

**HIT Standards Committee
Clinical Quality Workgroup
Transcript
April 2, 2014**

Presentation

Operator

All lines are bridged with the public.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Clinical Quality Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Also, if you are not the person speaking, if you could please mute your line so that we reduce the amount of feedback that would be appreciated. I will now take roll. Marjorie Rallins?

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

Present.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Marjorie. Danny Rosenthal?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Present.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Danny. Bob Dolin? Anne Castro? Brian Levy? Chris Chute? David Baker? David Lansky? Eric Rose? I know Eric's on, he needed to step away for minute. Floyd Eisenberg? Galen Murdock?

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

Present.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Galen. Gene Nelson? Joachim Roski? John Derr? Kate Goodrich? Keith Boone? Kim Schwartz? Mike Lincoln?

Michael J. Lincoln, MD, FACMI – Director General Standards – Veterans Health Administration

Here.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Mike. Philip Renner? Randy Woodward? Rob McClure?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Present.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Rob. Rosemary Kennedy?

Rosemary Kennedy, BSN, MBA, PhD, FAAN – Vice President for Health Information Technology – National Quality Forum

Present.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Rosemary. And from ONC do we have Alicia Morton?

Alicia Morton, DNP, RN-BC – Deputy Director Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Present.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Alicia. And Julia Skapik?

Julia Skapik, MD, MPH – Medical Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

I'm here. Thanks, Michelle.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

And is Kim Wilson on? Okay, with that I'll turn it back to you Marjorie and Danny.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Great, thank you. So as you can see on the next slide, this is our agenda for the day. And we're going to be hearing a little bit about some of the thought processes behind this for the voluntary 2015 edition proposed rule review by Lauren and then quickly we're going to jump into the meat of the conversation, which will be geared by slide number 6. We do have a number of questions that are being asked of us, and we have approximately, I think it's around 7 hours of allocated time over the next three meetings, does not mean that we need to use all 7 hours of the time. If we can complete all that's asked for us in the next one to two calls, obviously we don't have to keep on with the conversation. So, we'll do as much as we can on this call today. Before we jump into that, let me hand it off to Marjorie to see if she has any other comments and then Lauren Wu, to give us a little bit more background.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

No additional comments from me.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Ms. Lauren.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Yes, I'm here, can you hear me?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yes.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

Okay, great, can we go to the next slide? Okay, thanks. Thanks, Danny. So this is Lauren Wu from ONC. I'm in the policy shop and I work for Steve Posnack on the rule writing team. And so we wanted to start with just a few slides to set some background. I'm sure most of you may have attended HIMSS and other meetings where you know a little bit about the 2015 edition, but we just wanted to make sure everyone was on the same page. So, as you probably know, ONC in the past has only issued standards and certification criteria rule in conjunction with CMS's Meaningful Use rules and on average, we have issued these rules every two to three years. What we've heard from stakeholders is there is a desire to see more incremental progress, most stepwise progress and so – toward interoperability.

And so what ONC has decided is that we're going to step away from this paired joint rulemaking from MU and start issuing standalone standards and certification rules, starting with this 2015 edition, which would be completely voluntary. Meaning that no provider or hospital that's trying to attest to Meaningful Use would have to adopt EHR technology that's been certified to 2015, but that it gives folks the opportunity to start making more incremental progress. So I think we talked about most of the things on this slide here. As you'll see, the rulemaking does not change all of the certification criteria that were in our 2014 edition, it just proposes changes to some things where standards have accelerated, where there are new implementation guides for us to adopt or where –

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

I'm sorry, Lauren, there's somebody who's shuffling around, if they could please mute their line. Sorry, Lauren.

Lauren Wu, MHS – Policy Analyst – Office of the National Coordinator for Health Information Technology

No problem. As I was saying, where we've heard from stakeholders where there are needs for "bug fixes" or "changes to our regulatory policy" that were a hindrance to people in the past. And the last point on this slide is that we also think that our gap certification policy will be helpful. Because we've adopted this policy whereby if certification criteria do not change between editions, you can use your test results when you come to certification for the prior time you presented for certification, toward the new edition and therefore be gap certified. So we think that for a lot of EHR vendors, for those criteria that don't change, this won't be a heavy lift, they can just apply their old test results. Next slide.

Okay, so I think we've covered most of the bullets here. This is a new approach for us for incremental rulemaking and I think Marjorie and Danny will go into this later. There – as part of the rule, not only are we proposing some changes for this new 2015 voluntary edition, we're also using this rule as sort of an Advanced Notice of Proposed Rulemaking, to give us some advanced insight into issues that we might consider for the next edition, which is the 2017 edition. The 2017 edition is what we foresee will be tied to Meaningful Use 3 and issued in conjunction with CMS, kind of like we've done in the past. And so there are areas in the 2015 Proposed Rule where we're soliciting comment on 2017 issues that is less of a priority for this working group to tackle immediately. If there is time left of your 7-1/2 or so hours, if you've tackled everything else, then we can get to 2017 issues, but we just wanted to reassure you that the Standards Committee still has time, up through June, to continue to make recommendations on 2017 edition to ONC. Next slide.

So this calendar sort of represents our best guesstimates of our forward thinking rulemaking cycle. You can see on the left here, we're in calendar year 2014; we've released the 2015 edition NPRM, which is now open for public comment. And you'll see that we are looking to release the final edition of that – a Final Rule of that edition sometime later this year. The blue arrow that you see underneath the 2015 edition indicates what I just mentioned, that we are soliciting some advanced comments on issues for the 2017 edition. And so we'll use that feedback to begin drafting the 2017 edition NPRM, which you see we anticipate will be issued by the end of this calendar year, in conjunction with CMS's Meaningful Use Stage 3 NPRM. That will go through the normal public comment period and we anticipate we'll issue the 2017 edition Final Rule and the MU3 Final Rule sometime in mid-2015. And if we continue on this new incremental rulemaking approach, then we would issue what we're calling the 2018 edition, similar to this smaller 2015 edition rule, a standalone rule, sometime in calendar year 2016. Next slide.

And so to summarize, today you'll be discussing and commenting on this rule. The link to access the rule is here, but I know you've also been distributed the PDF with the preamble language. The way that the Standards Committee has been asked to comment is to use this public comment template to enter in comments and then submit it online at regulations.gov. And so those of us staff here on the line will be taking notes and summarizing the feedback. The goal is to have that summary presented to the Standards Committee at their April 24 meeting, and then comments are officially due through regulations.gov on April 28, as you see here.

So, I believe that the Standards Committee will be consolidating comments from the various working groups including this one, into one response, but you are all welcome as individuals to also submit comments. I know many of you also participate on other working groups such as HL7 working groups that are also submitting comments. So all comments will be received and considered. Next slide. And with that, I'll turn it over to Danny.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Great, thank you for that summary. So this is the work ahead of us over these next three phone calls. You can see that the one on the top is CDS and the rest are clinical quality measures. If you look over at the third column, there are two that are unchanged in the 2015 edition, two that are – that do have changes for the 2015 edition and then if we can get through those four, then there are three issues that they're looking for comment on related to the 2017 edition. So the two sort of biggies that I think we're going to have a lot of conversation on right now is going to be number one, the Health eDecisions proposal and number two, the changes to the patient population data filtering. But today we're going to be starting off with CDS and God willing, if we can get through that, we can move on to one of the other ones.

Next slide, please. These are our three meetings. Next slide. Okay. So this is the first area that we're going to be commenting on. So what I'm going to do is I'm going to read and summarize what's being asked of us and then summarize the areas that people that are looking for feedback on and then we can jump into the conversation. So for this topic over here, ONC is looking to adopt the HL7 implementation guidelines for decision support, Knowledge Artifact implementation guide, the January 2013 HeD standard, and they're looking to adopt that as a standard. And then they're going to require that the EHR technology be able to electronically process the CDS artifact formatted in the HeD standard, that's the first – EHR must be able to process the CDS standard in the HeD format.

The next aspect is they also are proposing to adopt the CDS implementation guide, Release 1, Version 1 as a standard. And that will require the EHR to demonstrate the ability to make an information request, send patient data, and receive CDS guidance according to the interface requirement. So those are the two aspects. Before we jump into conversation, they're looking for comment to these areas, ease to which the EHRs can consume the CDS artifacts, whether we should work to distinguish between complex and simple artifacts, the ability to map CDS artifact standards to data within the EHR technology. The ability to store and auto-configure Knowledge Artifacts. And then the last two over here are on the feasibility for the second part of implementing the interface requirements and lastly, specifically what should ONC focus on when it comes to testing and certification. So, let's first start off with, are there any comments or questions as to what is being asked of us? And if not, then we'll just sort of open it up to people's comments. Okay, hearing none, let's go ahead and just open it up to the first brave soul who wants to comment on this.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Hey Danny, this is Eric Rose.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Hey, Eric.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Hey. So I sent an email to you, Marjorie and Alicia Morton and don't want to read that word for word, but if it would be helpful for the group, I could reiterate what my comments were on this one.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Please, Eric.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Okay, so I think that what struck me here is that there has been a huge amount of very, very impressive work done for developing standards and implementation guides to support the – what the NPRM calls use case one, which is certified EHR technology incorporating electronically encoded CDS content. And I think actually this is one case where the readiness for implementation may lag behind the aggressive and highly successful standard development. And in particular what struck me is that they actually identified in this use case and in the implementation guide that's cited on the slide, they identify three different what they call CDS Knowledge Artifact types.

One is, what most of us, I think, think of when we first hear CDS, which they're calling event condition action rules or ECA rules and those are the rules I think that are meant to facilitate just in time alerts and reminders within the EHR to help avoid errors of omission and errors of commission, that sort of thing. And the second and third types are order sets and documentation templates. And so, in the premise behind this – the overall requirement is that they want to facilitate having one entity create the CDS content and other entities consume it and rather than the current situation, which is, everybody has to build their own.

So I think that that premise makes a lot of sense, that there's value in that. I just would propose that our feedback be that trying to do all three is going to be highly ambitious and may dilute the effectiveness of the intent here, which is to push forward the growth of interoperable CDS content distribution. And I would suggest that the – that we propose that the proposed rule limit the requirement to just one of those three CDS Knowledge Artifact types and I'd propose that it be ECA rules. Because I think that they're likely to – first of all, they're a proven benefit, there's good published data that shows the you can have a – properly implemented, these can have a positive impact on at least healthcare processes if not outcomes. And also because they're likely to be a lot less challenging technically to kind of bind the CDS content to the EHRs data model. So those were my – that was my main piece of feedback on this one.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Thank you, Eric. How about some feedback from the rest of the group?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, hi Danny, this is Rob McClure.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Rob.

Robert McClure, MD – Owner/President – MD Partners, Inc.

I also submitted material on this particular item. Some of you may know, I was actually directly involved in Health eDecisions work the S&I Framework – and as well as the HL7 clinical decision support work and actually participated in the development of the HL7 CDS Workgroup's response to this and actually sent that. I don't think it's appropriate to replicate that here, in fact, I think we'll have different opinions. But in any case, that was – I'm in agreement with the material that was put together by the HL7 CDS Workgroup.

I think, though, the point that Danny just made is actually – or sorry, that Eric just made, is we don't address that in the CDS response. I think it reflects the fact that when you're down in the middle of the trees, sometimes you don't step back and look at the forest. And I actually would agree with the fact that it would be an important thing for this group to consider asking that the – that ONC focus in one of these areas. There's a lot of – the reason I'm hesitating, there's a lot of background and kind of representational elements to the standard that are, to some extent, the key provisions of this admittedly leading edge standard that is well adopted. And actually I think demonstrating – there is a demonstrable use of the standard, it's not widespread.

And so there's a part of what this standard alludes to, requests that people begin to participate in is, how do you represent information in a consistent way. And obviously if you then go and say, okay and then in doing so, focus on event condition action rules or focus on one of these other areas, you might use some of that background need differently. But you'd still have to consider the overall approach that the standard is proposing in terms of how information is represented, how you kind of collect that information into – and transport it and that sort of thing.

And so – and quite honestly, and I think the CDS group would agree with this, the most important thing that those who were involved in putting the HeD standard together, I think many of us would say that the most important thing is begin to get organizations to think about how they represent information. And if we chose to focus the kind of implementation of that into one of those three areas, that actually, I think, still gets us where we want to go, but makes the entire spectrum of things smaller. So I'm really in support of that and I think that that could be one of the things this group does propose. And I would also agree that the ECA rule focus would be the right focus, as opposed to the other ones.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

Rob, this is Galen –

Rosemary Kennedy, BSN, MBA, PhD, FAAN – Vice President for Health Information Technology – National Quality Forum

Rob, this is – go ahead.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

Go ahead, please.

Rosemary Kennedy, BSN, MBA, PhD, FAAN – Vice President for Health Information Technology – National Quality Forum

Rob, do you think based on where the standard is and the use of it and the testing, pilot testing to date is aligned with supporting ECA and something that is then feasible within the current environment today?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, I'd – the simple answer to that is yes, I think that some of the pilots – that the pilots tended to focus on ECA, that they weren't only, we – obviously because there were three general areas of focus, we worked to try and get pilots to address all three of those areas. But, Eric's right, the ECA, I think everybody on the call would probably agree that ECA type rules have been around a lot longer than anything else. I think that order sets have also been around, but there's more variability in how that might be applied. So, the simple answer is yes, I think that there's good evidence that that's the right place to focus on.

There's one other thing that I was also going to say and I forgot and that is, and Eric alluded to this and I was really happy to hear, Eric when you said, but I still really think we should move forward with this, but let's focus in an area. One of the things that – the fact that ONC is coming out with this interim proposal that's not tied to a CMS requirement, is that I think many of us have felt we have to figure out a way to get the – to keep the ball moving even though there may not be a demand that you must submit therefore that's how you're going to get paid. Somehow we have to figure out a way to let the community know this is where we're going and get early adopters an acknowledge track to follow.

So, much of what Eric said I absolutely agree with, this is leading edge technology. There are very few commercial, up and running organizations that are – that could rapidly adopt this standard, other than those that are forward thinking or large organizations that have already been doing it, and to a large extent, were the participating organizations that helped us put this standard together. That shouldn't scare us and the fact is, the approach that ONC is taking by putting in this let's call it interim proposal is, I think, a reasonable way to show folks, this is the direction we want to go. For those of you that can climb on board, let's get more participation in what the community feels is the right direction, so that we can learn from it.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

This is Galen. I have two questions, Rob, you mentioned that it would narrow the spectrum and I'd like you to elaborate on that on what would be excluded from the more focused spectrum. And then I'll, if I need to, follow up with a second question.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Well, so in general what I was saying is that there are kind of two consequences of saying, for example, only look at ECA type rules is that the – when I said the background that then an ECA rule builds upon is a reflection on an approach to how information, however it happens to be captured, stored and actually even interacted with in any particular EHR system, that there be standard way that when you then actually need to communicate it in this context. And we want – this is what the latest S&I Framework clinical quality – the Quality Framework Initiative is trying to is to get this even more consistent across these various uses.

M

Yes.

Robert McClure, MD – Owner/President – MD Partners, Inc.

But the point is that if in adopting this standard, folks will need to begin to look at the way they record all of their clinical data and say, okay, let's see how we can map it to this HeD standard. Now the fact is that if we – if the end result of this is then to propose that the exchange of things that need to utilize that mapping will only be ECA rules, it makes – they still have to do that backend stuff. Now it may constrain the kinds of information that they really need to focus on. I can't say that I – anybody's looked to see what – whether, for example, order sets, obviously those focus on things that are orderable and not so much on the recording of clinical data. Whereas ECA rules can run a pretty wide gamut, so obviously not only including the results and potentially the orders of the same sort of things you'd see in an order set, but also the recording of clinical knowledge. And I just blanked on the third item, but, the –

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

The documentation templates or –

Robert McClure, MD – Owner/President – MD Partners, Inc.

Right, documentation templates, but the point is that ECA rules I think relatively well understood and it forces organizations to do this analysis of how do we take the way that we record clinical information and put it into the standard. The last thing that I'll say about the clinical documentation and order sets is that those two things while they're clearly used in many organizations, the standards around them, I think, have not progressed at the same rate that ECA standards have. Now that's not to say that there's one really well adopted standard for ECA, but I think that what we would see if we were forcing those other two is that the – there would be greater gaps in terms of what the standard says in terms of how to actually capture the nuances that are in place already. There's a bigger gap between what people are actually doing in the enviro – out in the real world and what the standard says they should do. So, I think there would be more frustration potentially in those two areas.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

This is Galen; I'm in favor of a focused approach that has us really putting forth the primary goodness inside of HeD, the ECA, not to diminish any value from the other things that are discussed there. But if – as I reflect on this, the primary goal is to foster adoption to affect patient care, then we ought to allow our EHR friends to focus. And if – what if I would propose to the group, what if this were combined with a specific set of say seed rules that were part of the criteria, similar to the way the CQMs have been specified and distributed, that further encourage adoption of this more focused ECA approach.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Let me actually just jump in, that exact recommendation was another part of what the CDS Workgroup put in our response. We feel the same way, we really need to, I think focus on easy to identify, implementable examples as what we want people to do. And so I absolutely agree with that suggestion. And also, not surprisingly, we also wondered if we couldn't in identifying that core set do two things. One, presumably we'd want to get something that lines up with eCQMs. We're working hard to try and make that occur in any case and we would certainly, I think, any implementer would love to – who's willing to take the leap to begin to do this, would want to work in the same area that the eCQMs are asking them to work. And the second thing is that we need a clearinghouse for these, right, we need a place like we currently have for eCQMs being published as of yesterday, by the way, at CMS. We would need a similar kind of thing for CDS artifacts that we're talking about.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

This is Galen, I support that wholeheartedly and I would also ask that – rather comment that having such examples really bridges a gap between the metadata and the thinking that goes behind the structure of how these ECAs are combined. And really bringing it home not just for practitioners and clinicians, but for the developers who have to think about that and wonder, why is this useful and why should I care? Having those real world examples may get their attention better than the science behind the ECAs themselves.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

This is Danny. I'm hearing a lot of conversation around the ECAs and I've heard three voices advocating for a constrained approach around ECAs. Are there others on the phone that have a different point of view or who would like to advocate for all three aspects? Then those who have been advocating for the ECAs, can you see a compelling counterargument for why ECA in and of themselves would not be sufficient for 2015?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

This is Eric – I'm sorry – so, I can't see an argument for arguing that they're not sufficient because any of this stuff is going to be stuff that's not available today. And I think that there may be – one thing to keep in mind is that there – for MU3, it's being proposed to require that one do notes in EHR as a Meaningful Use objective. And so there may be a perceived sort of connection between requiring that an EHR be able to receive documentation template content from outside and requiring that physicians complete their notes in the EHR. But, I don't think that's a real connection because nobody today is using documentation template, or almost nobody, is using documentation template content developed outside their organizations. I mean, the – in some cases the EHR vendor will supply a starter set and the organization tweaks it, but again, it's so – I don't think that there's a critical need there.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

So it sounds like that we've been talking a little bit about (a) through I guess (d), we haven't gotten into the implementing of – and interfacing yet. And we've touched a little bit on (f) at the very bottom, what the focus should be for testing and certification, but let's just go through these one by one, just to see if there are any other comments. So the first one is, what are our feelings about the ease with which EHR technology could be developed to consume CDS Knowledge Artifacts, and given our conversation, it sounds like that we're limiting the discussion to just ECA rules. So, is this an easy thing, is this a well, we're already doing it thing or is this a burdensome activity? We used a 10-point pain scale, 10 being the worst pain of our lives, where would we sort of put the pain for this, or pleasure if you want to look at it with a different scale? Any EHR vendors on the call?

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

This is Galen, I'm not an EHR vendor, but I did play one on TV and talked with several at HIMSS speci – several prominent ones who I won't mention. Who when I approached them about their need for rules and specifically a format in which these rules could be changed rather shared or consumed from a clearinghouse as suggested, they were all very receptive to the idea. Each of them had in turn created their own format for – each of them had created their own format internally for representing these concepts and these rules and saw that there was benefit in standing on other's shoulders to develop them in such a way so that they were more expressive and more shareable.

I didn't query them about their pain scale from 1-10, but each was interested specifically as to the benefits of doing so and interested in further participating. And I spoke with Chief Medical Information Officers as well as CMOs in doing so. And so they see the value, I think that each of them was much more interested in ECA than the other areas. I know that's not in specific response to ease, but when the vision is clear the price is easy sometimes. And so I did see clarity of vision in alignment beginning to form, as we would continue with the previous recommendations.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

This is Eric. One of the things we have to keep in mind is that the ease to the EHR developer and the ease to provider organizations are going to be very, very different. Because for an EHR developer, if the requirement will end up being something along the lines of you must be able to ingest and act upon the CDS content defined by this – these standards and these implementation guides, which means that the EHR vendor has to be able to handle the most esoteric, complex, idiosyncratic aspects of those standards and implementation guides, even if no one is ever going to actually develop content around them.

And having been an EHR vendor in a previous life and having had to handle similar issues around formulary and benefit standard, where we had to be able to ingest very complex types of data around very esoteric flavors of multi-tiered formularies and so on and so forth that no one ever sent us data for. You end up chewing up a lot of development time that never has a benefit for anyone. So this gets to the question about, is there a benefit to identifying simpler use cases. The answer, I think, is absolutely yes. So to answer your question directly Danny, for an EHR vendor to be able to ingest CDS content that's very, very simple, like saying, for instance, everybody – every adult should have their blood pressure checked once a year. That sort of thing, an ECA rule for that would be orders of magnitude less effort than probably all of the potential complexity that I would imagine the implementation guide supports today.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

Yup, yup. This is Galen; I couldn't agree more that to be required as an EHR vendor to support all of the potential rules that could be written would be far too burdensome. Take drug-drug interaction for example, and by the way, I should mention I have spent about 15 years of my career as an EHR vendor and partner, having personally implemented systems like this, I just don't happen to be doing so at a company right now.

The goal of say in drug-drug interaction is to – what if I, for example, mapped – well, perhaps one background statement would help. Underneath the standards, specifically the second of the two standards being recommended, the shape of the services in the implementation guide, it makes a nod to VMR for representing the model of the data in order to allow data for the – provide data to be acted upon by these rules. And if, as is the case, everybody's already supporting CCDA, if I were to map those CCDA artifacts to VMR, specifically for supporting drug-drug interaction, to seek certification in that thing, perhaps for that set of curated rules, I can – that's very tractable. Further, the effort required to support VMR from such a CCDA mapping today would be a good portion of the effort that it would take to map from CCDA to still some other standard, should the clinical quality framework and the Tacoma initiatives identify something slightly different than VMR.

And so the effort, even amidst the changing standards environment, is going to be relatively reusable. I do not think that it's easy, on a scale of 1-10, many of the rules approach the 5-7 range in terms of complexity. But if we have a specific set of rules that people can sink their teeth into, then I think we can get specific feedback on which rules might be most burdensome and which rules might be most easy. And I think the conversation becomes one where in general it might be painful, but there's a lot of low hanging fruit and that's where the industry could adopt first.

Rosemary Kennedy, BSN, MBA, PhD, FAAN – Vice President for Health Information Technology – National Quality Forum

This is Rosemary and I think Eric may have stated this and I think a few of you have stated it, in (a) it says the ease with which EHR technology could be developed and there's a side to that, and I don't know if that's addressed here. And just because it's developed as model and delivered by the vendor doesn't necessarily mean the provider, in terms of legacy systems that they have, it doesn't mean that they can just turn it on. And they need to go through that process of thinking about how information is represented on the front end, and may have to make some modifications to the data, the terminology as well as the clinician workflow and there's a need for implementation and guidance on that front as well, if it's going to be implemented at the provider sites.

Robert McClure, MD – Owner/President – MD Partners, Inc.

So this is Rob, again. And I haven't – nothing I've heard so far do I disagree with. I think that, and this is also, actually it's specifically alluded to in the NPRM, I can't remember if it's in this section, it might be in the CQM section, but, or both. But, the acknowledgement that we have to have some way of being able to figure out what are hard things and what are easy things. And in particular, in this context, can we somehow rank I think it was with the CQM so hard electronic quality measures, in this case hard decision support artifacts and easy decision support artifacts. The nuanced approach that I think we want to try and gain here is that we want to somehow encourage folks to begin this process of thinking how they represent their data and how they would “map that data” so that it can be exchanged or consumed in this consistent framework. And that they need to do that as a wholesale process, but that we need to acknowledge that some parts of that are going to be easier and some parts are going to be harder.

And if we can somehow identify in this context CDS, so CDS artifacts that we expect people to be able to map that focus on the easy parts. But don't lead them astray and our guidance doesn't in any way lead them astray so that they think well if I just do this and I kind of wall that off, I'm successful, that instead we say, here you need to be able to implement these things. That means that you've got to focus on core common areas, 80% labs, drugs, core patient demographics, vital signs and get those aligned in a consumable way so that you can receive things and be able to directly implement those. You may not be able to represent complex radiology tests or invasive procedures, and we're saying, you don't have to, even though the standard tells you some things about that. That's what we need to do, I think, somehow we need to be able to get folks to understand that this is an incremental process and that if they focus on the core, they're going to get benefits.

Julia Skapik, MD, MPH – Medical Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

So this is Julia Skapik from ONC. The example you just gave, Rob, might be something that's not optimal because the piece of the SGR requirements for CDS, my understanding, that we might need to allow something that's complicated like that in that specific case – but, I totally agree with your approach.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

So I've been hearing comments that for (a) it sounds like folks are saying that this – that the pain for this can be low, if the – if simple or more simple Knowledge Artifacts are chosen. And then that gets to (b) whether we should work to distinguish between complex and simple and it sounds like yes, if possible, because that will affect the ease to which these are implemented. Rob, I think you started talking a little bit about (c). the ability to map the Knowledge Artifacts standards to data within the EHR. And I want to hear what people's thoughts are on this. I – the only question from me to the group, if you don't do this mapping, how can you implement CDS Knowledge Artifacts, meaning isn't this – yeah, isn't this a requirement to even start?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, so this is Rob. My quick statement, yes, I think that it's like a basic requirement. I think that the only element to this that perhaps needs comment is it gets to my issue about walling things off. If you create a criteria that can be easily seen as a one-off, then you might just do that one-off. Let me give an – this is a totally hypothetical example, but if we just focused on allergies, I think it would be possible given that allergies tend to be kind of managed in a slightly different way in systems than other kinds of conditions, that implementers might say, okay, well we'll just map that part. But we won't think about the fact that the vital sign for an allergy is the same vital sign as it is when you're actually anywhere else, but instead, we'll just take those things that happen to be associated with an allergic event and store those differently.

That's not what we want. And so I think that points to the fact that to do this elegantly, we need to be careful about the kinds of things that we choose as our initial simpler set. And we make sure that they cover some breadth that clarifies for folks the expectation that there is going to be this foundational remapping or a mapping of their internal structures to this interoperable standard.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

This is Galen. I agree completely that – with Rob, what you just said and I would add that separating (b) and (c) therefore becomes pretty dangerous. We've got to consider the most meaningful set of simple Knowledge Artifacts, not simply include them because they're simple. We may even choose to, because it's more meaningful, include one that's slightly more complex and another pure simple one because of how it would motivate implementers to map to what Rob described eloquently in point (c). And likewise because, as was mentioned earlier, I think Eric by you, that nobody wants to implement rules, however simple, that are meaningless – that aren't the most important.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Thank you. So, what are people's – about the ability to store and auto-configure a Knowledge Artifact in the EHR? And you know, when I look at this, I ask the question of, again isn't this also part of the process for consuming CDS. Or is this basically saying, just because you can consume CDS does not necessarily mean that you are a) persisting that Knowledge Artifact in the EHR, which may be a good or a bad thing and it certainly doesn't imply auto-configuration. And so, my interpretation of auto-configuration is that it happens automatically.

And I think what we saw with the eMeasures is that while vendors incorporated the eMeasures, if you ask a vendor, they're method for incorporation was often not an automatic. It was a show me the eMeasure, I'm going to print out the human readable form, we're then going to hard code it or we're going to code it however the heck we want to code it. And so that sort of gets around the intent to sort of make this a facile, quick process for the eMeasure coming your way that the EHR can gobble it up and auto-configure as it's being called here. So, while we're talking about consuming Knowledge Artifacts, what are people's thoughts about this auto-configuration of automatically grabbing it, no matter what the CDS artifact is? As opposed to saying, consume it and however you want to implement it, that's really up to you, whether it's done automatically or you pull out your hammers and screwdrivers and squeeze it in there. Thoughts?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Danny, I – this is Eric Rose. I'm actually not sure that I know what the phrase auto-configure means. And all of the possible meanings that I can think of for it are covered in some of the other items on here. So auto-configure might be that all of the data elements mentioned in the CDS Knowledge Artifact are somehow linked up to data elements in the EHR. But that's kind of covered under (c) or it might mean that the Knowledge Artif – that the EHR can provide the behavior at the user – from the user's perspective that is implied in the Knowledge Artifact without any additional actions after its ingested by EHR, but that's kind of what (e) represents. So – and I would say that if we have a regulation that uses verbiage that anyone in these workgroups are confused by, it might be good to try to clarify that language. I'm sure it means something –

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yes.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

– but the first part of that, the ability to store a Knowledge Artifact, that's kind of – that's a no-brainer, anybody can store a data object –

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Okay.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

– as an intact file, if nothing else.

Robert McClure, MD – Owner/President – MD Partners, Inc.

This is Rob. Actually, and I understand the issue around what does auto-configure mean, it is kind of an odd phrase and that probably would be a reasonable comment to make, that it needs to be clarified. I think this is actually the crux item here and Danny, as you noted, what – appears is going on with HQMF is that if there is – I think there are organizations that say they have built something that can consume an HQMF. But I don't know that anybody can do them all and is doing them with absolute fidelity. Now that's a reflection of a couple of different things. In my opinion, one of the biggest ones is that the eMeasures to date have some pretty difficult inconsistencies among them. And therefore building something that could consistently consume something, even if you reviewed it, obviously I think – hopefully no one would take any of these things, CDS or eCQMs and have them kind of come in in the middle of the night and be running in the morning without anybody looking at them.

But, the fact is that because of the complexity of the eCQMs, building tools that just take that HQMF and immediately line it up with whatever you've built, as a mapping environment has been pretty tough and people have just said, screw it, we're just going to do it by hand. So in this context, if we were to follow the recommendations that we've already laid out with having simpler, focused area of expected conformance. Then I do think having something that would and auto-configure to me would mean that you need to be able to actually consume that artifact directly and have it result in direct changes in your system...

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Um hmm.

Robert McClure, MD – Owner/President – MD Partners, Inc.

– that obviously should be reviewed, but could potentially run, even without review in a sense, not that anybody should ever do that. That’s what I would expect and what that demonstrates is the things that Eric was saying, it shows that you’ve accomplished some of these other items.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

If that’s the – well, first question to the folks from ONC on the call, does anyone have any clarification about what auto-configure actually means, even if it’s hearsay?

Julia Skapik, MD, MPH – Medical Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

So this is Julia Skapik again. I think that the intent is sort of what Rob just described, that at some point you would have a good enough mapping available that you could plug-and-play. Obviously not that you would forgo testing and checks and all of that, but that you would consume it and it would find what it’s looking for in a manner that there’s a high level of data quality and integrity. I realize, and I don’t think ONC expects that that will happen immediately, but definitely laying the groundwork in the way it’s been described by the workgroup makes a lot of sense and I think that will get us in a few iterations to the intent of ONC.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

So, interpreting auto-configuration as plug-and-play, so it would be as easy for you to implement three CDS Knowledge Artifacts that are presented, it would be as easy for you to implement a hundred CDS Knowledge Artifacts or a thousand, meaning it would scale very, very well if this auto-configuration is built into the EHR technology. And I think this was the hope with eMeasures. Other thoughts from folks, is this too dictatorial to sort of say how the consumption of artifacts should be happening from the EHR, meaning it could potentially be their choice, if they choose to do everything manually, that is their choice. So, other thoughts about auto-configuration.

Julia Skapik, MD, MPH – Medical Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

This is Julia, I just have two follow up comments on that.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yeah.

Julia Skapik, MD, MPH – Medical Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

I think the intent is eventually not to allow hand coding because we have such a problem with consistency in the way that people do the hand coding. And secondly, one of the major challenges that we’ve had is that the measures as they are now are very static, they don’t allow for any technical corrections, they don’t allow the measure to be changed as the clinical evidence changes and the vendors consistently say that any updates, even relatively minor ones, are extremely difficult for them. So that’s part of the intent here is that these could be updated as needed or as appropriate and that the lift for the vendor would be very low.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

This is Marjorie –

M

Yeah.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association

This is Marjorie, I just had one question building on Danny's questioning and Julia's comments that I'd like to ask the group. So if in the context of auto-configuring, would one vendor auto-configure in a different way than another such that they would come out with different configurations, if you will? I guess that's my question, is there another standard that's necessary to put some guardrails around that or if you're able to auto-configure within your own environment, is that efficient?

Robert McClure, MD – Owner/President – MD Partners, Inc.

So Rosemary, this is Rob. It's my understanding, and again, I don't want to risk making this sound like we're still in the middle of the stream, but to some extent we are, and this is why the Tacoma Project that was mentioned in the Quality Framework Initiative are important activities that are occurring right now. But I can tell you that the intent is that again, just like what HQMF was supposed to be able to provide, and it's a good start to do this, it just shows that it's somewhat complex. But you would get that file and you would be able to design a system that would read that file and be able to take those artifacts and put them directly, and again here now we're talking about like ECA rules. That they would then generate ECA rules running in your system without any hands-on stuff that is absolutely the intent. And I can tell you that the Health eDecisions pilots proved that, my understanding is, I wasn't involved directly in those that did this, but my understanding was is that they accomplished that.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Well, this is Eric. I certainly don't know anything about the Health eDecisions testing, but what I have seen with a number of different EHR vendors with clinical quality measures, which is really analogous, is that there really is quite a bit of by hand binding I would call it. It's not really coding, it's binding one data element to another data element and – or a data element in the artifact that the CQM or in this case, the CDS artifact to the data element in the EHR. And a lot of the time that will require some data transformation because, for instance, the CDS data elements may pre-coordinate some information, like it may say, well, this CDS rule applies to patients with a first-degree relative with breast cancer, right. And the EHR may actually store those in two different data elements, so that's a challenge to be overcome.

The experience with Meaningful Use 1 and Meaningful Use 2 CQMs is that there is a lot of by hand mapping that has to go on, so I think if the goal is to get this sort of – get this thing moving, which is I think ONCs goal in trying to – in putting this in the NPRM. Then it's a good idea to try to set up for success and requiring plug-and-play type behavior is, I think, counter to that. So I think it's going to be a given that in all – unless there's a lot of effort put into identifying a very, very clear-cut, uncontroversial set of basic, basic data elements like date of birth and problem list and blood pressure. Even blood pressure, by the way, is tricky. In some cases you'll have systolic and diastolic as a single – recorded as a single data element, in others it will be split.

Julia Skapik, MD, MPH – Medical Director, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

So this is Julia and you're a mind reader on this one, that is actually a major missing piece of standardized data we think is – to enable this. And ONC is in the process of sort of unifying all the current work on core common data elements and doing that with the idea that eventually there will be that set of data elements that support that kind of mapping. And that if you already have those core things mapped, then the artifacts that only pull and grab from that set and that those – that set should be able to be the same set for CDS and CQMs.

Robert McClure, MD – Owner/President – MD Partners, Inc.

So this is Rob. I think – I mean this is one of those true, true situations. I mean, Eric – what Eric has said is unquestionably true and I can't foresee that changing in the next couple of years. What – as Julia was just mentioning, I mean and we've talked about, so there's all – there's current ongoing activities. We know for a fact that CDS, like the Health eDecisions artifacts and the artifacts that are used to create eCQMs are different.

So even if, one was to say okay, those two define the universe that I'll never have to go outside of, you would be building two complex, mapping environments. Because let's say in your environment, as was just mentioned, so you have blood pressure broken out into all the various little pieces, and the artifact in eCQMs has a number and a slash and a number. Well, so you're going to have to parse that and you're going to have to do it consistently. But once you've built that, if everybody's consistent on the eCQM side, I'm just using these as hypotheticals, and then you're parsing will always work and it can be automatically consumed. But the problem is, even right now we have two different standards.

And so the point here is that I think it's very reasonable for us to point at that particular item and say, well yeah, that's where we all want to go. So it needs to somehow be a part of where we say our direction's heading. But hey ONC, hey CMS, until you at least get the two very aligned things together, i.e. complete the Clinical Quality Framework Initiative so that we have one way that CDS artifacts inside our standards are represented. And that way is exactly the same way as you're expecting us to do quality measures, so that we build one complex engine to do our parsing and it works for both of them. Until we get to that point, I see that's your direction, but don't expect me to be able to do it.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

What do folks think about the ability to auto-configure? Is this a – I think we've agreed that this is an important thing, do folks think that this is an easy thing or a difficult activity? My personal sense is that this is a difficult activity, auto-configuration, but is very, very important.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

– this one, I'd say it's more than difficult, it's impossible without a very clearly agreed upon and straightforward essentially data model.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Got it.

Alicia Morton, DNP, RN-BC – Deputy Director Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

Hi, this is Alicia Morton; I just wanted to do a time check because it's 3:41. But also, just to be clear, I don't think any of us on the call really can speak to the exact intent of that specific question, we just have to do the best of our ability to try to answer it. And to bring to the attention of folks that aren't as intimately familiar with the standards produced out of the HeD Workgroup that it did not go into the implementation workflow integration piece. It really did stop at the front wall of the EHR. So, just take that into consideration as we're responding.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Got it.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah and so putting all these things together what I would say is that we would look at that and we'd say, that's a great future expectation based on the path that we're on. But no one should be expected to auto-configure an HeD rendered thing, unless they want to, because we expect that whatever – the HeD standard is likely going to change. And so as Alicia says, if this was – if we really thought this was mature and locked-down, it should be in the implementation side. This is in the hey, this is what we want to do side.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Great, thank you.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

This is Galen. This is Galen and I don't yet know whether this will come out contrary to the comments that have already been made. But if the goal of HeD is to help make sure that these Knowledge Artifacts are indeed shareable, and they're not electronically consumable and it always requires human intervention, at least in the early stages, as where we are. Then have we really achieved sharing? It seems to me that – I could be in favor of softening this, based on the potential complexity of those implementing it, but to omit it seems like it reduces the strength of the overall effort. And I'd love to know what's being proposed.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Well this is Eric. I think the answer to your question is no, it doesn't eliminate the benefit, it doesn't make it not sharing, it makes it require – it makes it easier than taking an artifact that's on paper and putting it into your system, a lot easier. But, so what you might end up with is something that gets ingested by your EHR, the logic is such that the EHR can execute it automatically and you don't have to put that in. And the data elements and the specific values for each of those data elements might – for some of them, they might – the EHR might say, I know exactly what this is, I don't have to require that a system administrator do any configuration. For others it might provide a limited set of choices, again easier than starting from scratch and for others it might say, I have no idea what this is, find where you store this information and bind it. So, I think it's a big step in the direction of the kind of sharing that I think we all support.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, again, I mean this may sound like I'm playing both sides of the fence, and to some extent I am, but the fact is this is really the most important part of this whole thing, that shows that you can actually do it. The problem is that we're still on a glide path here and we haven't landed and so it absolutely needs to be a part of this. It's just like for HQMF, HQMF is a defined exchange standard for quality measures, everybody's got to be able to consume them. I don't know if the auto-configure word is in there, I don't think it is, and as we've just heard, no one auto-configures it in the way that we're actually wanting to understand that phrase. But we – so we need to get people to make sure that they can consume this exchangeable thing, in a way that's not simply printed out and go and write a hard-coded program to do it inside of your program.

And I think this is, unfortunately, another one of these complex things that it's a combination of what are – how complex are the CDS Artifacts that we expect everyone to be able to accomplish whether they are in an 80% kind of thing. How consistent the representation that – because HeD specification is primarily an implementation that's a simplified VMR XML implementation. And I think many of the folks who worked in creating that feel that it's a very implementable thing.

So, I don't have the perfect solution here, I think this does need to stay in, but we do need to acknowledge that this is an interim thing. And so expecting everybody to have big, complex kind of consumption engines that do automated mapping to any – all of the appropriate elements inside their system, when we know that those will likely change over the next couple of years, maybe too high a bar. I don't know what the middle bar – of that bar is, but I don't want to lose this piece, but I don't think we should say that everybody has to get them completely consumed. We didn't even do that with HQMF and HQMF is, I think, now pretty well understood, not well liked, but pretty well understood.

Galen Murdock – President & Chief Executive Officer – Veracity Solutions

Rob, this is Galen, I deeply am aligned with what you're saying. I was concerned that we might have been going toward a case where there was no bar here, and I'm uncomfortable there. I'm just as uncomfortable with the bar being too high. Finding that middle ground, I would propose that from this group we recommend that the ease with which one – an EHR vendor can auto-configure these rules depends on the complexity of the set, hopefully how simple the set is, of Knowledge Artifacts upon which we're operating. If each of the ECAs is involving logic, a model and a certain set of terminologies, and if I can constrain the space. I can constrain the set of logic that I need to support and constrain the set of models to which I need to – on which I need to support it and on the terminologies that I choose to implement.

HeD is built by default to allow me to separate these concerns and I would like to understand from those who have implemented this before and those who have worked on the standards, given a proposed set of simple Knowledge Artifacts, how hard would it be to auto-configure? Precisely because of what was mentioned earlier that we don't want these rules to be static and require human intervention in all cases, I would like to know how achievable it is to make minor tweaks and for us to develop language that we don't yet see here of small changes versus big changes. And perhaps even in the early stage, require that small ones be able to be made to a simple set of Knowledge Artifacts.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

This is Danny; we have around 12 minutes left. ONC folks, you have to open up for five minutes at the end for public comment, correct?

W

Yes.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

That's right Danny.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

So what I wonder is, if we can see if there are any comments on (e) and (f). So (e) is talking about the second half of this, which is the feasibility for preventing interface requirements to perform an information request, send patient data and receive CDS guidance in near real-time. So what's the feasibility of that? And if you want to use the 10-point pain scale, you're welcome to do that as well. Any thoughts? It's so easy that it doesn't need any thoughts?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

So Danny, this is Eric Rose. This is the use case of requesting patient level guidance from a CDS supplier.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yeah.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

So, it's a lot easier to output stuff in a standard way than to ingest stuff. So I actually think that this is – this gives me less heartburn than the first one because the logic all would presumably run on the side of the CDS supplier, behind – in their cloud or what have you. And so I think the feasibility is probably pretty good, although there's a lot of devil in the details. The one thing that gave me pause about this is that the Health eDecisions standards do support a very wide array of different content types, which they list in the NPRM and include like everything from drug dosing calculation to disease management to immunization forecasting.

And so I think again, my advice would be to select a small number, two or three, and I think they have seven listed a small number of content types, just to maximize the chances of success. And my assumption here is that, I haven't looked at the implementation guides in detail, maybe Rob could clarify. My assumption here is that what comes back is more or less just information that you have to display to the end user, it's not anything that you have to treat as structured like place this order –

Robert McClure, MD – Owner/President – MD Partners, Inc.

No.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

– or what have you.

Robert McClure, MD – Owner/President – MD Partners, Inc.

No, it is structured. So – again, I would say the second use case was not as thoroughly piloted, but the expectation was that what comes back is – could be an order. Now granted, you wouldn't – I – well, never is a long time, it would take a long time for us to imagine an environment where if I say, here's the patient's immunization status, and it comes back and says, this patient needs to be immunized for this – with this drug, that clearly could be an order. And it's possible that given all the right circumstances that would actually feed in where in fact there are – that's the way that these kinds of things – for example, when integrated can, I think, do that sort of thing, can literally populate an order for someone to actually review and then click a button and say go.

But that is the expectation; that doesn't change the fact that there's also the ability to have something come back and just say, hey, you should do X, but it did include the former. And by the way and I realize we really haven't talked about that and I had kind of actually forgotten that both of these, in the context of this, I think this NPRM, were in the standard. We talked about focusing the use case one around ECA rules, I mean I'm sure – I know that some of my colleagues will not be happy with me in saying this but, part of this is again, we want to push people down a path. The complexity around a service is, I think, obviously higher to some degree than this other complexity. I really would like to see our community, this country, move down this path more rapidly than we're currently doing. That being said, if we just could ask folks to be able to consume use case one ECA rules under this, I'd feel pretty good, I'd drink a beer on that.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Rob, are you saying that this is not as feasible as the consuming the artifacts?

Robert McClure, MD – Owner/President – MD Partners, Inc.

I don't want to go on record as saying that. I don't know what's really as feasible, I just know that the – if we just look at the kind of volume of capability, and there are a number of entities and organizations that are creating CDS Artifact-like content.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yeah.

Robert McClure, MD – Owner/President – MD Partners, Inc.

I don't think the same volume is in play for organizations that are – well certainly, that are acting currently as a CDS service or even have that on their agenda. So, I feel that if we were to put the service capability as a future to do, we wouldn't be cutting out a lot of participation.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

And you know –

Robert McClure, MD – Owner/President – MD Partners, Inc.

Is that a good way to say it?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Sure and my opinion on this is that the core requirements to be able to gather standard data, send it to somebody and then be able to listen to what's coming back, 90% of that you'll be tackling if you can consume a CDS Artifact. You have to be able to know that there's a request being made to sort of –

Robert McClure, MD – Owner/President – MD Partners, Inc.

Right.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

– there is some trigger; there is some data that you're going to be evaluating. So the only incremental add here is really to take the infrastructure that you have with the CDS Knowledge Artifacts, doing it internally and simply sending it somewhere else, which –

Robert McClure, MD – Owner/President – MD Partners, Inc.

Well, it's actually more complex than that because you have to – so that second use case requires that you send patient information, right, like here's what my patient looks like.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yeah.

Robert McClure, MD – Owner/President – MD Partners, Inc.

So it gets, in a sense, to that part that I was saying before was a foundation for having a consistent way of representing your internal data so you can actually consume that CDS Artifact. Now you actually need to take that representation, that kind of common, standardized representation of patient information and send it. And then what you get back, it will be similar, but it has some distinct differences from “here’s an ECA rule.” Again, it’s going to look potentially much more like, “here’s an order.” And so it’s very – it actually has – it has very different aligned, but different artifacts that are going to be exchanged and it gets to this whole issue that I think Eric has pointed out. And that is, I can’t express how important I think this stuff is and it’s not easy and based on my personal opinion as to the volume of benefit from the second use case, I would rather we put our resources into the first.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

– so looking at the time, I believe we’re going to have to pause the conversation there and we can pick up with this letter (e) on our next phone call; handing it back over to ONC to open up the lines for public comment.

Alicia Morton, DNP, RN-BC – Deputy Director Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

While we’re doing that, I want to – this is Alicia. I sent homework to folks and I think the folks that put thought in in advance it will really help us go through the rest of this information. If you have thoughts, you can take a look at the information we’re asking and get your thoughts together and/or share them with the group in advance of the meeting; it’ll help streamline our conversations as was done today, thanks to Rob and Eric.

Public Comment

Rebecca Armendariz – Project Coordinator, Altarum Institute

Yes and if you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1. Or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. So just as a reminder, the next meeting is April 7 at 10:30, so hopefully everyone will be prepared.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Let me just say – this is Rob; I won’t be able to attend that meeting and so, my apologies in advance.

Alicia Morton, DNP, RN-BC – Deputy Director Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

Thanks, if you can send us your comments on the other stuff in advance that would be great.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yup.

Alicia Morton, DNP, RN-BC – Deputy Director Office of the Chief Medical Office – Office of the National Coordinator for Health Information Technology

Thank you.

Michelle Consolazio, MPH – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you everyone.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Thank you everybody, we’ll talk to you on April 7.

Public Comment Received

1. Regarding Data Elements for CQMs, recommend looking at ArchTypes and CEN 13606.
<http://www.en13606.org/the-ceniso-en13606-standard/archetype-model>