if I have for some chronic patient, if I have every specialty that patient is going to need already within my EHR system, then I don't need anything from outside. Whereas if someone answering that same question and all I do is primary care, then, yes, I am going to need information from outside.

So, that goes like one of the comments about some of them being subjective. But it seems like for some of these, there's going to need to be some underlying assumptions. Otherwise, the answers are all going to be entirely subjective based on what I do with my health system versus someone else answering how they do it with their health system and whether we actually need anything from outside.

Mark Savage: So that suggests the Kaiser example, too, right, whereas everything might be available at one place.

Alan Swenson: Exactly.

Jason Goldwater: All right.

David Kaelber: I mean there's a lot of details (at it) because even if you think everything is available where you are, the patient might have gotten care outside somewhere that you might not controlling and you still might want that information. The other thing I'd say because we're getting a lot of discrete data, there has to be some sort of temporal access. You know, for me to have availability of a PHQ-9 or allergies or medications that looked like they are three, four, five years old, I don't even want to look at that information even though it's available because …

Jason Goldwater: I understand.

Alan Swenson: Right. So I completely agree with that. I think that makes the first domain a little even more fuzzy, though, because if we say we're going to assume that the patient has been seeing somewhere else, like I cover everything, I have everything in health but my patient has been on vacation somewhere was seen somewhere else, then doesn't that make – does the measure require health information exchange or electronic health information be available for outside sources? Doesn't that make that be yes for every measure because we just assume if there is something available somewhere else regardless of the measure we would want to be able to get it. Otherwise, the other domains don't matter.

Jason Goldwater: Right. And I – this is Jason. I certainly understand that point. I think what I would ask is, you know, to think about looking at the quality measure theme was the ultimate objective of that measure is. You know, the metric is – that comes from the measure is to drive improvement and quality obviously.

So, when examining that measure, you know, would information from outside sources be beneficial in helping to populate that measure and create an overall better metric. So, does it require information from outside sources to do that? I mean you may very well, as you're going through these, say yes to all of them. And that's your opinion, if that's what you think. And, you now, that's just fine. It's not – again, it's not a process that is so rigorous that we're removing subjectivity. There's no way we will be able to that.

But what we would ask in terms of sort of framing this is in examining the measure given that the ultimate goal is to create a metric that drives quality. You know, would data from outside sources facilitate that process? So does the measure require that data from outside sources to do that.

William Rich: One final comment. This is Bill again. (I would hope when we sit down), and I appreciate the clinical work that's been done when we're down to 68 that there actually be some important process measures that are commonly reported, electronically specified but also some outcome measures. Some of those were electronically specified. And the data required is much more complex than some of the simple process measure. So, I would hope that we

have some (like prints) and surgical outcome measures because I think the level of interoperability in data completeness is much more demanding.

Jason Goldwater: Right, Bill. And this is Jason, again, and you're absolutely right. We do have a mixed of outcome and process measures and what you'll be getting.

William Rich: Great.

Jason Goldwater: But what I will say again is when we meet in-person, you know, there's going to be significant portion of that meeting that will be prescribing, so what isn't there. You know, what are the gaps? And, you know, can those gaps be filled by what exist? And if not, you know, what concepts can we develop that would facilitate the creation of measures to fill those gaps. So, you're absolutely right.

Any other comments?

Mark Savage: Jason, this is Mark.

Jason Goldwater: Hey, Mark.

Mark Savage: Under grading sheet, will there be something like a comment box where people can state …

Jason Goldwater: Yes.

Mark Savage: ... what they think as an important assumption made? OK, very good.

Jason Goldwater: Yes, absolutely. And we promise to read them, all of them.

Mark Savage: Do you promise to quantify them?

Jason Goldwater: Mark, don't get carried away. So, yes, there's comments. And, again, you know, if you have questions as you are doing this, please reach out to us. We will address each questions as they come in.

You know, I think what's exiting about having all of you on a committee is that you are representing so many diverse experiences; you know, whether it's

vendors, whether you're informaticist, whether you're clinicians, whether you're quality measure developers. You know, here at NQF, we've got a tremendous clinical team, and they all have significant background in quality measure development, which is, you know, why it made perfect sense for them to do the first round of review.

All of you have numerous experiences that really produce I think a lot of very interesting scores and answers. But inevitably what it will do is it'll drive us down to sort of a corset of measures for the framework that I hopefully we'll be able to reach complete consensus on our interoperability sensitive and could be used perhaps now or in the future to really assess the impact of interoperability on healthcare outcomes and processes.

So, I think that's what we're looking forward to. And, again, you know, I think we would all tell you there is no right or wrong answer. This is not where we're scoring. And, you know, we call Mark Savage up and tell him he's dead wrong and he shouldn't do this anymore. And we're not – it's not bad. You know, everybody's opinion is their opinion. And if you, you know, feel that none of these measures are interoperability sensitive that you get, that's just fine. That's what your scores represent, and you should tell why you scored it that way if you think a handful are, if you think they all are. Again, it's fine.

We really want to hear from you and what your opinions are because the framework that's going to be developed from this is going to be representative of this committee. And this is going to (inaudible) all of your expertise is driving with this framework will be because that's really what we need. It's what the government would like. And I think inevitably that's what makes the framework actionable because we don't want a framework that is just sitting there. We want a framework people are going to upload and use, and it's – the chances of that are much greater when you got the sort of breath and diverse experience doing this work.

Hans Buitendijk: This is Hans Buitendijk. Can I have a clarifying question, if I may?

Jason Goldwater: Absolutely, Hans.

Hans Buitendijk: And it's all this terminology that we're going back and forth. So just as a clarifying aspect. In some other ways that we talked about it, we are very clear about we are trying to identify the extent to which measures are sensitive to data in both (inaudible). On the other hand, we use terminologies such as fill in or does require. And I just want to make sure that those two terms might have a slightly different interpretation than being sensitive to.

I can continue to interpret that (where it) still uses the terms to fill or does require, when what we really mean is, is sensitive to. Is that accurate because they have a slightly different meaning? And we are going back and forth in the way that we talked about I want to make sure that I interpreted in the right direction.

Jason Goldwater: So I don't know if they would mean exactly the same thing. I think what I would say is, you know, if you're examining, so for example, the first domain in your opinion, does the measure require the electronic health information be available from outside sources to create or effectively have a better impact on the measure itself. Does it, you know, create a more robust quality measure? Does it help ultimately achieve the impact of expanding or moving healthcare quality?

So, I think it's – I don't think I necessarily would say is, you know, overall, we're looking at whether the measures are interoperability sensitive, yes. But basically, by breaking it down into three domains and essentially saying if you look at those measure what it really requires outside information from sources in order to be more effective. So, I'm not sure I would say those are the same side.

Hans Buitendijk: Well, I think the way you describe by extending the sentence for the question mark in the first domain, I think it clarified what I was looking for. And the reason is that in other parts, we have been talking at times about that the data that is interoperated actually contributes to the actual valuation, which is that it's just the (house) measure populated itself versus what it's sensitive to. So you clarified what I was looking for.

Jason Goldwater: OK, great. OK. Are there any questions that anyone has? We will, as Hiral said, send these spreadsheets by the end of the week. And we have a week to score them. If you have any questions, you're welcome to send us an e-mail, and we will do our best to answer them as quickly as we can. We got plenty of staff available to assist.

Again, I don't think it will take up a significant amount of your time. We did everything possible knowing how busy all of you are that it would not. And, again, emphasizing there's no right or wrong answer. This is really your experience coming forth and trying to give us, you know, your best assessment of what you think with respect to these measures and what the impact of interoperability will have on them.

Mark Savage: And, Jason, just to make sure I didn't miss something, end of the week meetings means end of next week, right?

Jason Goldwater: For you, Mark, it's Friday. But, no, I'm kidding. It's, yes, the end of next week, Mark.

(Crosstalk)

Mark Savage: OK. Thank you.

Jason Goldwater: And then we will compare what you have scored with the scores here at NQF, and then we'll probably come up with an average score. And then from that, we'll be able whittle down the score, the measures that we have into probably more final set of measures that we'll then discuss with all of you and determine whether we need to push that down even further to a core set that will be included in the framework perhaps to expand it or leave it alone. And then we'll talk about, you know, as Dr. Rich mentioned, what's not there, what are the gaps and how we fill those gaps.

OK. Well, if there are no further questions, we'll open it up for public comments. Operator?

Operator: At this time, if you would like to make a public comment, please press star one on your telephone keypad. Again, that's star one to make a public comment.

And there are no public comments at this time.

Jason Goldwater: (Go ahead). All right, well now, I'm going to turn it over to Vanessa for next steps.

Vanessa Moy: OK, so for our next steps, as we mentioned, we'll be sending you information on the measures score card that will give you in a few weeks. And, also, we'll give you also the key – the environmental scan reports for you to see before the in-person meeting, which will be held on March 21st to 22nd at NQF here. And I know the committee, there was an e-mail that was sent to you by members, how to register for the in-person meeting. And so you can click on that e-mail, and it directs you to a link where you can register in RCP for that in-person meeting. And after that, there'll be a webinar after the in-person meeting which will be held on April 5th, 2017. It will be just a follow-up to the in-person.

And just a little bit more, the next slide is the project contact information. If you have further information, you can e-mail us at interoperability@qualityforum.org and here's our phone number. And we update gradually our project page, which has – we'll post up the webinar slides that we discussed today as well as the transcript. And also you can access those materials through the SharePoint's website as well.

Jason Goldwater: And as we mentioned, you know, earlier, we are going to send off the key informant interview summary report as well as the environmental scan report to you all, and hopefully within the next week or so, so that you have time to review. And hopefully that will provide some good context for the meeting.

We'll also probably sending out some instructions about what to think about prior to arriving so that you already have, you know, some knowledge of what we will be discussing and have some thoughts ahead of time. We only have two days to talk to each other. So we definitely need to make sure we get the

most out of it so that at the end of the meeting the NQF team has a very good idea of the framework you want to create and that we adequately and accurately represent that.

So, as always, we thank you very much for this robust discussion. We really do appreciate all of you and everything that you're contributing. We're very looking forward to meeting many of you in person and getting to have, I think, what will be a very productive face to face.

So thanks all of you very much for your contributions. Thank you in advance for participating and scoring the measures that you received. And we look forward to speaking with you. If you have any questions please, don't hesitate to reach out. Other than that, thanks to all of you and have a wonderful day.

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