NATIONAL QUALITY FORUM

Moderator: Floyd Eisenberg
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Operator: Welcome to today's eMeasure Learning Collaborative conference. Today's call is being recorded, please stand by.

Female: You're in the main conference. You're good to go.

Floyd Eisenberg: Good morning. This is Floyd Eisenberg, Senior Vice President of Health Information Technology here at National Quality Forum and I welcome you all to a - what I think will be a very exciting day - our eMeasure Learning Collaborative In-Person Meeting.

I am very excited for the day. I've looked at - it seems to be a who's who of folks in quality management and electronic health records. And I welcome those in the room as well as those who are on the phone and on the Web.

We look for an exciting day with - we'll be describing not only the initial kickoff in the morning but there are five breakouts you'll hear more about later in the day. And we'll give you all the logistics for that as we go.

So as we go through the day, we will hear from our chair of the Health Information Technology Advisory Committee for NQF our HITAC Committee - Paul Tang.

We will then hear from a keynote - we're going to have a little switch in order from Kate Goodrich from CMS as well as (then) Farzad Mostashari who I don't think needs an introduction but I do understand in Washington, we always give introductions.

And then we'll give you some instructions for your breakout. So I think it will be - exciting morning and afternoon. Just a bit about what is an eMeasure Learning Collaborative.

It is a public initiative open to everyone (to deem) by NQF with HHS funding in order to bring together diverse stakeholders to talk about eMeasurement. We've all been in the process of looking at eMeasures being used in Meaningful Use (stage one) some proposed for - more than some proposed for (a) Meaningful Use (stage two).

And we want to look at what are some of the best practices, identify what are some of the key success factors that are happening in order to make this work and to move this forward because the whole purpose is to unobtrusively get data that's there from routine clinical practice to be able to evaluate performance and improvement in outcomes - that's where we're headed.

So what you'll be seeing as the (deliver) - what the deliverables of this effort are to identify those best practices, identify gap areas that need to be fixed soonest and even some that need to be fixed later but especially soonest. And develop recommendations for the future to expand and resolve the gap.

So as you go through and you'll hear this again later, your breakout in each area, what are the best practice examples? What are some of the key success factors you hear and what are the common themes in order to make sure that others can reuse those in implementing measurement and evaluation?

What are the mechanisms to enhance the data flow and workflow capability? What are the recommendations for a future health IT and how can we rethink how we do all this so that it works and that we really can improve outcomes, improve care, decrease costs, everything the National Quality Strategy is moving toward?

So I want to thank - I'm not going to read all of these names but I want to thank all of the planning group members. They've been working really hard and (are) very excited.

And I think almost all of them are here today. And I think they've planned a very good day for you and we look for continued work by this group so I thank them all.

What - okay so what I want to do is introduce the chair of our HITAC committee - Paul Tang who I think many of you know. He also - he has a - quite a history in Health IT and I think many of you are aware he also co-chairs the HIT policy committee, the Federal Advisory Committee. So we look forward to his comments inviting you to the Collaborative. Paul?

Paul Tang: Yes, thank you Floyd. And welcome to everybody. I'm just sorry I couldn't be there. I'm very excited about the fact that ((inaudible)) NQF is hosting and (HHS) is (funding this forum of stakeholders in) the entire quality measurement space.

So Floyd asked me to say a few words from the perspective of NQF - HIT Advisory Committee. This is an extremely important activity at a very important moment in time.

I think we all agree about that and I think the stakeholders in this room and on the phone are just the stakeholders that can make a difference in measuring and improving the (stakeholder) - and improving the quality of (health and health care) in America.

The health care industry which is support - I think by some very innovative federal initiatives that's going through a fundamental transformation. I think a (movement) away from this dysfunctional reimbursement system - (and) I think we all agree with that - that we have (a) - one that is based on a more rational goal for (improving) performance and outcomes.

To do that though, I think developing a robust quality measurement system upon which we build a performance-based system is the motivation for today's meeting. And the important part is the ongoing collaboration in this eMeasure space.

I think in some circles such as the work that Don Berwick did at (A) - IHI and (continuing the same message - always in pursing the triple aim) - better health and better care for an affordable cost.

But we've always been (tethered) to our paper-based information system that really left us overly reliant on administrative and claims-based quality measures.

And so people that are familiar with the reliability of (this) data - it's frankly not surprising that neither providers nor patients trusted the data or made choices based on those reported measures.

(So) I think what the successful EHR Incentive program in place led by ONC and CMS who we're going to hear from (and) I think our data desert is hopefully coming to an end.

But the data that we (make) - that make up the water in this desert is only going to be as drinkable and sustaining as the effort we take to (ensure) its purity and nutritional value.

So ideally, sort of like as it's shown in this diagram that Floyd is showing - the data would be used throughout the entire quality measurement supply chain.

It would stretch from the outcomes data used in randomized control clinical trials to the specifications in clinical guidelines to the data triggers that (evokes) clinical decisions (support) during (CPOE) to the functional outcomes reported by patients to the definitions - and (finally) to the definitions of publicly reported outcomes.

In that ideal world, as sort of NQF and the members that have been participating in many of the committees at the national levels that works in (this) - that work in the quality measurement space, the reference to data and the derivative measures would all point to some common data model so it would have (the) ((inaudible)) to deal with.

So (the) NQF's Quality Data Model or QDM is an example, I think, of an evolving national resource that could potentially play that sort of - (link) each role.

(And) NQF has also developed - you probably know - its first version of the measure (authoring) tool and that would help convert the measure concept in the QDM into eMeasures that would be consumed by EHRs.

So both the QDM and the measure (authoring) tool - I think will play information roles in a quality measurement (maybe) platform that can be leveraged across the entire quality measurement supply chain.

So I think this meeting's all about having all of us - the relative stakeholders in this quality (enter) - quality measurement enterprise - collaborating and sharing best practices as Floyd mentioned - to build the Quality Data Model and the quality measurement platform upon which future quality measures will be defined, collected, analyzed, reported, and ultimately paid upon.

So I think certainly we're looking forward to the outcomes of today's kickoff meeting and really enjoy the fact that we're going to have an ongoing collaboration involving everybody in this quality measurement enterprise.

So on behalf of (sort of the) NQF - HIT Advisory Committee, we're really excited about this collaboration and we're anxious to help in any way we can. (So), thank you, Floyd.

Floyd Eisenberg: Thank you very much Paul. And as Paul stated, we really look forward to a lot of good output from this (org) - group to help move this whole process forward as he had indicated.

So what we're going to do is have a little bit of change in order. We're going to start with Dr. Kate Goodrich presenting from the Center for Medicare and Medicaid Services. Kate is a Senior Technical Advisor to the Director of the Office of Clinical Standards and Quality and Chief Medical Officer for CMS.

She also provides leadership and quality measurement - oversees HHS-wide efforts to align measures across programs and is also CMS liaison with National Quality Forum.

And we've had a very - terrific relationship about how to move all of this forward. She's terrific to work with plus she continues to practice. I don't know how she does all (this) - (as a hospital) ((inaudible)) George Washington University Hospital and is (a) Clinical Assistant Professor of Medicine. So I welcome Kate and...

Dr. Kate Goodrich: Can you hear now? Okay, (and so I was just saying) - so I was working closely with Floyd and the rest of the NQF team at the time but the idea for this collaborative came around - so it's really wonderful to see it come to fruition.

My job for today is really to give you context for - at a fairly high level for how at CMS and even more broadly at HHS - although most of my remarks are about CMS - are thinking about our measurement policy, what our measurement strategy is going to be - particularly with the passage of Affordable Care Act, and the development of the National Quality Strategy.

This really afforded us an opportunity to really think through what our strategy's going to be in the context of a National Quality Strategy and I'll talk about that a little bit.

So I think as you all go forward with your discussions throughout the day, I'm hoping that you'll keep what I talk about in mind in terms of our sort of high level principles about measurement. I'll also talk a little bit about measure alignment which I think is really a critical component of what we're doing at CMS and across HHS.

And while most of my remarks are not specific to eMeasures, they are about all of our programs of which, of course, HITAC and Meaningful Use are a very integral part. And I'm - of course, we think, you know, going forward we'll be moving more and more into the eMeasures space.

So I think what I'm going to say is applicable to certainly all of our programs. So many of you are very familiar with the three part aim - so this - I want - the reason I have this slide is just to point out that for us at CMS and I think for all quality components of HHS - the three part aim is really what drives it.

I would say that pretty much everything that we do at (HH) at CMS and certainly within the Office of Clinical Standards and Quality - just every day comes back to the three part aim.

And we certainly have Don Berwick to thank for that - (who was) mentioned earlier. And his influence was tremendous in our organization. So this is how we think about everything we do

every day - better health for the population, better care for individuals and lower cost (to) improvement.

And I think over time, you will see that all of our measurement activities address this three part aim. We hope they do now but we think we can certainly even improve upon that. So Section 3011 is the Affordable Care Act - asked the Secretary to create a national quality strategy.

I imagine everyone in here is fairly familiar with this. The National Quality Strategy adopted the three part aim and also identified six priorities for the nation. And I do want to emphasize - this a national quality strategy - this is not a federal quality strategy.

And so we've seen really I think great interest in this - a lot of buy-in to what we came up with here and I say we - (well) this happened with tremendous input from the private sector as well with NQF (taking) the national (priority) partnership and all the public comments that we received.

So there's six priorities making care safer patient and family engagement, effective communication and coordination of care, promoting the most effective prevention and treatment practices - starting with cardiovascular disease and the Million Hearts Campaign that you all may be familiar with - is a big part of that, working with communities to promote (the) wide use of best practices to enable healthy living, and finally, of course, importantly making quality of care more affordable for all.

This is just a slide to outline to you all of our reporting programs at CMS - there's a lot of them. We have sort of divided them up into these buckets here although (you - I suppose) you could divide them up in other ways as well.

So we have as many hospital quality reporting programs, position quality reporting, post-acute care quality programs, payment model reporting. So (there it's a) ((inaudible)) (shared) savings program.

(ACO)s, hospital (value-dated) purchasing, and then population quality reporting which we - which we've - under that bucket we put the Medicaid adult and CHIPRA quality reporting program - the health insurance (of) - (changes). You are going to have a quality reporting (component too and is outlined by the law) and then (Medicare Part C and D).

So we have a number of programs and I think one theme that you all should be aware of - and I'm sure you are is that, you know, (one of the things) that the law afforded us is the ability to really start substantively moving from quality reporting programs into a value-based purchasing construct.

So we now - and that's important for our - how we are thinking about measurement. So we now have (an) - (in) - well we had our first (program) end stage renal disease, quality improvement program.

We, of course, also had the hospital value-based purchasing program and soon to come is the physician value modifier. And the law also required an analysis of post-acute care - value-based purchasing programs, which is important to Congress. But we do not have the authority to implement those at this time.

So I want to talk a little bit about an activity that has been underway for almost a year now at CMS that's really critical to our overall measurement strategy. So we call this group the Quality Measures Task Force. And its charge is to develop recommendations on CMS measure implementation.

Really the initial goal of this group - and I say - I would say the primary goal of this group has been to align measures across all of our programs. But I would say it's also to - and has very actively been working to align measurement policy across CMS.

The goal is very much to avoid duplication of effort which I think no one here would argue we've definitely seen over the years. And - so we are establishing an (operationalizing) policy for program specific as well as CMS- wide measure implementation and development.

I'll give you an example of some of our achievements there already. We're aligning and prioritizing measures, we are coordinating the development of new measures across CMS and then again, coordinating measure implementation development and (policies) with external HHS agencies.

And at the very end, I'll talk about a new group at HHS that is really trying to do much of the same type of work we're doing within CMS but across the entire department.

So this is made up of senior representatives from across CMS and I don't know if there's a - oh yes - there we go. So here you can see who's involved. It's run out of our office at OCSQ but involves the folks from Medicaid and CHIP - the Part C and D folks, the (CIO), the Innovation Center, MMCO is the new name for the Dual (Eligible) Office. I think it's the Medicare-Medicaid Coordination Office - lots of acronyms.

So basically what we've been doing so far - what we've really been focused on is trying to go measure by measure for each of our programs as we are writing our rules - as we go through our rule making cycle.

So with the express purpose - not only (of analyzing), you know, should a measure be in or out? And this is with (tremendous) input from the Measures Application Partnership as well but also, do our measures align with one another?

And I will just say don't expect by next year it's all the same measures and all the same programs. It takes a long time to do this. This incredibly hard work but we clearly are making progress on this which is really exciting.

So we also explicitly reviewed the MAP input on each of the measures that we review. Now not all the measures from every program went to the MAP this past year. For example, the Medicaid measures were not considered by the MAP. So we're thinking about incorporating that for future years.

But for this past year, it was primarily the - I think it's the Title VIII Program which is (the) - most of the Medicare programs. Alignment of measures is a (forced) function so we try to make sure that that occurs.

And at this point, it's probably more at the measure concept level although certainly in many instances (this is) at the actual measure level. And sample accomplishments are alignment of quality dimensions across CMS programs. In my next slide I'll talk more about that.

We felt that this was really key - a key first step to being able to actually align measures - is to (under) - is to come to consensus about what the dimensions of measurement should be.

We also have developed - (so) measure selection removal and retirement criteria that we plan to implement across all of our programs. We have been collaborating with ONC very closely on a day-to-day basis on the stage two rules. And the (QMTS) has been - members of the (QMTS) have been very involved with that.

And then finally we also - not only want to align and prioritize measures across our programs but also many of our national initiatives to primary ones being Partnership for Patients and Million Hearts. So this is what we affectionately call our Bubble Slide.

This is a representation of the six domains that we are going to be implementing for all of our programs. And you will see they look very familiar because they map really directly to the National Quality Strategy.

So they include clinical care, care coordination, population and community health, efficiency and cost reduction, safety, and person and caregiver (centered) experience and outcomes.

With all of these domains we feel that measures - we should be driving towards measures that are patient centered and outcome oriented particularly as we move into a value-based construct.

We feel like outcome measures are more important. The Board knows we have a plethora of process measures. Some of those, I think, are still important for us to use but we really need to be moving much more towards outcomes (stage measures).

We also recognize that we have a lot of gaps. And I would say we have a lot of gaps particularly in the five (gray) ones here. So I think one of our - one of the things that we are also (explicitly) talking about - not just internal to HHS but also with our private partners and other stakeholders - is how can we work over the next several years to fill key gaps within those areas.

And our work with NQF and with the MAP has been (in) - has and will continue to be instrumental in figuring out how to actually go about doing that.

You will see there are a number of subdomains listed here. Those are sample subdomains. I don't want people to walk away from here saying these are definitely the CMS subdomains because that is a - activity that we're undertaking right now - is to identify which concepts go under which domain.

And this is important because for some of our value-based purchasing programs, we score (our) providers based upon their performance within a (different) - a particular domain.

So what goes under which domain actually really matters. And we know that there are some measure concepts out there - or measures out there that could potentially fall under more than one domain. So we have to figure out how to deal with that.

And we also feel like all of (the) - measures concepts in each of these domains are common across providers with the exception, you know, clinical care - there's obviously specific measures for a specific (task) - provider. And we hope that over time - our goal is to get to a place where in all of our programs that we have core sets of measures that cross all of these domains.

We're definitely not there yet because of the problem that we have with (the) measure gap but that is our goal. And we think that having measures in all of these domains - again, on an outcomes level, is going to be what would drives the ability to actually implement and realize the goals of the National Quality Strategy.

We feel that quality can be measured - improved at multiple levels. Right now, most of our programs measure at the individual position or practice setting. So hospital, physician group, post-acute center - what have you.

We think that's still important but we think in order to again, achieve the three aims of the National Quality Strategy - that really - we need to be measuring at all of the levels including the community level.

We're obviously much farther away from being able to do that consistently across all of our programs but that is the goal. Again, we would like to have patient centered outcomes oriented measures.

And we believe that measured concepts should roll up which will allow or cascade is a word that we hear a lot with the MAP having cascading sets of measures - that will help us to align quality improvement objectives at all of these levels.

So just a couple of slides that (on) just sort of high level principles for us related to (quality) - performance measurement. Again, we want to align our measures with the National Quality Strategy in the (six) domains, implement measures where we know that we have measure gaps.

And - working hard to select the development of measures that matter and I think that's going to be a really important concept for this group - is to be thinking (to) that and we'll be looking for your guidance and other organizations' guidance on that.

Again, align measures across programs. Leverage opportunities to align with the private sector. This is really a focus for us for this upcoming year with the work of the Measures Application Partnership is to really, you know, I think get our hands dirty and really figure out how do we actually align with the private sector we're - that is a very high priority for us. We know it's a high priority for the private sector as well.

I think we'll get there. It's going to take a lot of hard work. And then again, a common theme - I've said it four or five times already, "Focus on patient centered measures and patient outcomes."

You know, we're - we definitely - we hear a lot from providers that we have too many measures and we would agree. We have a very large portfolio of measures. I think even NQF portfolio of measures is probably approaching close to 1000 so it's a lot of measures out there.

And we hear from our stakeholders - and we do believe that we need within our programs - (has very parsimonious sets of measures that matter). This is important also for developing core sets of measures and measure concepts.

There are going to be some of our programs though - and we have to balance this - where having a fairly large diverse set of measures is really important. So for example, in the (PQRS) program and for the physician value modifier coming up, there's many specialties out there.

There's some specialties out there for (who) we really don't have really even any measures or very good measures. So we need to balance that goal of parsimony with having enough measures within certain programs to address all of our specialties out there.

We would like to - the other thing that we've been very focused on is removing measures from our programs that are no longer appropriate. So as I said before, "We've developed measure removal criteria."

An example of that would be measures that we - that are (topped) out. And overall, the goal of our program is to maximize - (improve in quality) and minimize provider burden.

So since this is the eMeasure Learning Collaborative, I figured I'd have to have at least one or two slides on electronic (specification). So just a couple of - again of high level - of high level concepts here.

Our goals are to develop the (de Novo) measures that capitalize on the data captured (in the EHR) - to provide very clear interpretation and understanding of the (specification to presenters and providers).

I think this is something that we can definitely continue to improve on. But that is certainly something that we're very focused on and then work towards continued standardization of eMeasures to meet the needs of multiple programs.

And I think this is going to be somewhat of a challenge given the diversity of all of our different programs but I think we have to do that. The next step in eMeasures and reporting - so (continue) - so Floyd (referenced the) Measure (authoring) tool and as did Dr. Tang and also the QDM.

These will continue to evolve over time. I don't know how many of you are familiar with our CMS Measure Manager Blueprint. It's basically a very detailed step-by-step for eMeasure specification and eMeasure development. This has been updated to include the (HQMF) - (DSTU). And as that continues to (evolve), we'll continue to incorporate that.

One of the ways that that has continued to evolve is through our eMeasures issues group which some of you may have been involved with. Floyd has been very involved with this for us.

This is something that was started at CMS - I don't know - maybe a year ago now - I'm not sure - something like that - which is a forum for members of various federal agencies. Primary - primarily CMS and ONC but we've had other participation as well - measure developers, contractor.

Again, as I said, "Floyd has been super involved in this," to work through eMeasure standardization and related issues to some of the enhancements that we'll see to the (HQMF) (have) come from multiple discussions through this group.

Anybody's invited to come - anybody wants to - it's, I think, been a really - very successful group - very fruitful discussion. Obviously, alignment of the EHR Incentive Program with other CMS initiatives.

We are - you know, the law says that we have to align (our) Meaningful Use with (PQRS) and I think going over time, we need to continue - as we develop more eMeasures and have - and use electronic health records more in other settings for capturing clinical quality data, that we'll need to continue (to do) that as well.

We will be pilot testing transmission specifications and then finally over time, the goal is to integrate the eMeasure with other HIT functions such as clinical decisions support.

So I referenced earlier the sort of HHS-wide effort that is sort of the parallel to the Quality Measures Task Force that we have at CMS. So this is a new group called the HHS Measurement Policy Council. This co-led by myself and Nancy Wilson from AHRQ.

We have participation from pretty much every agency that touches quality measures. So this is really focused on measure alignment across the department but I would emphasize this is not just about alignment of measures.

And one of the discussions that we've been having recently actually at our latest meeting we had a terrific discussion about, you know, how much alignment is enough alignment because when you start - as I said before, "When you start sort of peeling back the layers of the onion of alignment, it is just unbelievably challenging."

But it’s also a tremendous opportunity such that we need to make a decision within, you know, across certain programs, you know, again, how much alignment is the right amount.

We don't want to let ((inaudible)) the enemy of the good, but we want to get as far as we can in order to reduce burden on providers and have sort of a coordinated national approach to measurement.

So, we have been tasked with - by the Secretary's office with aligning and prioritizing measures in about six areas, but we're starting off patient safety in cardiovascular disease, mainly because of the two large initiatives that we have, Partnership With Patients, (The Million Heart).

So that work has started over just the past few weeks. And the good news is as we start peeling back those layers we see that this is definitely possible. It's going to take some time, but it's definitely possible. Will be a step wise approach I think.

And then I think also very importantly for this group is that besides just alignment, you know, plain alignment of measures I think it's important for HHS to establish an operationalized policies -- measurement policies related to measure implementation and measure development. Getting back to that trying to reduce measure burden, trying to reduce duplication of efforts.

So, we will be tackling some of those thorny and difficult issues over the next year. It's a very exciting opportunity I think.

So I hope that this has given you a sense of what - where we're headed at CMS and at HHS more broadly. Again, I think this provides sort of a good context for you as you start your deliberations and discussions today. We will be very eagerly be looking to you and to see what comes out of this collaborative and just very excited that this is happening.

And I'm happy to take any questions. Although if they're detailed e-specification questions, then I have to look at Farzad and get him to answer for me.

Any questions? Okay. Good.

Floyd Eisenberg: And so, thank you very much ((inaudible)). This is - I really appreciate and I'm sure everyone else appreciated the direction in which CMS is headed. So this is very helpful to the group.

And I want to introduce our next speaker who probably goes without introduction, but I'll introduce him anyway. I have to say my first introduction to Dr. Mostashari was when I was working in his HITSP with one of the leads of the Public Health Data Standards Consortium who speaks with a Russian accent.

So everytime I hear Farzad's name, I hear it in Russian in my head. And - anyway, let me just give it an introduction. Obviously many of you are aware, Dr. Mostashari, the National Coordinator for Health IT and runs the Office of the ONC.

His - he did a lot of work there in the past and recently became coordinator. You're the fourth National Coordinator. Did I have the number right?

Also, previously worked at New York City's Department of Health and Mental Hygiene as Assistant Commissioner with some key projects leading CDC funded New York Center of Excellence in Public Health Informatics, and AHRQ quality funded project on quality measurement at the point of care.

They have a lot of experience working with vendors to get data for public health and reporting.

So we look forward to his comments, thoughts.

Dr. Farzad Mostashari: Thank you. I don't think I have any slides, so I'm just going to - just going to talk. It's, you know, that interesting hearing the introduction and remembering the HITSP days and remembering days of leading this initiative, that quality measurement at the point of care.

And this was about five years ago. Five years ago. And I'm sure many of you have been doing this a lot longer than that, thinking about how do we use electronic health records to measure quality -- measure quality continuously. Measure quality as a tool for improvement, not for accounting.

And it seemed five years ago, so close. Oh, there's just a few things we're going to do. We just need a common information model and a universal query language. And we just need to get the plans on board to pay for EHR generated quality measures. Oh and yes, we're going to drop these quality measures into these different electronic health records that are commercially available.

And you know, we'll do it in the course of a two-year AHRQ funded research project. How many of you have gotten grants like that?

And it is sometimes discouraging when we look at all that youthful or naïve optimism that we can change systems, big systems, $3 trillion systems through individual action in spots throughout the country. That we can turn quality measurement, engine that has generate precedence. And we can just change it?

And many of us have learned painful lessons about just how damn hard it is to change systems when you're only holding one part of it.

When the system resists, when the system has six heads, trying to change classes without changing payment, trying to change payment without having information tools and the delivery systems to be able to carry that.

But the good news is that we are now perhaps uniquely at a time and a place where the pieces, where those strands are actually coming together. And I don't think this is more youthful optimism, so I'm not so young anymore.

I actually feel like it's going to happen. And it's happening now. And it's not going to be this year. Okay. It's not going to be this year. But it's not going to be ten years from now either.

But the pieces are falling into place. Well let me review a little bit what were all the problems that we face, and why do I feel optimistic.

One of the - that we were trying to propose, right? That payment be based on quality measures derived out of electronic health records and that those quality measures be the same measures that providers see and use and own as part of their own practices, for their own medical record. There're even two concepts of quality measurements going on.

One that you do for improvement and one that is done unto you for payment, right? That's the idea.

So what we're - first of all, how many of you here in the room, and I think we have two people online, who we can't call readily, right? How many of you in the room here had ever actually generated a quality measure out of your electronic - your or somebody else's electronic health records? Right? It can be done.

How many of you -- keep your hands up -- how many of you have ever been paid on the basis of those quality measures? I see a little ((inaudible)). Maybe one person, two people have their finger defiantly up in the air.

So, what's the problem? And let's take a second to think about this. Because of HITAC, because of meaningful use, and a note about this. When Congress wrote the passage that said, there will be meaningful people who get paid for meaningful use of electronic health records, they didn't micromanage what meaningful use should be. Thank God.

But they said, meaningful has got to include through - only three things that they said including. And one of them is quality measurement. I think that was a pretty important signal about how important it is that electronic health records carry with them quality measurements.

Now, one of the problems we had back in the day was health plans would say, "Well listen, I can't pay differently for being in charge to generate quality measures which even if everything was perfect I can only get from 10% or 15% or 20% of all the providers." Right?

We have to have our system that are based on claims data because we get that from everybody. And they would say, "You know, it's going to be a long time before most of the people who are in my network are going to be able to generate these quality measures."

What? That's changing. We went from 20%, 17%, however you want to measure it, right? Double, triple in the past two, three years. By the end of this year the majority of healthcare delivered in this country will be delivered through electronic health records that are certified. Period.

We will have tipped the scale, yes. So that's speech one. That happened. That's a massive trend. And is the thought that two, three, four years from now, 2016, what are we going to do then? It's going to be the rare provider who doesn't have an electronic health record.

Are we still going to be doing chart for years? Are we? Really? I see some people saying, "Yes, we'll still - yes, we're still going to be doing cartridges."

And put another way, what do we have to do so we don't have to keep doing chart reviews? You have an electronic health record that captures a consequence of care, all these data, the blood pressures and the diagnoses and smoking statuses and medications, and we're still going to have - do chart reviews) on a sample of the patients who generate quality measurement for accounting purposes that actually doesn't help me in my practice today, figure out who doesn't meet the criteria so that I can improve care?

Are we still going to be doing sampling? Not census? So what do we have to do to get to that point? I think the way we approach -- the (ONC) approach - challenges is to think about some of the principles for action. And I'm going to tie each of those five to one principles to what I think are the priority things that we need to do together.

Our first principle is, open inclusive processes. And that's what this is. Right? We're not going to be able to solve a problem on our own, we're not smart enough. And I remember being on the outside, feeling like I have something to add here, to the national conversation and there was no way in. There was no way to take the work that I had done, that I thought was really important and get that heard.

And we need those bright lights, we need the perspective and we need the advice, and we need the collaboration because we can't do it alone. We're not smart enough. We don't have enough money.

So that's what this is. The goal of today is to find people who have done it, who understands deeply what it takes and not just the challenges but how to overcome those challenges, and to use our inpatient community role to accelerate -- accelerate consensus, accelerate belief that we can change. That's principle one.

Principle two is eye on the prize. Eye on the prize generally means what - you're having a very, crisp, clear view of what is the future that we're trying to get to, that North Star that we align to, and doing everything with our eye on that ultimate prize.

And the pictures that I started with of a world where people not only have electronic health records but the quality measurement comes out as a natural consequence of the care processes, that those quality measures are used for improvement purposes that every second and every provider sits down next to a patient they know how well they're doing, what this patient needs, that decision support is linked to quality measurement, that population health management, and there're lot of talk of population health management today.

That population health management is integrally linked to quality measurements. That's the vision. But this also means something else in this context. Eye on the prize also means focusing on what matters.

And when Kate talked about the six domains of the national quality strategy, when she talks about prioritization, when she talks about (Million Hearts) in partnerships with patients, that's eye on the prize. That says, you know what? We can't do everything. Providers can't do everything. We can't focus on 140 issues at the same time.

We need a focus. We need prioritization. We need to say, start here based on some principles. We need some parsimony. Why is parsimony never valued?

So eye on the prize says, you'd start with questions like, what kills the most people that we can improve to save more premature deaths? Start there. Right?

I think we can get providers and health plans and purchasers and payers and government behind the concept that maybe we shouldn't kill people, that maybe- that maybe that maybe the goal of healthcare should be to get them healthy.

And it's astounding how few quality measures we have that actually get at those domains of the national quality strategy. Because we took our eye off the ball. Because as we were developing thousands of measures, we didn't have to question what is the single most important measure if we're going to be trying to impact care coordination?

It's not just looking under the street lamp where we have data. It's not like that. I ((inaudible)) keep getting our eye off the ball. Eye off the prize.

If we look at safety out-patient context, what's probably the single most important thing that we could do, outpatient safety probably medication-related, right? Medication related. What's the measure we have? And appropriate drugs to the elderly.

What percent of all ED visits among the elderly are due to those 100 plus medications? What percent? Important question, isn't it? If we're thinking about outcomes, I was talking to a colleague at (CDC) about doing surveillance for adverse drug events and he said, "Well, the kinds of stuff that you guys are doing, I don't think we see it in the data about ED visits."

And I thought to myself, what was the four letter word? Right? We should start there and say, if we want to see an impact in the big picture surveillance numbers for ED visits for the elderly, what should we be measuring and moving?

And what is it? There's one call for 33% of all ED visits among the elderly's emergency room from adverse drug event. Thirty three percent for this one cause, 3% for all the other inappropriate drugs for the elderly. Three percent.

We do a great job of that measure; we've reduced ED visits among the elderly by 3%. Max. But there's this other thing that accounts for 33%. You all know it. What is it? What is it?

One medication I'm thinking about it. Coumadin. Medical management if Coumadin. Is an (INR) in range? Where's the quality measure for that? Where is it? There is not an NQF endorsed measure for approach in dosing of Coumadin. Not one. Or insulin, number two call, hypoglycemia.

And it's irritable. Why do we have an electronic health record that captures your medication, it captures the (INR)? It's the (INR). It's normalized.

What the end means? Normalize. Right? So we took our eye off the prize. We do things and go down the list. Care coordination. Did you close the referral loop? I am - I can't tell you how frustrated I am when we hear about, well this measure's not appropriate for me.

And if you did a referral, if you get a referral, did you close the loop? Is there room for improvement in this measure? How often do we close the referral loop? How often in this country? Flip a coin. Fifty percent. Half the time. Half the time. There's room for improvement. Right?

Do we have a measure for closing the referral loop? Do we? No. We don't. Do we have fifty other endorsed measures? We got those. But we took our eye off the prize. So when Kate talked about

developing measures, priority de novo measure developments, that's what we have to go after. That's what we're going after.

And actually you know what turns out? Someone did develop a quality measure right out of an electronic health record for Coumadin. VA. There's one agency who's done it. They've actually done it.

They've done it and they're doing it and they're - it worked. And they're rolling it out to other people. They just never thought, what if anyone cares? To move it out into the broader indoor space? Because sometimes it's not.

Doing a de novo is taking something that already works that someone like you has been working on. And if you look at what you put into electronic health records, and it addresses core areas where we have gaps, like care coordination, like patient safety, like patient centeredness, we need to hear about this, part of this project. So eye on the prize.

Principle two, feet on the ground which says, we got to keep one foot where we are today. Not two feet. Not - anywhere we are today, but be one foot where we are today and step forward be somewhere where we are today. Live in the real world, which means incrementalism.

But let's be bold about incrementalism. And sometimes you need to pivot. Pivot means you keep one foot down and you move direction but you know where you're trying to go.

So building on what exists today, not assuming that we're going to have a clean sheet of paper and we're going to stretch out the ideal health care system of the future and we're just going to get the direction. No, we have to build on what we have today step by step but let's be bold about it.

Principle four, use the market. Use the market. And you know, I hear a lot of them, the national coordinator for Health IT, a lot of peer - a lot of people tell me, why didn't you just build the system and roll it out to everybody? UK tried that.

You know? That gets also back to, you know, feet on the ground. We are a country that believes in the power of the free market. The power of effective and efficient market, innovating and creating competitive solutions that we couldn't have done on our own. Right? The massive engine that's out there turning and it's creating this movement towards electronic health records is motivated by profit and there's nothing wrong with that.

But sometimes, it needs to be channeled, led, a context created for what we're driving the markets are - that the big engine of the market is driving us towards.

So we use the markets, we're smart about that. We understand how capitalism works, and we embrace how capitalism works. But it doesn't mean that it's a game where the odds are rigged, where the public benefit is forgotten about.

And that's the role for government is to make sure that the policies we establish are one where they create a concept where the markets work to the public benefit, that the markets actually can work efficiently and effectively, that there's transparency. Markets can't work without transparency.

Resolve information asymmetry. Use the market.

Five is watch out for the little guy. We're open to all.

There's a lot of work that's been done, and unfortunately the smartest people in the world get in a room and they build things that only the smartest people in the world understand. I'm looking at you Floyd.

And so, valuing simplicity and building systems so that the least able can participate is a principle that we bring to the work we're trying to do, which often means ((inaudible)) (Steve Poznak) our reg writer, don't be too clever.

Sometimes you can find solutions that have 24 exclusions to meet every person concerned about that, but maybe ((inaudible)) better. Maybe not having those 24 exclusions, not expecting that you can find the data for those 24 exclusions in the electronic health record is better.

Maybe having a manual override that just says, excluded for patient. Means ((inaudible)) medical reason is better. It's not worth - it's not a get back to step forward. Maybe simplicity is a virtue. Maybe parsimony is a virtue.

And the last principle is watch out for the little guy what calls is the prince among principles is putting the patient in the center. And this has a lot to it. It's about the point of what's it's all about, right? It's about yes, we should talk about patient centeredness as an independent goal for some quality measurement more profoundly I think. It's about the patient's voice too.

We've forgotten a lot and we're playing catch up frankly on that. And it's not just as a way it gets frankly minimized as patient - is the patient satisfied? That's not what I'm talking about. I'm talking about if the patient doesn't feel that their care was coordinated, you know what? It wasn't coordinated.

Someone told me about a study where they - as they correlated - maybe the one who did the study - they correlated the patient's report of cleanliness in the hospital with hospital infection risk, it's a pretty good correlation.

So the patients voice, I'm talking about functional measures, I'm talking patient safety, I'm talking about patient care coordination, I'm talking about patient experience. And not just for a sample of patients who are mailed something. As an active tool for managing patient care we don't have systems right now to do that, and we need to get that.

So we could use multi-modes, you know? A lot of our patients now have these things in their pockets: Smartphones, text, they access the internet. And to use those - sort of getting - broadening the range of ways in which we interact and engage patients.

So there's a lot that we have to do, but I think if we keep to those principles we will get through this ((inaudible)) calls it this biggest barrier to health care changing; which is a product of long disappointments like I talked about at the beginning.

They have lead to a wall of disbelief that health care can change. And in many ways the biggest barrier to health care changing is that wall of disbelief that it can change. And I'm here to tell you that that wall is paper thin. Because health care is changing because the tools are there, because payment reform is here; and it's not going away. We're not going to be paying fee for service 10 years from now. It's not, we can't afford it. It's not going to happen.

Health information technology is happening, it's here. And patients having tools to engage differently in their care is happening, it's here, it's not going away. And it's up to us to take those three strands and tie them together, twist them together into this new DNA for health care.

And quality measurements out of electronic health records is the absolute key to it's heart of that new health care system. And we can't fail. Thank you.

Floyd Eisenberg: I think there's time for questions.

Male: Yes, you're one person who's been picked, first of all introduce yourself and tell us who's paying you for EHR-generated quality issues.

(Crosstalk)

Male: Oh your own health system.

(Crosstalk)

Male: That's a step. That's a...

Male: ((inaudible)) technology.

(Mike Mirro): (Mike Mirro) I'm a practicing electro-physiologist involved with day-to-day HIT-hand-to-hand combat I would say. So very nice stuff, talk philosophically, but my question to you, first of all our health system pays us a bonus quarterly based on submission of data through a ambulatory registry called Pinnacle.

Male: Yes.

(Mike Mirro): I also represent the American College of Cardiology, been involved with cardiovascular medicine for some time, so one of the problems that we see at the ground level is although these are very lofty goals is the systems that are in place, the vendors community...

Male: Yes.

(Mike Mirro): ...most of the solutions although they're certified they're not usable. And so there's no usability metric for positions, and this is particularly apropos to the smaller practices...

Male: Yes.

(Mike Mirro): ...and are challenged with selecting a vendor. In cardiovascular medicine most the physicians have been driven into health systems now being employed so that they're forced to use - de-install functional systems and actually use some legacy systems that although certified, are not usable.

Male: Yes.

(Mike Merrill): So I don't know...

Male: If this is a single issue that I probably hear the most concerns about from practicing physicians, is the usability of the systems. And one of the most disheartening things for me, was when I - two different electronic health records and there is now hundreds of options. And I see the extent to which they have not valued usability in their design.

So if we're talking about data collection for quality measures as one example, the easiest solution is you put a check box in, right? I have a data element here; the hard way is to collect the data as the exhaust of health care, right? Put it - that data element - in the right place in the workflow, sometimes to get one measure there are five different data elements that have to come from different people at different times in the workflow, right?

And what is the easy way for the vendor to do it? Make a check box that requires the provider to essentially do a chart review, and then check the box to measure the quality measure. That's not going to work, right.

So the question is - the observation is dead on. The question is how do you move from there? How do we move from there, how do we get usability to be valued? And I got to believe that the market has a mechanism for this. We buy this brand of Smartphone over this brand because we perceive that it's more usable, and usability is driven by the market where the market works efficiently.

Why in this market do we think usability has been slow? I don't think it's not happening, I think there is more and more attention to it, but there could be a hell of a lot more attention to it on the part of vendors then to adding the latest gadgets. I think a couple of reasons explain it.

The first is oftentimes the consumers are asking for bells and whistles, not usability. They're asking for more widgets and more things that are specific to them, rather than a simplification and a focus on usability.

So if I'm a vendor - and I know some vendors very well who want to do the right thing by their customers. And they say to me, I have 600 requests for additions to my health records and I have newer requests for subtractions, in fact every time I take something away, there are people screaming that I liked that easy way of doing things because I'm used to it, usability ((inaudible)).

The other thing is there isn't information available for people to make their choices. I have heard so many physicians who say to me, I didn't know what I bought until three months after I bought it.

So having transparency around usability is the first step, so that when someone buys a system they can look at costs, not only future functions costs, but also usability measures. And we're working to develop those usability measures, working with this and the industry stakeholders to have some transparency around that.

The other problem, frankly, is that oftentimes the decisions to purchase the system are not made by physicians; they're made by the CFO, because we already have a contract with this vendor because of their practice management.

So that also, I think is a call for physician leadership in these domains. But I'm not, I don't need cope with that, I actually think that there are now vendors who are doing very well in the marketplace because they value usability. And these are going to be the vendors that succeed in and efficiently function in the marketplace.

Mike Mirro: Thank you, you're spot on with the comment on that. The typical decision maker is the CFO. Even in the smaller practices it's a, you know, the ultimate decision on what vendor to select is based on billing charge capture because we're in a ((inaudible)) environment.

Male: Yes and when that changes all of a sudden, one of the things I've heard from the chief medical information officers is as we start getting into accountable care and improving quality, all of a sudden I have a seat at the table, that we didn't have before. Thank you. And cardiologists are leading the way on meaningful use, thank you.

Male: Very good talk of course, definitely expect that from you. But two things come up here. When the ATO regulations came out with quality measures, as opposed to simplifications we got all those exclusion criteria on the measures when it comes to looking at the quality measures.

So now the regulations are actually instilling complexity in the collection as opposed to simplification. So now we're going to have another update on EMR vendors where they go in and they put in check boxes that are required ((inaudible)) ATO collection driving their providers away.

The market analogy - the other thing is the market analogy that you talked about, one of the big keys for that was when we had number portability between our carriers.

Male: That's a good point.

Male: And we can't take our data and move it to the best new offer next year. I think those are the opportunities...

Male: Yes.

Male: ...where I would say the government has to play a better role and I - I'm not meaning to...

Male: No, no, no, listen, we have a proposed rule out for Stage 2 certification criteria which says that to the extent that it's feasible today, we think the most feasible thing is to take consolidated CD efficient care summary and do that over every patient in the practice and get a batch of CCBs out of the - one health record for portability reasons. We're going to hear a lot of pushback from people who say it's not enough, it's not good enough or it was a security risk, or whatever but if you think that moving on portability's important we need to hear from you in the commentary by May 7th ,through regulations.gov.

We have proposed it but if there's not support for it, it's not going to be in the final regulation. Portability's really high switching cost of practice cause a monthly failure and we're trying to see what we can do to address that.

Your point about APO rule, and I mean any rule, right? Is - the problem is the tension between the tried and true today and where we know we have to go. So, you can be sure that there was plenty of discussion within HHS and within the administration as a whole about the quality measure component of the APO rule and we tried very hard to align.

And there is a great deal of alignment actually, between those measures, between meaningful use measures, the in-patient quality reporting, and the physician quality reporting systems, and this is something - one part of the problem is the cycles of rule making. Before you can incorporate one new quality measuring in this cycle of rule making is going to come out of this cycle of rule making.

So my hope in working with (Kate) and others is that we can start to wrack and stack these alignments. So that many cases the vehicle used ((inaudible)) program can be the point of this here introducing development and deployment of new quality measures that are smarter, that do work better within electronic health records ((inaudible)) burden and then the payment and transparency programs can follow in the wake of that.

Male: Just a last compliment, it's only because you improved the quality measures ((inaudible)) care about it. Whereas before it was just so burdensome that nobody was going there.

Male: Yes.

Male: So I mean it's nice not worrying about it now because it falls...

Male: We should have such problems, as my mother-in-law says.

Male: Thank you, always a pleasure to hear you talk. Your lack of enthusiasm it needs to improve, but...

Male: Only you laughed.

Male: I think ((inaudible)) should help you out. I am CEO group and we've been doing this ((inaudible)) for five years. I want to say two things and get your comments. In the May 2010 New York Times on data-driven life. I won't summarize that but if you go to May 2, 2010 you ought to read it. ((inaudible)) emphasis (((inaudible)) O'Neil) made the following comment: I'm going to quote it. I'll read it because I can't quote it.

((inaudible)) admirable rhetoric the real focus is on Plummet's Indicators chosen for ease of measurement and control rather than because they measure accurately but the ((inaudible)). Probably the most challenging thing to these measures is that the processes that result in improved health. And the metric set demonstrates outcome metrics that demonstrated improved health which will result in decreased cost which really addresses sustainability which is the triple-aim.

And I'll restate it saying improved processes, improved outcomes in a sustainable fashion which is just...

Male: Yes.

Male: ...another ((inaudible)). Is that it may be a five step, and you already said it, a but a five step process that doesn't resolve to a single measurement but it can be aggregated electronically if it's thought through...

Male: Yes.

Male: ...and the process without the provider having to check a box.

Male: Yes.

Male: Or an outcome that is a multiple data-driven issue that can be aggregated electronically. But we've got to have the endorsement of these metrics and you - I wanted to comment on that - but I wanted to say one other thing because I won't get another chance.

You ask how can we get past these issues of chart reviews, I love NCQA but they refuse to accept electronic data for medical home, for diabetes recognition, and all these other things they demand that you have a subset of the whole rather than a - the whole being the subset. We can give them data on 8000 patients with diabetes, they want 50, but so about...

Male: Yes.

Male: ...the complexity and we've got to address that because it's possible to address it.

Male: Yes, I think you make great point about the different ((inaudible)) quality measures and ideally have they're linked to each other, so quality measurement and accountability and quality improvement.

There may be - I was talking yesterday in Milwaukee with the leader of an HIV practice whose implemented outcome measures around viral load in their electronic health records. And so then the bottom line is of all the patients with HIV how many are on medication due to an undetectable viral load? And he said that he asks HIV practices in the leading institutions around the country, "What's your rate?"

You're an HIV clinic you should know of all your patients how many of them are on meds with an undetectable viral load, right? Everybody should know that. Every plan should want that, right? And he said, "We benchmark institutions around the country say, I don't know."

The other point he made was that's the outcome - undetectable viral load, unmet. But he said to get to that outcome, there's like 10 different process measures that he also tracks. The patients come in for the visit. Are they lost or followed? Okay well we have an intervention for that process. Right, we go out and we reach out and find them and bring them back in.

Are they on the meds? Did they fill the prescription, right? That's another process measure. If they're on the med are they on the right med, if they're on the right med is the viral load responding? Have they had genetic tests done?

There's like 10 different processes if you can get optimized with different process measures they all add up to that big outcome measure. He needs to own those process measures. And for benchmarking, accountability, and reporting because we need to know the bottom line.

So there's this different between process measures for quality improvement and outcome measures for accountability and the two need to be linked to each other. But we don't need to duplicate the process measures, I think, I believe in our accountability.

(Larry): ((inaudible)).

Male: That may be your process measure.

(Crosstalk)

Male: Yes.

(Larry): ...in fact to accomplish that ((inaudible)) simpler, easier...

Male: Yes.

(Crosstalk)

Male: For those on the phone, Larry's talking about making the processes easier so that's the right thing to do, the easy thing to do is the right thing to do. So ((inaudible)) linked to make things easier and protocol.

Male: Okay I'm getting the hook.

Male: First of all I want to thank you, that was terrific and I think the best short we can have for today. So let me just make a couple comments that I think - when I called to give this charge to you folks the first thing he said to me, "Where did you find the bright lights?"

And that's the whole purpose of today. We've seen challenges, we've also seen what happens when you take a measure intended for a claims-based process and try to find that data in the EHR, what we found was people who answered it in a claim using say a CPT-2 code, now have to enter a check box.

So that didn't really change anything. So what we want to do is move forward to outcomes. The - it's the VA measure you referred to work with. It's terrific there are challenges, in how do I say it in the standard, how do I put the logic in?

So what I want all of you to think about is, as you go through today, you're going to go your breakout in each of the areas, and Rosemary Kennedy's going to come up and give you the charts for each of those areas, how can we get there? And how can - you're going to listen to vignettes of bright lights in each of your areas.

How can we, what are the key success factors to make that work? And how can that seed where NQS is now moving to outcome measures? Not looking at process but the leading process to get to the outcome. How do we get there? And electronically how do we make this directly queriable.

So, you're going to hear now from Rosemary, so thank you very much, I'm sorry we couldn't have longer questions, but keep them for the day.

Female: How about this?

Rosemary Kennedy: Oh that's better. And good morning everyone, I think we should just give a round of applause for Dr. Kate Goodrich and Dr. Mostashari. For those inspiring words to start us off today. I am Rosemary Kennedy and new National Quality Forum Vice President for Health Information Technology, and registered nurse, and also associate professor and practicing at Thomas Jefferson University, Philadelphia.

So, and this is an exciting time if you think about it, it's the first time that we've convened measure developers, providers of care, standards organizations, and health care providers, vendors together in one forum. So what I'm going to do is walk through our message for today and our work.

And I promise this will be short and brief, we'll just spend the next five minutes and kind of go over what we're going to do today, and then we'll break out into our groups.

There are basically five major groups covering the key domain areas of quality measurement. There's the implementation acute group, and the implementation office based practices. Both of those groups will be looking and center on the (Clinician) interface. Much of what you heard this morning in terms of data capture, workflow management across the domains of acute care and office space practices.

There's a third group that's the technical group, and they will look at data and format of data, and the structure and everything that's needed for quality measurement, looking at it from a technical perspective, focusing on the – QDM and focusing on health care and measure format.

Also then there's the clinical data analytics group. This group covers the complex domain areas where data are collected, scrubbed, analyzed, and using that data for aggregation and looking at outcomes. So that's the clinical data analytics group.

And then last there's an innovation group, thanks to input from our planning committee in (HITAC) we added the innovation group to really rethink at the whole area of electronic quality measurement and look at some innovative methods and ways that we can approach the problem space areas.

I just at this point want to thank our track leaders if anybody in the room is a track leader if you could please stand up, they really worked extremely hard to help us put the content together. And if you think about it, this is really important because...

And the breakout group presenters if anybody is in the room and if you're on the phone you can stand up on the phone and we'll give you a round of applause because the breakout group presentations refer back to the best practices examples of what's going on in the market today.

And I think this is really important because all of the group track leaders and the vignettes represent all domains of the market that have come together to make this a success.

Now we'll get into the breakout groups, and each group is a different color as you can see here on the screen. So I want the two groups that have signed up for implementation acute and implementation office space practices just for now to stay in this room.

Before - oh one more - And clinical data analytics will stay here as well. Okay thank you (Beth). I just want to say that if you end up going to a different group - just a housekeeping item - lunches will go to the room that you're in for your breakout group, so if you switch groups, please just let us know so we make sure that we get you lunch at the appropriate time.

So those that are in - part of the technical group will go with Floyd Eisenberg, I think we all know who Floyd is. So when we break if you find Floyd Eisenberg, Chris Millet? Chris raise your hand - right there in the back of the room - and he will help get you and Ahmed here will get you to your breakout group.

The clinical data analytics group will go with Beth Franklin, Beth please stand up, wave you're arm, blue group, so if you look for the color card, and that's the group that you should go to; so clinical data analytics is blue.

The innovation group will be coming with me or Beth Carey, Beth Carey where are you? Keep your arm in the air and as well as Lindsey. So what we're going to do now is we will break into our groups.

Work will be conducted within each group from now until about 2:00, 2:15 - 2 o'clock. And then we will reconvene in this room which is very important for - to summarize the work over the next four hours. So at 2 o'clock we will reconvene in this room.

That's okay we will just guide them (Christina). Thank you very much.

Female: Just an announcement everybody needs to more or less at this point vacate this room so we can set it up for the breakouts.

Female: Good morning everyone in case you didn't hear the announcement earlier, we need to reconfigure these rooms for the breakouts if you would kindly make your way out of the room to your respective room. If you're back in here, if you would step into the hallway we'll let you know when the rooms are ready to reconvene. Thank you so much.

(Janet): ...that we all very much want and it's absolutely critical to deliver high quality, cost effective care. I'm just very, very pleased. I want to thank our federal partners for providing start-up money for this activity. Floyd tells me we have one more in person meeting and we have a webinar and we'll be thinking a lot about how to keep this going long-term. This is not the kind of collaborative that should only last for a few months. We need this to be going on for several years now that we've really got the right people at the table.

I also want to take just a minute to thank (Paul Tang) and the HITAC committees and also, very definitely, Floyd and Rosemary and the whole staff who have worked so hard on this effort to bring you all here together today. Thanks very much. Floyd, I'll turn it over to you.

Floyd Eisenberg: Okay, thank you very much, (Janet). I also heard tremendous feedback from what happened in every room. My apologies that I pretty much stayed in one room - not that I'm an entire geek, but pretty much. That's why I wore my pink tie that was the pink color of technical today. I've heard that there has been great discussion, everyone seems very excited and I think we do have the right people in the room to have these discussions.

What I'd like to do is move toward - the schedule for the afternoon is we're going to hear breakouts from each of the five groups about what were the goals, challenges and key success factors that you heard. We're going to be recording those. We have also a significant help from (Shawn Griffin) who will be helping to pull all of these together from Memorial Herman.

For those of you who remember the webcast from March 15th, he presented the webcast on using ambulatory measures and was it 300 practices? Eight hundred practices. Maybe it was 300 that you updated in a month - that was their software - within 300 separate practices in one month to get them all running on quality measurement. That was tremendous and he'll be helping with this summarization.

What I'd like to do is not waste time, but move directly to the report outs from the groups. I believe the first group will Dr. (Mirro) from the office based practices.

(Kendra Hanley): Okay, thank you. For those of you don't know me, I'm (Kendra Hanley). I'm with the AMA - Convened PCPI, so we're one of the major measure developers. With Dr. (Mirro), I helped coordinate and lead the discussion on the office based practice. We had two clinical vignettes presented to us. One was from Dr. Marty Peifer at Lee High Valley in Pennsylvania. She shared with us a lot of the good work that's going on there and then Dr. (Mirro) also presented how at his practice, in Fort Wayne, Indiana, they're using the Pinnacle cardiology data to actually collect data on the patients at the point of care and report out on the quality metrics as well.

We came up with some best practices, gaps and challenges in the recommendations. Some of the best practices that were shared included to capture data at the point of care and the importance of working with the vendors to be able to actually make sure that you're collecting the data in a way that makes sense with your clinical workflow. That was really, really key and we kept coming back to that throughout the morning and afternoon.

Kind of linked to the capturing data at the point of care is actually providing feedback to the clinicians also at the point of care. We talked a little bit about the importance of having clinical terminologies using to capture the data in a structured manner using some of the standardized nomenclatures like SNOMED-CT, in particular, Dr. (Mirro) is advocating for using that. It's

problemless because of the ability to capture the granularity that you're looking for in the clinical data.

Another piece is when implementing an initiative to start collecting and reporting on quality measures, the importance of transparency with the individual physicians. Make sure that the message is clear and the practice really understands sort of the what, but also the why. So in looking at what is the quality initiative, why is it important to capture these measures and then in looking at how you actually record the data when you see the patient. Why is it important to make sure you're reporting the data in the structured fields?

That was another point that we kept coming back to that you really can't underestimate the importance of education with the clinicians and working with the vendors to actually make that happen. Another best practice is to start with something easy. Start with a small, committed group that would be willing to maybe not live with the perfect solution from the start and then again, education on the importance meaning and methods before the measurement, use the structured data and then sharing data to refine data collection.

I think this point was really that you want to enter the data once and re-use it. If you can minimize the points of data entry, you minimize error and that will increase the reliability of the data.

A lot of our best practices are also recommendations, but we'll go through the recommendations. We talked a lot about harmonization of measure specifications, measures, terminology and the use of measures and output for reporting. The need to not only use the same measures across programs, but also have the same reporting mechanisms across programs with the same specifications.

We had several representatives from various specialty societies in our group and you know, there is a gap, I think, for a lot of the specialties that either there aren't measures, but also we talked

about not having EHR technology for a given specialty. That uptake of the EHR products - the folks from neurology, for example, said uptake is fairly low in their specialty.

Another thing we talked about was the need that the information in the EHR does not provide all of the information that you need, so we talked through the example of how do you know if a patient has died. All you know is that they stopped coming to your practice. That practice - it could be that the patient moved, they changed doctors, it could also be that they died, so how you get all of those other external inputs into the EHR just so you have the pieces of information that you need, but also, how do you validate that information that is potentially coming into your system to make sure that it's been reconciled, validated and is accurate?

We thought another recommendation would be to explore the use of new technologies such as natural language processing. That could be one mechanism to help maybe with this input of data into the EHR. And then we talked about something that Dr. Mostashari said this morning, to emphasize what the eye is in the prize. What are we really looking to get at? I think that's it. Is there anything else you want to add, Dr. (Mirro)?

Dr. (Mirro): Thanks, Kendra. We had a very energized session with a nice discussion, but I think the big issues are we're still struggling with some of the challenges, as were articulated here. We're hopeful that we get clinician buy in early for the specialties that don't seem to be adopting e-measures and even more importantly, the electronic solutions that are already out there.

I think more case examples of success stories of how practices have demonstrated the value of this are important and I think (Marty) from Allentown is in the back there, her group actually created their own CMS registry just for their multi-specialty practice. That's a good example of how they were outside the box and demonstrate on a point of care basis exactly how each clinician is doing. The clinician has instant feedback by querying the registry on how they're doing, for example, with heart attack care or heart failure care or diabetes care. Thanks.

(Kendra Hanley): Yes, one final piece that we talked about was the specialty societies could certainly take a lead in identifying the pieces of information, so the actual data that is important to be measured in a given specialty, but that could be one place of a starting point as well. I wanted to mention that one. Does anyone else from our group want to add anything?

Floyd Eisenberg: Okay, well I want to thank you. That was excellent. I've heard a lot of great things from every group. Thank both of you. I'm sorry I didn't introduce (Kendra). I introduced Dr. (Mirro).

So our next breakout is acute and I heard terrific things about that one as well. Who is presenting from the acute breakout? (Zahid Butt) and (Ginny Meadows).

(Zahid Butt): Thank you, Floyd. You sure you don't want to come up here? Leave me all by myself. Okay. Well, we had a very energetic group as well and it was actually well represented by a whole bunch of different stakeholders, if you will, which included obviously hospital folks. We had not just hospital folks, but IT and quality representatives within the institutions. We also had vendors. We had consultants, a couple of physicians and also (Debbie Krauss) from CMS. We had a well-rounded group and very, very nice, and good discussion.

Our two vignettes were presented by two acute care facilities, one in Rolla, Missouri. They are a 242 bed hospital. (Pam Feeler) and (Linde Merrow) who are back there, presented their experience with meaningful use. They have tested their hospital and then we had from Texas Health Resources, (Tanna Jackson) and (Amy Crow). They both, again, represent both the IT side as well as the quality side. They are a very large health system with 13 hospitals and I don't know how many millions of visits every year.

They presented their experience; again, in being able to attest for stage one. The most important was that in both cases, they have not just attested, but they have done, it appears, the seek grams with a lot of effort and part, which is very commendable.

In terms of the best practices, interesting, the first bullet was that someone within the group said best practices has a connotation which sometimes gets them into trouble with physicians because physicians will bring in a piece of document or a study that will be the best practice, and the guideline is not quite the best practice at that point in time because of the lag in how the guidelines get updated and implemented. They used the term leading practices as a substitute to get out of that problem, so we sort of thought that was an interesting point of discussion.

In both instances, they were very successful because they had a very collaborative, multi-stakeholder team concept that got involved right from the beginning, which included the IT people, the quality people, the clinicians, as well as their vendor in some cases. That was one of the important takeaways from their success.

They had strong physician leadership/champions who were going around and were being proactive about the effort. They do try to proactively spend time to educate people. The two types of education they described are important. One is sort of the general education about this whole space and how it is changing quality measurement, but then also specific education in areas that those measures apply to. For example, ED would get specific education towards ED measures whereas perhaps, the cardiologist would deal with the cardiology measures.

Again, the gist of the whole thing was that they engaged a lot of people in the process. Some of the gaps that were identified - there is again, the timeliness issue that I just mentioned. Of course the second one is probably not new information for anyone in this room; it's all of the difficulty in trying to capture structured data because much of the data capture nowadays, at least currently, is unstructured.

What the group felt was that it is possible to actually increase the amount of structured data capture, as long as you have the right people at the table and they come up with the right workflows. In some cases, they had to push the envelope a little bit beyond what the vendor provided them to accomplish some of the data capture, but certainly, there is a gap in terms of not having enough structured data so the e-measures can be totally seamless.

There are certainly technical issues in capturing the structured data in terms of how the system is designed. We had a lot of discussion around that, but there are also cultural issues that need to be overcome. Again, that sort of comes back to clinician engagement leadership that helps to make it less painful. It will not be painless, but hopefully is less painful.

Again, the recommendations we came up with were that there was a definite need for field testing of these measures because there is a risk of losing credibility with clinicians if the measures have not been tested and they are being asked to follow them or record data for. The more measures that can be field tested before they are implemented, we feel that would be very helpful at the institution level.

So leading versus best practice, we discussed that little issue. The next recommendation is really to try to sort of keep the idea that we're all moving towards as much structured data as possible, but we had some back and forth on that. Unless we sort of keep that as our sort of truth north, we're not going to get there because if you already go with the premise that the majority of data cannot be captured in a structured fashion, then you won't actually have eventually structured data.

I think there was the feeling that we should try to have whatever cultural and technological solutions that we can have to try to get more and more structured data as we go forward. For whatever pieces of unstructured data that is left, hopefully the innovation group or somebody will

sort of give us some ways to convert that into more usable information. That's one of the sort of missing pieces at this point.

We had some discussion around usability testing as quality issue because it is often discussed in the context of well, how easy or difficult it is for someone to use a product. The group felt that it actually has quality measurement implications as to how easy or difficult it is for clinicians to capture data in a more structured fashion. Usability should incorporate the quality measurement as a specific goal in terms of data capture.

Finally, there was a fair amount of discussion around specification and standards sometimes not jiving or matching each other. There were some examples where the specification may not have had the value sets that are being captured in certain ways. The idea was to try to align the specifications and the standards that have been approved so that there are no gaps within that framework.

Also, I think that everyone felt that we understood the reason to try to capture things in SNOMED-CT, but I think there was also recommendation that ICD-9 or 10 would be sort of necessary at least for the foreseeable future, in addition to provide the necessary data that e-measures would take and be captured during the workflow of the coding process and physician documenting against problem lists.

Those were some of our recommendations. The final recommendation which was not on this was that there was recognition that there was a lot of talent in that room and we were feeding off of each other, and we are hoping that this is something that can be continued. Many people recognized that a lot of hospitals around the country don't have the type of talent that was there. If there was some way to synthesize this information and broadly distribute, that would be very useful for folks out in the field. (Ginny), you want to add anything more to elaborate?

(Ginni Meadows): Thanks. The only thing - I was looking at these slides and thought we had talked about something that's not up here that came up in both best practices and recommendations was around the time that both of our folks that did the vignettes talked about that they took at the very beginning of the whole process, doing a really thorough analysis of the quality measurement specifications, really thinking about their workflow and really understanding how they needed to do their implementation before they started. That also came up as a recommendation because we all felt that, you know, they tried to put in as much time as possible, but we all know that we didn't have the luxury of a lot of time.

We really think that a strong recommendation is to allow more time to really think about this whole process of how you're going to implement these, so time for the measure of specifications for de novo measures to be developed in a thoughtful way and with field testing, time for the vendors to do the right thing about how they get implemented and then time for the healthcare providers to really absorb the changes that are going to have to happen as a result of some of these new quality measures.

(Zahid Butt): Great. More time and I think in both of those instances, probably even a little more resources because this is really an additional thing that they are doing at least through the transition. Anything you guys want to add? No? Okay. That's our report. Thank you.

Floyd Eisenberg: Thank you very much to the entire team and especially the presenters as well for pulling that together quickly. We are now going to the technical breakout and I believe we have (Aneel Advanti) from Indian Health Service to present. Since I spent most of my time there, I want to thank everyone for a very interesting and productive discussion. I'll let (Aneel) summarize.

(Aneel Advanti): Great, well it's great to be here and really exciting to see fellow quality measure specialists in the room. I'm associate director for Informatics at IHS and part of my purview is

working on the sort of nitty gritty on automating our quality measures, as well as our measurements. Let's see, can we go to the first slide?

So we had a very animated discussion, including over lunch and sort of every spare minute, so this is only the beginning and really just food for thought for all of us in the room. Other than Floyd, we had the folks who are developing the technical specifications for the HQMF and the query health project that ONC is sponsoring, as well as folks who are measure development stewards - AMA, NCQA and similar organizations - and then actual on the ground folks at hospitals, so it was a nice mix of folks and everybody sort of was highly opinionated as well as sort of had a lot of depth behind their opinions. It was actually really excellent discussion.

I'm not going to be able to completely give you any sort of crystallized, logically consistent summary. That was one of the points we made in quality measurement, so this is a somewhat organized, but not sort of perfect list of everything that we talked about. I think we did have some structure which was sort of to try and identify goals, challenges and gaps, as well as recommendations like all of the other groups did.

We did come up with sort of three really specific things that are going to be very helpful for the balloting process for HQMF or sort of similar efforts, and sort of the general coordination between the quality data model and the HQMF work at ONC. I think it was actually a really productive conversation from that perspective. We actually got three or four very specific, technical level strategies that will really kind of oil the gears and make sure that everybody is working together in harmony, so that is coming up in a second. Let's do the bullet point thing first.

I think one concept that - so we start off with our goals and one of the goals was that in fact, there is a distinction between trying to create a logical model or technical specification for what's in a quality measure and what quality measure is and the processes in quality measurement verses

the sort of logical model of the data itself in the EHRs. Each of those will have its own evolutionary pathway sort of going into the future.

In spite of the fact that we would like to have some sort of practical, on the ground work going on immediately or very soon, we shouldn't forget that those are independent elements that have their own sort of dynamic and we want to make sure that we leave room for capturing the sort of work on both of those ends.

The other goal is of course, the sort of opposite of that which is in fact that we do want to have electronic tool sets that allow you to sort of measure directly, but also that you want to have electronic tool sets that work on that first piece - that quality data model itself, that process of modeling and quality measures which in essence, is the sort of most human part of it.

That is sort of what all of us most directly deal with and there is a lot of room for automation there whether it's sort of coming in with automated to compare, whether one set of measures for cardiovascular care, MI, Million Hearts, sort of exactly the same or derive from something that CMS has come up with in the past in PQRS, etcetera.

Being able to maintain overtime the same quality measure as new drugs are created and as there is sort of a diversion for a temple gap between standardization and sort of development of best practices, leading practices. The relationship between physician support and guidelines and evidence based medicine and quality measures derive from them - that's sort of on the authoring side of the process that could benefit from computational tools.

This idea has been mentioned very well in the previous two summaries, which is you really want to have as a goal to reduce sort of the operational clinical burden to actually do quality measurements. It was mentioned earlier in the day to embed quality measurements in the regular, clinical operational process.

There was another point that was mentioned earlier in the day which is that we don't want the tail wagging the dog. We want the improvement of human health, the improvement of health, the improvement of medical care to be the fundamental driver of the requirements for all of these technical tasks and so in fact, we want to not limit our measures to things that we think can currently be measured the easy way. We want to all expressivity in our languages for quality measurements that allow to sort of express in English or in something more structured what we really want to measure and then have the rest of the infrastructure kind of play into that, as opposed to the other way around, even if we are trying to be practical. That's the first bit I think.

We're up to challenges. So we hinted at some of these and obviously there are connected to the sort of reasoning behind the goals a little bit. We mentioned some dialectical relationships here where there is no answer, so the design constraints are somewhere in a sweet spot in between. One of those is this idea of data liquidity versus expressivity and that's sort of been more of a buzz word from the pea cast report.

For instance, here the question is you know, whether or not you want to create really flat measurement specifications languages or allow sort of variation and depth to allow much more specific meaning to be modeled, but then have a greater burden of implementation to sort of map all of the details from your EHR, or even from just your quality measurement process.

Related to that is the second bullet point where, basically, do you expect systems to just be able to sort of have the data there with a simple query or do you expect some sort of black box reasoning to be required, and therefore much more expensive, custom implementation before you can actually produce the answer.

Of course there is an optimal sweet spot in there to allow quality measurements to achieve state of the art goals for improvement for a healthcare system and yet not completely be so

unreachable that we can't actually, practically kind of give legs to our clinical policies. We sort of mentioned this as well, which is that other saying sort of being caught in between, relying on the burden of the end user or the physician clinician at the EHR to do their own, so the mini charts review, have a lot of checkboxes, versus have something completely very explicit that is very liquid.

Related to that is, sometimes you want to actually pause and force physicians to make note that they've actually kind of carried out a specific step and attest to a specific step, so there is no right answer here as well. There is a tension between having an explicit in your face sort of burden from requirement on the quality measurement versus just having it happen automatically.

A couple of other issues are copyright issues with standardized tools and results and for the cognizant, that should be self-explanatory with specific examples. This other one, which is actually really interesting, and if you imagine this conceptualization of the distinction between EHR data models and clinical quality measure data models, the mapping between them can be done now today hard wired, or it can be a little bit more sophisticated with a little bit more parameterization, allowing the sort of good side of being underspecified today because that allows you to evolve over time. That's what this next bullet point is that hard wiring measuring implementation has both its benefits, as well as costs. Okay, next slide.

Okay, so we have more challenges. Let's just go through these quickly. EHR is sort of more of a use model, whereas quality data model is sort of more of a model of meaning of making inferences after the fact about data. There is sort of a distinction there. Prescriptive requirements is exactly for the EHR data, so this is again, that sort of hard wired versus non-hard wired issue.

Then there was sort of the whole cycle time of actually, just like there is with the measurement cycle time that was sort of mentioned earlier in implementation groups, there is also the quality development cycle time or the standards processes, which also have their cycle time. They're

sort of managing that within the choices that are made and what types of standards and what types of technical specifications to adopt is really important.

Okay, let's go onto the recommendations. Okay, so here is where we come back to sort of those three things that we crystallized on. Number one is you want to leave room for future innovations and implementations, either of design of the EHR's of additional effort to actually specify quality measures, and so just like HL7 currently has an escape patch where they have sort of a narrative block in addition to the structured information, we said that we should leave room for narrative blocks in English to accompany any sort of structured parts of e-measured specifications, whether that's on the quality data model side or the sort of mapping side of healthcare quality mark-up frameworks in XML's.

Although we like structured information and structured exchange, we shouldn't forget that English is also a placeholder for the ability to ask more complex queries and we shouldn't disallow that in our structured sort of standards processes. Don't forget tool sets because that's the second recommendation is really the sort of winners are the folks that are the most successful with marketing their tool sets. Supporting our community with really great tool sets is a really important goal of technical specification as well.

The third point of prescriptive requirements should be avoided as much as possible to leave it in this revolution. We made the point about distinctions, you know, quality model and the EHR model and then of course there is sort of education and training requirements. I think that's a reasonable summary. Oh, another slide. Let's go into that.

Well, there are the other two things about HQMF. I think the main point here was we don't want to be so prescriptive on that sort of relationship between the models for what you put into a quality measure and the model for which you get out of EHR, which you can ask from any EHR. We

don't want to be so prescriptive of that relationship now that we don't leave room for HQMF templates to evolve over time.

The main point here is that XML specification for that mapping between those two sides of modeling and then actually hitting the data should allow for English clauses and escape hatch. We call that sort of like the phenotype rather than specifying the genotype. I think that sort of captures - oh, there's more?

Oh, I think that English thing is what I made. Okay, so there is a long list. Okay, all right. I tried.

Floyd Eisenberg: That's great. Technical is always good detail, as you see. Let's move to clinical data analytics breakout and we have (Dana) here to present.

(Dana): Hi everyone. The good news about going towards the end is you're going to be writing a little bit less, but there are a lot of great points. We had a really nice room full of people will various expertise. Two of our members, Dr. Ted Palen and then Dr. Chris Snyder, went ahead and provided the vignettes.

When we think about some of the best practices that we talked about, you know, a lot of times, it comes back to some of the key things that Dr. Mostashari brought forward at the beginning of the day - keeping it simple, right? Don't jump in with both feet and not forgetting about the underdog - the small guys out there. A lot of times we look at what's going on in the larger hospital organizations, the larger medical groups, they have more resources, they have more technical knowledge and at the smaller level, the community level, we're not going to be able to have the same kind of reach as far as the technology.

We focused a lot on the fact that getting clinicians involved is really key. It's been brought in before, but we started thinking about measures and we started thinking about what Dr.

Mostashari said - Coumadin, right? It's low-hanging fruit. It's something that could make a huge difference immediately. One of the things that Dr. Snyder had mentioned is that some of the measures that they've developed at their organization has brought really remarkable, rapid change. It was able to get the physicians to really buy into it because they could understand, they could see, how it would bring immediate benefit to their patients.

Not only do you have to go ahead and create these opportunities, but then you have to share it and really show the best practices. When we think about some of the things, for instance, that were done in Dr. Snyder's organization or at Kaiser Permanente, Dr. Paileen's organization, great models that are proven to have wonderful outcome. Maybe we need a better forum to go ahead and start sharing those best practices as well.

Now there are a couple of things obviously that came up about measures themselves. The whole idea is, you know, at the beginning of the day, we heard this great analogy, right? So we've gone from a drought a data to now a watershed of data, it's kind of murky, there is a lot of it, but now we need clarity. We need clear water, we need nutritious water and how do we get through all of these data and to offer these kinds of views from the data that we have.

When we think about the measures, let's use the measures to bring some of that nutrition that we want. Are we measuring outcomes? Are we seeing an opportunity to revise and improve? Then ensuring what's actually being measured is what we're after, right? A lot of the time, if it's a claims based measure, we're actually looking at billing codes and not really capturing perhaps what's really going on with the patients. Is that really what we want to measure? Is that really going to give us the outcome that we're looking for?

Gaps - well, we know that it's probably going to get a little worse before it gets better. We're going through some growing pains. Some of the opportunities from the NQF webinar is if you've been lucky enough to be a part of them in the past, if not, hint hint. They are on the website. Take

advantage of them. They were really good at showing some of the opportunities that organizations have had to learn and to start to understand just how rich and wonderful the data is going to be as a result of going through this evolutionary process. There is nothing non-painful about it. I think we can all agree.

In the end, where we're going to get as far as being able to understand how to better care for the patients is what we're starting to see in the discussion. One of the things that perhaps is, again, the translation of data - there is not just one system capturing the data. In a hospital system, you've got multiple systems. We have to be able to do a better job as far as getting the knowledge out of all of these systems and that's going to take time, but from a measure development standpoint, if a measure is going to be developed requiring multiple systems to capture the data, it is going to require a lot of extra time. Nothing is really going forward without still a lot of human intervention.

It was discussed earlier, the concept of maybe some more time up front, maybe some more resources because this is an iterative process where we're learning through this evolution and in addition, there is going to have to be an opportunity for people to stop and improve along the way, but in a way to be able to make sure that the data that is being generated actually is going to be able to provide us that end result.

You're going to see this concept of death by 1,000 clicks. Are we getting to the data with 1,000 clicks or can we get there a little faster, right? That gets to the point of not all of the data that we think is there is so easily accessible can be easily reached and interpreted and put into care immediately.

Setting standards - we've been talking about that. We've already talked about the claims base environment. This last one gets back to harmonization, but it's harmonization from the standpoint of, can we all get around the table and agree? It could be that the guidelines are saying one thing

and the measures are being developed based on those guidelines, but what the payers are asking the medical community to do might not exactly match up to exactly what those guidelines are and the measures of things.

Okay, opportunities and recommendations - so, first and foremost, making sure that we get buy in upfront by providers. Go after the low-hanging fruit, right? We actually think that there's an opportunity to - and this goes against what was just said by the previous presenter - which is start small and then go ahead and get more complex over time.

A lot of the things that we're hearing, especially as we start getting ready for meaningful use stage two, a lot of people are saying, "Can we just slow down on more measures?" We just had to figure out how to first capture the data, now we have to figure out how to really report on the data. Can we just focus on doing that step next instead of trying to bring in more and more measures all of the sudden? It gets back to that time issue. Can we just have a little bit more time to get our feet squarely planted in this new world so that we can understand how to make the most out of the data that we're not capturing, how to really do process improvement based on this new data that we have.

One of the people in the room was a major developer and this was what was so wonderful about having this mix of people today because the idea is you know, measure developers are out there and they're trying to understand, okay, where is the crystal ball and where are we going to be. I'm going to build a measure, but what does it have to be based on where the technology is going to be? That is an important discussion that actually has to happen when we talk about people coming together and educating. That was one of the things that we were talking about were the education opportunities as well.

I've got the time sign, so that's a good thing for you. I'm going to get down off the stage real quick. I don't think there's really anything else here that's going to be breathtaking. Let's see, usability

and then of course considering the care in the entire value chain. Okay. I think we're done. Thank you.

Floyd Eisenberg: Thank you very much. We saved innovation until the last presentation and they are going to solve all of the problems for us.

(Dwight Brown): Is that what we're supposed to do? Hi, everybody. I'm (Dwight Brown) and I'm from Mayo Clinic. (Shawn), how's the hand doing there? All right, got that pitching arm all warmed up. All right, good. Excellent. Unlike the other groups, we didn't' have any enthusiasm in our group whatsoever. Laziest group of people you'd ever see - terrible. No, we had a lot of enthusiasm in our group and really had good brainstorming about what the issues are challenges were. Rather than spend time on the issues, I think can we skip right over to the solution - I'm sorry, keep going. Go back to the innovative examples. Let me touch briefly on these. I think we've got a little bit of time to make up here, so I'll go very quickly.

We tried to get down to a little bit of the nuts and bolts, so we did a little brainstorming session and had everybody come up with an idea of what they thought might be an innovative approach. Some of the ideas that we had were to have the EMR vendors and measure developers have some sort of e-measure collaborative to help them learn, come up to speed and think about common data models, use the common data model as a common ontology, have vendors have some sort of standardized areas within the EMR dedicated to quality measures, register based reporting, statutory requirements for EHR vendors - that one went over very well with our EHR vendor person in the room - integrate population management and case management into the EHR. Next slide.

Have HIE's collect and report one measure per highest cost condition, vendors need a single source of truth library, common interface of devices to the EHR, really monopolizing on the

technology that is out there, patient centered input and aligned quality data that will travel with the patient.

We tried to boil things down to what are the biggest concepts and really it fell into one of three categories. One of the categories was the learning category - helping EHR vendors understand and everybody understand quality data model and different data types that are out there. They either fit into that category or the category of structure and then we talked also a lot about the business case for all of this. There is a lot of investment going on, but what we're seeing and hearing is the investment seems to be a one-way street. The dollars are going out, but they are not necessarily coming back in for the investment.

Some of the ideas - the unique personal health identifier, very consistent with what we've heard from the other presentations is transparency of measures, both at the physician level and at other levels, some sort of knowledge library including some sort of harmonization of existing measures accessible at the point of care, aligning with clinical design support, QDM as the common ontology across all measurements. We talked about the patient goals and getting the patients involved in the care and the fact that we're being held accountable for these measures. Some of these measures, you have low patient adherence to some of the evidence based care. Let's have some of the transparency out there with that.

Standardization across the EHR vendors - this thought that the quality measure should be incidental to case. It should not be a goal that we're aiming for, so it should just be part of the bread crumbs that are laid along the way within the document process. Sustainable business model of HIT basically for everybody, measure developers need the funding to be able to develop the measures providers need the funding - everybody needs the funding in some sort of business model that is sustainable for this to work.

A lot of focus on the value equation and transparency around the value equation, looking at decreasing costs, increasing the quality, make doing things right easy, being mindful of personal preferences and privacy, especially on the part of the patients, standardized quality reporting. Those of you who are on the provider end can sympathize with the fact that we report our quality measures in multiple venues. We have hospital IQR reporting, we have meaningful use reporting, PQRS reporting. In Minnesota, we have Minnesota Community measure reporting, registry based reporting - on and on and on. We're reporting to all of these different venues. We need one single point of submission.

Transparency value equation and provide tools to help the EHR vendors understand the quality measures. A lot of talk around the table that EHR vendors are feeling like they're on the uphill curve of learning about this and I think we all feel that way to a bit of an extent. Those were the main points from our meeting. Thank you.

Floyd Eisenberg: Thank you. I've heard a lot of great discussion and a lot of common themes. We now have a bit of time where we can kind of discuss things that we've heard and look toward next steps as we move forward. We'll be talking about that for a bit of time and we're actually - we'll have (Shawn) with comments that you've written down here kind of help lead some of that discussion of some of the common themes that we've heard.

(Shawn): It may be tough for you to see in the back of the room. What I was trying to do is I was trying to write down things as they came up, obviously writing a lot in the beginning and then sort of cutting down as things went on. Some reoccurring themes I tried to circle in red. I just want to talk through some of them.

I think as I was listening to this, my mind lately is caught up on the idea of frameworks. I think that we have a lot of constituencies in the room. When I try and think about the concepts that I would really want to lift out of this, very few of these things are brand spanking new. I think that if we

would've put a list together a couple of years ago, it would've been very similar to many of these things. That was actually something we talked about down in the innovations group was, okay, what are we going to put up here that's innovative? What are we going to put up there that wasn't written two years ago?

I do want to sort of run through the things that I highlighted in red. These are not the right answers just because I answered them in red. These are just my thoughts. I'm perfectly happy to take comments. Partnering - there are a lot of people that we need to have on board with this, everybody from the vendors to the users to you know, in our organization down at Memorial Herman, you know, the EHR touches everything. It touches the patients, it touches the caregivers, it touches the clerk in the emergency room.

As I go out and I work with offices, I find that the office turnover at the front desk where people are registered completely compromises what you have for demographics and then you have de-duplicate and all of this sort of stuff. All of these things feed together, but when we partner, it's easy to sort of represent your own area. We need to partner with the clinicians, we need to partner with the vendors, we need to partner with the payers, we need to partner with everybody.

I think that the NQF is in a unique situation where it can bring this sort of group into the room. Down in the innovation group, we had a vendor representative down there and I said at one point, I said, you know, this could turn into the vendor piñata where everybody just sort of picks up a stick and starts swinging until the candy falls out. That is not what this is meant to be because I think we all own pieces of this.

Workflow - I think the idea of quality documentation is being in exhaust of the work that's being done. Nobody walked across the stage at medical school, was handed a diploma and said, "Congratulations, you're a documenter." They went into medicine; they did not go into documentation. Standard structures - what can you standardize? What can't you standardize?

This idea of liquidity verses expressivity balance - I'm pretty sure there are five federal grants you can get just from trying to explore that one area here. What do you need to structure? What do you not need to structure?

Three years ago, I was a primary care physician practicing in my office and I try not to forget that in my organization, I represent everybody from top of the line neurosurgeons at the Texas Medical Center to a podiatrist out in a rural area. How do we engage all of those people? How do we not just become representing the people who we saw at work yesterday?

Education with clinicians - most busy clinicians are sort of like the person on the treadmill on the cruise ship. You may be going to the islands, but they are worried about the next mile they are doing in their office. You can change course, they are still doing their mile. They are still getting through their next hours' worth of patients. I think we need to educate them - and to not just educate them, but to educate everyone around them.

If I talk to the doctor in a practice and I don't get the office manager engaged, none of that is going to stick. If I don't get their office nurse engaged, none of that is going to stick. We have to think about who we bring into the room and who we spend the time to get their buy in. Start small and build success.

In some ways, this is like all of those technology implementations that we've done for all of these years, you know, you need some early wins, some quick wins, some poster children that you can point to and say, "See, they did it and they didn't crash and burn." I used to have a partner in my practice and he was one of those guys who defined himself by how many patients he saw this day. Every time we'd go through something new, he'd say, "Griffin, am I going to be back where I was in three months and happy with the number of patients that I saw?" I said yes, you're going to hurt for a while, you're going through chaos, you're going to come back up on the other side.

After about the third time of me reassuring him and him coming out the other side, I didn't have to reassure him anymore. We have doctors out there who are small business people who are worried about making payroll. If you want to tell me that you're going to put in six quality measures that they need to do, then what's in it for them? It may not be money, okay? This transparency is another thing that I think we heard a lot about, especially within organizations.

I've said before, I feel like a trainer on The Biggest Loser when it comes to talking with physicians. I am telling them that they need to get in shape because their quality measures are going to be exposed on the billboard and on the internet. Most of them just think it's the day after Thanksgiving and they can't imagine that swimsuit season is coming. Well, swimsuit season is coming for all of us - every doctor, every clinic and every hospital.

Bedside user involvement, as I said, liquidity expressivity balance, model of use versus model of meaning. You know, we've had too many systems that were developed by people in a little cubicle and not listened to the people at the bedside. We need to find ways to engage them earlier in the process because if we go through nine tenths of the design before we get to the end user, we need to undo five tenths of the design.

The cycle time standards - okay, I think that has gotten better recently. I think that having some sort of fence post out there where we know where things are going, where we know some of the quality measures, is an improvement. You can't just change technology on a dime. If anybody has gone to buy lightbulbs recently and has seen that they are phasing out some and phasing in others and those sort of things, you know, you can't just drop everything and start up your new game.

You never find the same team in the NBA championships as in the Super Bowl. They are great teams, but they are playing different games. Harmonize everything, okay? Give us one choir

book, please? That's what we need. We need measures, we need the specs on the measures, we need the reports, we need the way to submit the reports.

Natural language processing, inference engines, those sorts of things - I'm a little concerned about that and this is just a personal bias. I think we're always looking for the hover car and the personal robot made. I think that we've sort of seen that in the diagrams and I think natural language processing I think has a role for advancing what we can do, but I have a deep seeded fear of a career of check boxes. Make sure we're ready for that as it gets better and better.

I tried a tablet computer in 1997 and I stopped trying it in 1997 and my wife bought me another iPad just last Christmas. I think that we have to be ready for technology to change the rules that we've been playing by. Better, more structured data, but not all just structured data. Standardize what we can, put it in fields if we can, field testing, usability.

One thing we talked about in our group, which I thought was very interesting but didn't make the final cut was I thought if in your HCAP survey you recorded what the EMR used to deliver your care and how satisfied were the caregivers and patients with it? Did it interfere with care? By the way, we're just going to post that on the website by vendor. Would that change things? I like being a little disruptive at times. Involve the patient.

In our organization, we talk about serious safety events and a couple of our hospitals now actually have a patient come in and present their case that became a serious safety event. It has turned the morbidity and mortality noon meeting from five people to 200 people with patient consent and all of those sorts of things, but you know, we need to involve the patients and the people and the caregivers and the family. I want to hold them also accountable for the things that they do and we need to find ways to capture that, also. Plug and play, you know, it'd be nice if I stepped on my scale and it gave me, this is what your weight appears to be, do you want to upload it to your HER and I can change it. We need to do those things.

I think we're on a burning platform because I love cliché's, but I think we're on a burning platform and my feet aren't hot yet. We need to take the time to build the next platform right and better than we've built the old ones because there have really been some bad things that we have tried to implement and then uninstall. Logical data models, electronic tool set for common components, reduce the burden of collection, you know, I just think that is huge for organizations. I think that we're using the sneaker interface and the paper interface when we should be having electronic collection and electronic interfaces.

With the finances and the values going the way that they are, I don't think we can afford to do that. I just know that in my organization, we have an army of people going out and doing what I call chart dives where they put on the scuba gear and they jump down into the paper chart and they come up two days later with look, I found something. I think we need to reduce that burden.

When you get down the practices that I have where you have a physician, their spouse is the office manager and one MA, they're not going to be able to do it. When you put a threshold of ACO participation of 100% of hitting these measures, congratulations, you have not only marginalized them, but you have slapped them in the face by saying you want their involvement in what you're doing when it comes to quality.

I got tired at the end, so I stopped circling things. Sorry about that. Sustainable business model - I'm pretty sure all of us had to pay for our clothes, had to pay for our trips here, had to pay for the hotel last night and I think that we need to figure out how we're going to pay for all of the things that we want to do and that we need to do to deliver quality care. It's a different model than what we got paid for yesterday. If you straddle the fence long enough, you're going to get hit between the legs. It's quite a visual isn't it there?

Anybody in the room have other comments? I was just riffing on this one.

Floyd Eisenberg: So first of all, I really appreciate another view on everything that was heard and I think it was terrific. Let me ask the group, from everything you've heard and that actually excellent summary, what are some of the key things that you've heard today that you want to see happen and that you feel are important as we try to move this forward? For those of you who speak, can you keep it to two or three things?

Dave Stumpf: Floyd, a consistent thing I've heard is how good of a job you guys have done in putting this together and we need to do some more of it. Before everyone starts heading to the airport, thank you and (Rosemary) and your staff. You did a great job.

Floyd Eisenberg: Thank you. Before you head to the airport, I want to absolutely thank all of the NQF staff and especially the HIT team and some of the Performance Measure team as well who are here actually helping us with all of the logistics. This is the first time we've experienced five breakouts across the building for a large team like this. It seemed to go very smoothly from everything I saw, so I think them as well.

Chris Snyder: Just one thing - and I think our group, I was in the clinical analytics team - it's hard to get measures without measurability and I think you do a great job. I use ESPN as my reference because you know, we like to look at statistics as humans, but when it helps improve care, we have to make sure that we have accurate reflection of what we're doing and give it to the people who need it. We've had great success with behavior change in our providers by showing them, not necessarily where they're weak, but whereas a population, we need to improve our care.

Give me measure capability with my measures and hopefully we can make some change.

Floyd Eisenberg: So let me just give you some of my own thoughts of what I've been hearing through the day and having had some very interesting experiences over the last three years since I've started

here at NQF. We've been through a big process of trying to move and trying to move in some ways, too quickly. If I look back on it, it was an R and D process to do research. If it were done just as research, there wouldn't be any pain in the room and I understand that, but I wouldn't have gotten done.

What we learned were a lot of things. One thing I think we learned was measure specified for a platform in claims, don't translate directly to measures looking for data that ought to be in an electronic record, so electronic records weren't developed in that way. Some change needs to happen there, change needs to happen on how we think about what we want to measure and how we capture data.

I heard between the rooms because I wasn't in every room and I know in our room that it's not just the doctor and the nurse and it's not just the EHR that contains the information you need. It's in healthcare and it's somewhere. That doesn't mean it's not available through measurement, but it's not a push button that I can say, "Here's my thumb drive. Give me my results." The results have to have meaning. There is a lot of learning that we've had and I think this is going to help us tremendously to pull this together. You're going to see a summarization of all of these components.

What we plan to do - now I believe we have some slides to lead to what our next steps will be, so what we plan to do is have a webinar in June. We believe it will be the 14th of June; we don't have an exact time yet. We will work with the Planning Committee with the summarization, we will come back to discuss what we've learned and get your input, we would like to but I don't have guarantee on how soon we can do this, have a site where you will see all of the presentations, but be able to also make comments and continue to participate.

We will also have another face to face meeting where we will continue this kind of discussion and we look for your comments about the best way to do this. It's possible that our five breakouts

were helpful today because we got groups together with like interests, but I did hear from many of you, I wanted to go to all of them. I wanted to go to three of them, so we may actually look for another way to consolidate a bit so we can get even more input. We're looking for ways to make this continue to continue to give you value and we look for your feedback about how to help it continue to have value.

There have been some discussions about can we use social networking to make this a bigger thing. We're interested in your interest in that and what you would like to do so we can explore how to expand this beyond our August meeting and a report that will come after that.

I look for your input; I thank you all for great presentations and great discussions today. I think we have a comment. We should have a public hash tag for this. Good feedback. I can't guarantee anything today and we're not taking up a collection either, but no seriously, we are looking for that kind of feedback if you think there is value in this.

I found one thing that really surprised me is I got a new iPhone and I said all right, I'll take the Twitter app. I have five followers within five minutes and I haven't posted anything. I guess there is some interest. Maybe if I posted, I'd get more.

I definitely want to thank - I won't go through all of the names in the list, but our planning group members. Here are all of their names with their respective organizations. It's been really an exciting effort to work with all of these people and to get all of this feedback. They have worked really hard and we've spent a lot of time, as has our staff, to kind of pull this together.

Again, we thank you all, we look for your continued support and input and even on the technical side, we look for making it easier, quicker and less complex. We'll end a little early then and thank you all.

Operator: That does conclude today's call. Thank you for your participation. Have a good day.

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