

**HIT Standards Committee
Clinical Quality Workgroup
Transcript
March 13, 2013**

Presentation

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon everybody; this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Standards Committee Clinical Quality Workgroup. This is a public call and there is time for public comment built into the agenda. The call is also being recorded and transcribed, so please make sure you identify yourself when speaking. I'll now go through the roll call. Jim Walker? Marjorie Rallins?

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Marjorie. David Baker? Is that you David? I think we just have an echo. If I could just remind everyone to mute your computer speakers, so we don't get the echo in the background. Thanks. Keith Boone?

Keith Boone – GE Healthcare – Standards Architect

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Keith. Anne Castro? Chris Chute? Jason Colquitt?

Jason Colquitt, PhD – Greenway Medical Technologies – Executive Director of Research Services

Jason's present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Jason. John Derr? Bob Dolin? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – Independent Contractor

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Floyd. Rosemary Kennedy?

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

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Rosemary. David Lansky? Brian Levy?

Brian Levy, MD – Health Language, Inc. – Chief Medical Officer

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Brian. Rob McClure?

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

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Rob. Galen Murdock? Gene Nelson?

Gene Nelson, DSc, MPH – Dartmouth University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Gene. Philip Renner?

Philip Renner, MBA – Kaiser Permanente

I'm here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Phil. Eric Rose?

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

Hello, yes.

MacKenzie Robertson – Office of the National Coordinator

Thanks Eric. Danny Rosenthal?

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

Present.

MacKenzie Robertson – Office of the National Coordinator

Thanks Danny. Joachim Roski? I believe you're on the line. Randy Woodward? Kate Goodrich? Kim Schwartz? And if there are any ONC staff members on the line, if you could please identify yourselves?

Julia Skapik, MD, MPH – Office of the National Coordinator

Julia Skapik.

MacKenzie Robertson – Office of the National Coordinator

Thanks Julia.

Alicia Morton, DNP, RN-BC – Office of the National Coordinator

Alicia Morton.

MacKenzie Robertson – Office of the National Coordinator

Thanks Alicia.

Kevin Larsen, MD – Office of the National Coordinator

Kevin Larsen.

MacKenzie Robertson – Office of the National Coordinator

Thanks Kevin. And I believe we also have Jon White on the phone?

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Hello.

MacKenzie Robertson – Office of the National Coordinator

Hello. Thanks, Jon. Okay, with that Marjorie, I'll turn the agenda back over to you.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay, thank you very much MacKenzie. And good morning everyone. I'm Marjorie Rallins and I work for the AMA-PCPI, in case you are not familiar with me. Thank you for joining us today and this is my sort of first official meeting as co-chair, so bear with me. Today we will be discussing the quality data model and the vMR, and we have two presentations today, Aziz Boxwala from Health eDecisions and Chris Millet from the National Quality Forum will give us an overview of those two models and then we'll follow that with a discussion on the perspectives from measure developers and stewards, specifically Patty Craig and Rute Martins, from The Joint Commission. And after that, hopefully we'll have enough time for ... and with that, since we're starting late, I think I'll turn it over to Aziz, who I believe is on the phone, correct?

Aziz Boxwala, MD, PhD – Health eDecisions

I'm here.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Please proceed.

MacKenzie Robertson – Office of the National Coordinator

And in terms of the webinar, if you can just say next slide when you want to advance, we'll have the slides advance for you. Thanks.

Aziz Boxwala, MD, PhD, FACMI – Health eDecisions

Thank you. Good afternoon or good morning to everyone. I'm going to talk a little bit about the work we're doing with the vMR in Health eDecisions and how we're trying to work towards aligning it with the QDM, some of the work that's going on in that respect. I want to apologize that I think both of these are moving targets and so some of the statements I make may already be outdated in some cases, and hopefully there are others on here who might be able to correct any of those.

Next slide please. So vMR is an HL7 specification for a patient data model that's used with clinical decision support and has two artifacts, one is a UML class diagram and the other is an XML schema. The specification was balloted as an informative standard, so it's not gone through the DSTU and normative standard. I put in quotes influenced by HL7 RIM because there isn't a formal HL7 v3 model that has been created for vMR; it's a straight UML model that's borrowed many of the ideas of the RIM within it. The adoption at this point is it's used within an OpenCDS project, which is a decision support service project, and there are other groups who are using it internationally as at least I was told by Ken Kawamoto about this recently. The history that was release 1 was balloted in 2010. I mentioned that it's going through some changes right now, which is release 2 that we're going to submit this week to HL7 for balloting in the May cycle. And this release has some minor changes, primarily a few new types of elements, which are new classes and some new data types and some minor changes to existing classes. These changes are being made primarily to support the Health eDecisions pilot projects, which have just started.

Next slide please. I wanted to show just a snippet of the vMR, we can't go through the whole model in this much time, but this snippet shows UML class diagram of the procedure clinical statements within vMR. And as you can see, there's a hierarchy of classes that are created here, and you can see the procedure base is a type of clinical statement and then that leads to a procedure proposal, procedure orders, scheduled procedure, procedure event has different types of clinical statements related to...about procedures. Next slide please. This is a snippet from the QDM, December, 2012 guide showing similar structure for procedures. Again there are these categories called procedure intolerance and procedure order and procedure performed; so there are some parallels here, but they're not quite correspond with each other.

Next slide please. This slide just describes how we use vMR within Health eDecisions. It's similar to how the HQMS release 2 uses its data model, which is QDM. So it does it by reference, which is vMR is not built into the Health eDecisions spec; rather it's a requirement in the implementation guide. So, it allows data model changes to occur without changes to the HeD schema and it's used in two places. One is its used as a model of patient data, so that's when we're writing in existing data from health records and we want to write data mapping expressions within the CDS rule or within an order set, and use those data within logical expressions. The second place it's used is as a model of interventions. So the output of the CDS essentially, which is the CDS recommends a medication to be given to the patient that's written as a vMR structure, too. So this is the prospective side of the vMR.

Next slide please. And this is my interpretation of some of the key differences between the vMR and the QDM. So the first one, as you could see from those diagrams I showed you earlier, vMR has a more formal model in the sense that vMR has a UML class diagram, and I haven't found an equivalent structure for QDM, although I understand there is some work going on towards creating that. Within CDS it impacts how we do reasoning, automated translation of CDS artifacts into native formats for execution, for example. QDM includes an expression language, it's built into QDM whereas vMR does not have that, and I think we've had some discussions between the two groups and we've agreed that those two should be separated out. VMR supports prospective proposals, although again I think in the December 2012 edition of QDM, I see there are structures to support prospective actions within QDM, too, now. QDM definitely has more classes and concepts, more details. VMR can stop, for example, at procedure whereas QDM has many more of those detailed subclasses.

M

Hello, can you clarify what you mean by vMR supports prospective proposals. That was completely unclear.

Aziz Boxwala, MD, PhD, FACMI – Health eDecisions

Okay. I'm sorry I will certainly do that. Within vMR, so, within clinical decision support, the output of clinical decision support ...

(background discussion interrupts speaker)

MacKenzie Robertson – Office of the National Coordinator

I'm sorry this is MacKenzie. Can I just remind everyone to please mute your lines if you're not actively speaking. We're getting a lot of background noise. Thanks.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

And this is Marjorie and I might ask that we hold our questions until the end.

Aziz Boxwala, MD, PhD, FACMI – Health eDecisions

So, within the clinical decision support, the output of clinical decision support would be some recommendations or proposals to do some intervention, typically, and those are what I'm calling prospective proposals. vMR calls those classes as proposals, and so they are things that have not yet happened and they're not yet in the health record. Does that clarify?

M

Thank you. Yes, that does.

Aziz Boxwala, MD, PhD, FACMI – Health eDecisions

And vMR – so QDM has more classes, more, I think they're called categories in QDM. vMR has more detailed attributes so far, while vMR has fewer classes, each class seems to have more attributes. Again, that difference seems to be getting smaller now with the new version of QDM. And vMR has the ability to be extensible by the end-user, so you can add new attributes that weren't conceived of in the original model.

Next slide please. So I'm going to do a quick pros and cons of vMR and I think Chris Millet will cover the QDM side of that. But we've found that vMR is generally well balanced in expressivity and that is amount of detail and then the generalities so that a model doesn't become really unwieldy and large, although I think there is some room for fine-tuning that. vMR is a computable model, just because it's a UML class model. Again, there is room for improvement in terms of clarifying some of the semantics. It has both retrospective data, which is data that already exists in the health record, and the prospective actions, and it seems relatively intuitive, to us at least. For example, the namings and the attributes that you'd typically expect to find. It does have an XML serialization format which is how you transmit an actual patient record as a vMR, which is reasonably lightweight. Again, it's used within CDS in a CSD web service where the patient data is sent as a virtual medical record and then proposals are returned back by the service.

Next slide please. And here are some of the cons, some of which we've tried to address in this release 2 that's going for ballot soon, and then there are many more that need to be addressed in the future vMR QDM harmonization. So one of those issues is the model semantics are not quite what we'd like them to be, and I don't know if I should go into too much detail, but it's extending the proposals, all the different types of proposals. For example, are under different hierarchy, all the different types of orders are not in the same hierarchy, so that, for CDS, at least some of the reasoning we'd like to do, we can't do it in a straightforward way. I mentioned earlier that some attributes need more precise semantics associated with them. It's not sufficiently detailed, so this is what I meant earlier when I said the expressivity and generalizability needs some fine-tuning.

And the extensibility mechanism also needs some fine-tuning, it requires use of “related clinical statements,” “related entities,” which makes a CDS artifact much more complex and verbose. It also requires specification of constraints that live outside the model in these things called templates, that again make, add more to the complexity of the model and we’d like to reduce some of that. Some of the ISO data type namings, we’ve gotten comments from the HeD ballot about their difficulty to understand some of those, it’s because they use two-letter names which just are not easy, as easily readable. And we’d like to add some more scope to the model, in terms of clinical context, for example, workflow, those kinds of things that again are needed much more in CDS maybe, than in quality measures.

Next slide please. And so the proposed path forward that we’ve been discussing. We’re going to complete a requirements definition of the data model for CDS and quality measures. We’d like to certainly revise the model semantics and we’ve explored some approaches for doing that. We’d like to extend the coverage of the models. So right now vMR is not going as deep as, for example, QDM does, so we’d like to extend that. And then we’ve talked about separating out the expression language from QDM and consider balloting this at HL7 in the near future. That’s my last slide.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay. Perhaps we should proceed with Chris Millet from National Quality Forum. Well, maybe we should take questions now, if you’d like them. Questions anyone? Let’s do that.

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

Yeah. Hi, this is Danny Rosenthal. Thank you Aziz for that presentation. Can you explain a little bit more what you’re referring to by the QDM expression language?

Aziz Boxwala, MD, PhD, FACMI – Health eDecisions

Well, QDM has, if you review the QDM guide and again, I think there are others who are more knowledgeable about this on the call. But you could, as part of the QDM, there’s a specification that says you can write things about event starts before, event ends before, those kinds of expressions. And they are part of the QDM specification.

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

Got it. Okay. Thank you.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Any additional questions on the vMR? Okay. If there are no more questions, then can we have the slides for the quality data model and Chris Millet will be presenting.

Chris Millet, MS – National Quality Forum

Thanks Marjorie. Good morning everyone. I wanted to just do a brief overview, not just on the QDM, but also on some of the recent discussions regarding this QDM, vMR harmonization, building on some of the things that Aziz has just presented. So, if you can go to the next slide. So this is just a brief background from where some of this discussion has come from. There were some initial discussions at the latest HL7 in-person working group meeting, in January, where we talked about harmonizing the two models. And one of the key things identified in that discussion was that the goal is to have one model that we can use for these different quality-related use cases, such as measures and clinical decision support.

We wanted to move away from having people having to learn one model if they were implementing a quality measure and another model if they wanted to implement CDS. So, that’s one of the few things that was clearly identified. And to get there, everyone agreed that we need input from both the quality measures community and the CDS community and just below, on the slide, these are some of the groups we’ve been engaging in the weeks after that January meeting, to sort of get there. So, we have some folks from our QDM user group, which are really users of the QDM, that includes measure developers starting to use the QDM in their quality measures, and vendors that are trying to implement those quality measures that use the QDM. But it also includes a lot of participants from the HL7 CDS Workgroup and the new HL7 Clinical Quality Information Workgroups, as this really relates to both of those workgroups work. And we also have folks like Aziz and others from the S&I Framework Health eDecisions Initiative.

So, next slide please. So just a really brief overview of the QDM. In general QDM was created to be a model for representing data criteria that needs to be used in various quality use cases, like clinical guidelines, quality measures and clinical decision support. So, I have a lot of those goals of what we want to do with this harmonization, kind of the guiding principles in coming up with the QDM. And what QDM does fairly well, and this is based on a lot of feedback from users of the QDM, is that it allows you to express simple criteria for data elements. So if you want to create criteria for an active diagnosis or something, QDM provides a structure for doing that, for providing value sets to define the codes you want to identify the diagnosis with, these kind of simple criteria, is what QDM does fairly well. There is also one other benefit to QDM right now in its current state is that it's mapped to HL7 v3 standards such as the HQMF, which is the Health Quality Measures Format which is the format that all the eMeasures are available in. And the quality reporting document architecture, which is the format for quality reports, based on eMeasures.

Next slide please. What the QDM doesn't do so well, and I think Aziz touched on some of this, and a little bit of this came out in the question that was asked, regarding the expression language. So the QDM allows you to relate different data criteria to each other, but it doesn't do so in a really robust or elegant way. So the example on the screen is just to show you what this looks like in the QDM. And this is, a lot of users identified how non-intuitive this can be, and we know there's a lot of room to grow here. So these are some of the things we look for when we try to do a harmonization. We want to make sure we can relate different data criteria to each other in a much better way.

Next slide please. This slide is just to go over some of the options for the harmonization that we've been discussing over the last few weeks. One option was to just, well, two options were just take what we have now and just kind of add to it, so we either take the vMR as a base and we add components of the QDM and any other models that might be relevant. Or vice versa, we use the QDM as the base and we add components of the vMR and other models and then we just keep building from there. A third option that seemed to have some significant interest in, was creating a new model that incorporates both QDM and the vMR and any other relevant model. One of the key things that came up in our discussions is that there are a lot of other models that might be able to help in some of the areas where we know we need to grow, particularly around relating different complex criteria together.

So a lot of models were thrown out there. GELLO was thrown out there, the FHIM was thrown out there, and HL7's new FHIR was thrown out there. So, I think some analysis needs to be done before we really know what's the right approach there, and almost the scope of this harmonized model that we want to create. There's been a lot of back and forth on well, what's really in scope, what's out of scope. So, the one thing the group decided on was, for now, we might not be ready to make this determination, but we need to do this real evaluation against the real use cases for quality measures and clinical decision support before deciding on which of these approaches we can move forward on.

Next slide please. This is just to cover the impact to harmonizing the QDM with the vMR or another model. This just shows where the QDM is being used right now. So the QDM is being used in over 90 eMeasures, most of which are in Meaningful Use, but there are some that are not in Meaningful Use. So, these are all measures that are based on the QDM right now. The QDM is also incorporated into the measure authoring tool, which allows for the development of eMeasures, but those eMeasures will use both the HQMF and the QDM. And then there's the Meaningful Use Stage 3 measures that are currently under development, and they're also using the QDM. So, if we combine the QDM with another model and...or if we come up with a better way of doing this, these are the things that are impacted and we have to figure out how do we transition from all these measures that are currently using the QDM. And there's the same concern on the other side as well for the vMR. The vMR's being used in pilots and once we get a harmonized model, significant work will be impacted, so we've got to figure out some way of transitioning.

Next slide please. So for next steps, and Aziz touched on some of this. For the short term we jointly determined that let's just keep evolving the QDM and vMR separately to meet their short term needs and keeping in mind, well, let's look at the other models so that at least they're getting incrementally closer together. QDM's short-term needs are to support meaningful use eMeasures development and vMR's short-term needs are to support HeD pilots. So, some examples of the short-term changes are the vMR release 2 that Aziz mentioned and the minor QDM changes made in February, which are not published, but they are available in the Measure Authoring Tool, so for users creating new eMeasures, they have those changes available. But the key next step is to scope this broader effort to combine the QDM, the VMR and any other model that might be relevant for quality measures and CDS and eventually ballot this new model as HL7 Domain Analysis Model. Next slide please. So, that's all I have. Happy to get into questions when we get to the question and answer session.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay. I think we're at a question and answer stage. Are there any questions?

Keith Boone – GE Healthcare – Standards Architect

So, this is Keith Boone. One of the points that I'd like to bring out is that I think it's critically important that as we're developing these standards in order to pilot test them, we don't necessarily want to place barriers in front of these activities in order to get them to pilot. But when we're talking about actually making these standards part of our national infrastructure, it's critically important that we're not dealing with a bunch of standards that have not yet been harmonized to deal with the same issues. So that we don't wind up with one model for dealing with modeling quality measures and another model for dealing with clinical decision support and another standard for the structure of quality measures and another standard for how decision support's going to be implemented. It's important that all of that actually be harmonized, when we go to implement and just understand that when we're talking short term. We're talking about things like pilots and not necessarily what we need to do before we get to Stage 3, the kinds of things we want to implement in various meaningful use stages need to have a long-term outlook.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

So, this is Marjorie. I think that's a very good point Keith, and maybe that's the kind of comment that we might want to save for when we have the general discussion on what does the Clinical Quality Workgroup want to respond and recommend?

Robert McClure, MD - Owner/President at MD Partners, Inc.

Marjorie, this is Rob McClure. So, a couple of kind of questions and comments, the first is, and these are not going to be new, we've mentioned this sort of stuff before. So first, my sense is, and I've participated in all of these activities and this was mentioned, that what QDM has that vMR doesn't have is this expression, a syntax of describing how the various elements that are a way of describing things you find in a clinical record, did combine and create in the context of a measure. For example, a clause, where so for example the thing that ... actually described as being an issue, is those things of this occurs before the start of this and that sort of the thing. VMR doesn't have that, and so a key element that we're dealing with in this harmonization is where they do overlap, is a description of what one finds in a record, a patient record. And I think to some extent what Keith was kind of targeting, and what we've talked about before is that it's really important that where we do have overlap that we have consistency.

And I know that's actually the whole intent of what Aziz presented and that sort of thing, but I think that we can't overstate actually, the importance of somehow encouraging as quickly as possible a common way of describing the artifacts that we find in clinical records. And then all of these other things sometimes it will only be useful for measures and not for decision support, some things will be useful in decision support, not measures, etcetera, etcetera. But if they all draw from this common way of describing information that we expect to find in clinical records, then the variations are going to be less important or actually required.

And so, and I think this is true, but I hope that in terms of priorities, what we prioritize is that, and that's one of the reasons why, I think it was Aziz, but it may have been – but where we talked about these other models that are also in play, like the FHIMS and those sorts of things. We have to, I think, figure out and ask that those who are doing this work focus on figuring out what is the level of detail about data in health records that we need to agree upon. And then basically, I mean I'll even go so far as to say, set that in stone, and then expect that all of these other activities draw from that. So that's the one thing I'd like, that's my proposal, I'd like to see if we can somehow decide whether that's important and figure out a way to push that aggressively forward.

The only other point that I'll make while I still have the floor here is that, and this is totally biased, one of the things that I think everyone is interested in doing, and again I think that it would serve this group well to promote, is that we also work to try and have common terminology, common value sets for these things. And so the work associated with vMR, the work associated with Health eDecisions, the work that's associated with the Meaningful Use, I mean I'm saying something that everyone agrees to already, but it would be nice to actually have this formally stated, that what we would expect among all these different activities, is that they work from a shared set of value sets so that the information that we expect to be communicated within each one of these data elements is the same. Again, this could easily be done through the NLMs VSAC. And with that, I'll stop.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay. So, thank you very much for the two comments. I'd like to move on to the perspective from The Joint Commission and then we'll circle back and pick up on the comments during the discussion time. So, are we ready, the slides from Patty Craig and Rute Martins?

Patty Craig – The Joint Commission – Associate Project Director

Thank you. This is Patty. Just a little background, for those of you that may not be aware, The Joint Commission, like CMS, is a measure developer, a measure steward and we also receive quality measure data, and we use that data in our accreditation and certification processes, and we also report the data publicly. Next slide. As Chris has already mentioned, the Quality data model is an informational model and it is used to develop the eMeasures specifications, which are sent out in the Health Quality Measures Format and then data is received using HL7's Quality Reporting Document Architecture. There are many entities that actually have adopted QDM at this point, it's not just CMS with the eCQMs, but CDC has also adopted QDMs through their usage of both HQMF and QRDA for their cancer registry and for their early hearing detection and intervention measures. Also S&I Query Health has been using the HQMF.

Next slide. I've been asked many times why anyone should be concerned about ensuring there's a technical linkage between clinical decision support and quality measures. And from The Joint Commission's perspective as an accreditor and certifier of healthcare organizations, we really see how CDS will affect quality measurement, because as doctors are being prompted by clinical decision support rules to provide appropriate care or given information to affect the care that they provide, that obviously will, in the end, have impact on the quality measures. So if there is no alignment between CDS and quality measures, or minimal alignment in the information model, we run the risk that while doctors are responding to the clinical decision support alerts that they are receiving, that they may still not receive the rates on the quality measures that they expect. And so then there would become this finger pointing of well who's right, is it the measure developer or is it the clinical decision support rules, and in most cases both are right because they'd be developed on the guidelines. But if the data is being pulled from different places within the EHR to affect them, then they could be coming back with different results.

Next slide please. So from our perspective, for the pros of the alignment, we feel that a unified model for the clinical concepts to support patient care is a major pro to perform this alignment. And we also think the unified model would therefore decrease burden for EHR vendors and providers. While, Rute and I have not had a chance to look at vMR in great detail, we do believe that vMR additional granularity would be useful for quality measurement, because that is one of the issues we've had in defining quality measures is granular data that the QDM does not surface for us. On the cons side, and this is coming from many different areas, not just The Joint Commission but also discussions we've had with other measure developers, obviously the scope of change for each side is really unknown. And the point – we can't really decide whether it is CDM that wins, vMR that wins or what portion of each one "wins," when the alignment happens.

From a cost of change, there's really no way at this point for us to estimate the cost of alignment. It's not just going to be the efforts of the two teams coming together and aligning the models, but then we also have to keep in mind all the downstream implications to HQMF, to QRDA, then to everybody that has implemented the measures. There obviously will be a cost to maintain the model, once we're done. Ownership questions, as Chris has stated, is looking as if it will become an HL7 information model. But whether the government owns the model or HL7 owns the model, the Joint Commission can see issues from both sides that's going to relate to the timing of being able to up ... models to everybody, whoever owns the model, are they going to actually remember all of the downstream implications for making any change. And therefore HL7 could do something that could blow a government project out of the water or the government could do something that then could affect perhaps international folks or other entities that have adopted the standards without the government being aware of it. And then, at least at this point in time, one of the cons to this alignment is we're not working in a sandbox, and we do question can alignment improve both models, and I think our summary will answer that question.

So, next slide please. Talked about this to some degree, we threw out the two different ways or scopes in which QDM and vMR can be aligned. One is either through harmonization where there are still two models but the differences are resolved, or merge into one model that is expanded to meet both needs. We would prefer to see the merger happen, we think it would be a lot better for everybody involved if there was only one model being used downstream for both clinical decision support and quality measurement. From a timeframe factor, the question is, are we just aligning the good or are we also fixing the bad and ugly. As measure developers and as data receivers, we have seen both the bad and the real ugly with ... and we would like to see all of that fixed. But depending on how fast it has to be fixed, as Keith has alluded to, or Rob, if we can do this in a sandbox that would be great, so that we can get it right. But if we have to do it based on regulatory timelines, I think we need to accept the fact that while we can align the good and might be able to fix the bad, the ugly is probably just going to come along in that first iteration, which means there's going to be a lot of rework downstream. And not just again to the model, but then that will affect the standards which will then affect everybody's implementation of those standards.

We'd also like to remind everybody that there's more stakeholders involved in this than just the quality measurement and CDS folks. There are the EHR vendors, there are the data receivers, and then there are those entities like CDC that has adopted this for public health and other activities. And then obviously, I think what's on everybody's mind, is the cost to change the measures...the models, not the measures, but the cost to change the information model, the standards, the applications and then the cost to maintain them.

Next slide please. So, last, our summary from the Joint Commission is, do we think alignment makes sense? Yes. Is it going to be hard to do? Absolutely yes. But we really feel alignment is inevitable and so if you feel that way too, then we think it needs to be done sooner than later. And that's the end.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

So thank you very much for that Patty. I think we're at the point where we'd like to have a discussion from the group on the two models and what recommendations we would like to think about and discuss. So, what I'm hearing is that, a comment I heard from Keith that harmonization is necessary, the clinical quality measures, clinical decision support, etcetera. And then Rob, you highlighted the fact that the overlap needs to be consistent, so if we harmonize, it has to be consistent. I guess there's the other piece is where there is an overlap, how do we address that? So, with those two comments, I'd like to then proceed with a discussion.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Hey, this is Jon White from AHRQ. I've got a quick comment and then a general question. The quick comment is everybody has made some good points about testing things out. There's experience in the past with doing pilot testing of standards that later on get incorporated into regulation. We worked with CMS in 2006 and a couple of years after that on ePrescribing standards. It may be meritorious of an offline conversation, I won't bore you with the details, but there's some experience for doing that. The question is a little tangential, but not inconsequential since we're talking so much about HL7, and it has to do with general access to HL7 standards, since we're talking about balloting all this stuff through HL7. There was some recent public release of a statement by HL7 that they were going to make things publically or easily accessible and openly accessible in terms of their standards, does anybody know if there's been any progress or change or news on that front?

Keith Boone – GE Healthcare – Standards Architect

This is Keith. I can clarify that.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Thanks.

Keith Boone – GE Healthcare – Standards Architect

So HL7 made an announcement Monday at HIMSS that their open-access policy to HL7 standards and domain analysis models will become effective April 1st of this year, and that means that anybody will be able to freely download those standards from HL7, use those standards to implement them in health IT systems. And so that's going to be effective at the end of this month. They're going through, right now, an administrative ballot which is required to make the bylaw changes needed to actually enable that process right now, and that actually closes the 31st of this month.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Thank you Keith.

Keith Boone – GE Healthcare – Standards Architect

(Indiscernible)

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay. Any other – Jon, did you have more discussion?

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

No. No, no, that's – I've heard enough of me. Thank you.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay. So then moving on with respect to how or what our group would like to discuss and recommend. Because we've invited our speakers so that we could get a sense of what models are important for the clinical quality measures, for the meaningful use program, I believe that's why we – well in fact I know that's why we've been asked to look at these two models. So I guess from again, a discussion standpoint, I'd like to talk more about the harmonization. But before we do that, I have a question for Chris, if you're still there. Chris Millet, are you there?

Chris Millet, MS – National Quality Forum

Yes, I'm still here.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Can you talk a little bit about the mapping that you described between HQMF and QRDA to the quality data model?

Chris Millet, MS – National Quality Forum

Yeah. So, the QDM is more of a logical model for describing the kinds of data that we want to use for quality measures or these other use cases, like CDS. But it doesn't have representation in the XML that's needed. So instead, what approach that was taken with QDM is that we created HQMF templates for the different components of the QDM and those templates, so for diagnosis active, there'll be a template for how to represent that in HQMF, and that's what's actually present in the quality measures. But that mapping, that's for all the components of the QDM to the HQMF and then all those HQMF templates have a mapping to CDA templates that are used in the QRDA reports.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay. So that's quite helpful.

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

Marjorie, this is Danny. I have a follow up question to that.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Sure.

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

So Chris, it sounds like that the QDM is sort of the...are the types of data that a measure developer commonly uses in plain English and that those are act...they're a representation of those classifications of data are in the CDA, correct?

Chris Millet, MS – National Quality Forum

That's exactly right, and in the HQMF.

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

Yeah. And so part of the conversation earlier that I was hearing is that one of the gaps that the vMR is looking to fill is that rich expressive language of "A occurs before B," all the logical stuff, am I hearing things? Okay, so, my question to you and it sounds like that one of the gaps is that expressionability, and I just wanted to be clear on this. Is the expression "A before B," all that kind of...all the logic that makes quality measures complex, is that expressive language part of the QDM or is that expressive language part of the HQMF standard.

Chris Millet, MS – National Quality Forum

I'm glad you asked that.

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

Yeah.

Chris Millet, MS – National Quality Forum

Originally that was not part of the QDM, the original scope of it was just to describe the concepts that are needed. But along the way, we kind of adopted components of the HQMF within the QDM specifications to specifically to capture things like "A starts before B." So we've added that along the way to the QDM and it's really just taking what was available from the HQMF and making it part of the QDM specifications so QDM users can get a sense for, how am I going to relate these things together. But we know that's not enough, we know that's where a lot of our users struggle with just trying to make that "A starts before B," and a lot of those expressive components work for them. But that's one of the key things we know that can't stay as is, in terms of being part of the QDM.

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

Got it Chris and thank you for clarification. And just one other question to that, so it sounds like that the QDM is aligned very, very clearly with the CDA and I believe that a lot of that logical representation is also aligned with the CDA. So, aligning with the QDM is, in essence, aligning with the CDA.

Chris Millet, MS – National Quality Forum

I would say it would be aligning with CDA and the HQMF.

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

Got it.

Chris Millet, MS – National Quality Forum

Yeah. But otherwise I think that's – sure.

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

Okay. Good.

Matt Humphrey - Telligent

This is Matt Humphrey from Telligent, if I could just jump in for a second on this point, this ties back to Rob's point about where it overlaps and where it doesn't. There's a very key piece here of defining logical syntax versus data elements and as was mentioned, since vMR doesn't contain a logical syntax, in my mind the correct approach to harmonization is harmonizing just the data model itself. The correct approach is to design this logical syntax or query language independent from a data model. So it should be, for example, like SEQUEL, so there's no need to say "A starts before the start of B," in the logical syntax itself. You can represent it that way in the human readable, but what you're really saying is "A dot start date is less than B dot start date." You know, another example is the first or the most recent that you see in a human readable, it really should be handled by order and index so order descending, index 1 and you want to define this logical query language independent from that data model. And I think that's an important thing to establish, whether you're talking about the syntax that drives the comparison of the data elements or how that syntax is represented in the human readable, or the data elements themselves, I mean, there are three pieces of that QDM that lines are historically quite blurred.

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

Yeah, so this is Rob McClure again. And thanks Matt, thanks Chris. I think that, just to reiterate what I said, which is, this is kind of a prioritization of this process and a lot of this builds from that, I'm going to say a phrase that I'm going to regret because it's used elsewhere, but that data model. And the work that was just discussed today, and the work that's occurring in the context of the HeD, CDM work is that, where they're identifying what things are the same, and there are different levels of what you might call granularities, where those things line up, and then filling in so that the detail is sufficient. As Patty was saying, one of the things that comes up frequently, and this is true both in quality, but particularly in clinical decision support is that you often times have to have pretty detailed things. Actually I'd switch that, it's more often in quality, because the things that you're looking for in quality are often very detailed, specific things that you want to see occur. And so again, I just want to kind of push that this group think about, recognize and then perhaps promote the importance of aligning at an acceptable level of detail, this data model across all of the things that we would like to see occur in the context of our standards work. I want ... and that I think is pretty straightforward.

I actually want to say one other thing, because this aligns with what Chris was talking about in terms of the templates that are used. There's some other activity elsewhere that are where this idea of templates or consistent groupings of the various data elements to accomplish a common goal, have been found to be really useful. And I can say that in the meaningful use quality measure work that's being done, we're seeing this, where you have a series of data elements and a number of different measure stewards attempting to do similar things and the difficulty everyone's facing, they approach this, eventually, in slightly different ways. And one of the things that's been discussed, it's not actually the top priority right now, but based on perhaps this group it could become a top priority, is to identify in this harmonization process, focus on identifying, I'll use the word template, there are other words, archetypes for example comes to mind, where key kind of collections of these harmonized data elements are the things that we focus on creating first.

And if we did that, I think we'd move a couple of parts of the process rapidly forward, we would get this harmonization around these key areas, we would provide guidance for both measures and for quality or decision support, about how you are expected to at least exchange information if not even represent in systems these key areas. And so I think that would, that's a stretch goal because I think our baseline is we have to get the data elements in a common format. But if we even then say, let's group these into groups of areas that we know we need to do, we'd even be able to move that harmonization past where we are now.

Aziz Boxwala, MD, PhD, FACMI – Health eDecisions

This is Aziz Boxwala, if I can just add to that. I think, I mean I agree with many of the comments made earlier, so I think data model alignment is important and I think expression languages and data model, like Matt Humphrey said, should be kept separate. And that's the way we've done it within Health eDecisions and vMR does not have an expression language by design and we've separated those two out within the HeD syntax too. So that is a separate expression language that can operate on the vMR data elements and you can write logical criteria about it, you can write some data mapping expressions within that and that would allow both the data model and the language to evolve separately from each other. And if I can just add also to Patty Craig's slides, a little bit more commenting on those. I mean those kind of laid out the issues very nicely. I would say that timing is important, that we start moving quickly on this, not necessarily doing things in an expeditious manner cutting corners, but the faster we can move, the better it is so that we don't – as Chris pointed out, there are a number of eMeasures already existing, a number of tools existing that support HQMF. HeD does not have that yet, but if we can move and create a common model, then within Health eDecisions we can at least adopt that common model, after the pilots.

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

This is Danny again. Based on the conversation earlier, it was my understanding that not having expressive...an expressive language in the vMR, in some ways was a gap that wanted to be filled, but now it sounds like that was done intentionally and that's probably a good thing. Is everyone on the call clear about what the problem is that we're trying to solve by bringing together these two models, because I'm not. Could someone on the call sort of clarify, is it just that when one activity is saying active diagnosis of diabetes, that's represented in the same way that the other activity does it?

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

So Danny, this is Marjorie. I'm doing to sort of provide the thirty thousand with you and then others can discuss more the detail. So I think that there's sort of an acknowledgement that the vMR and the QDM address some very similar issues. And I think in the spirit of not moving forward with competing standards, we thought it was important to sort of discuss the objectives and goals for each of those standards. And that's the purpose of having this discussion today and then how can we sort of apply these standards to the clinical quality measures that will be used in the meaningful use program, either together or separately. I hope that provides the overall reason of why we're having this discussion.

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

Marjorie, this is Rosemary Kennedy.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Sorry.

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

Is the scope and the focus just on meaningful use measures or broader things that facilities are trying to do to improve quality?

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

I would say our charge as the Clinical Quality Workgroup, I would think that the meaningful use program is one of the things that's important for this group to discuss. Although we haven't formally been asked by ONC to address that, but that is something that was on the table for discussion. But I think the other point that you raised is also equally important as well. Does that help you get to the – does that sort of help frame things for you, Rosemary?

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

Yeah, yeah. I think facilities are trying to use this standards, the data standards, the expression language, the whole entire infrastructure across the organization for measures that have been endorsed, but also for new measures they may be working on or just broader areas of quality measurement. So I guess we could assume that if it meets the specificity related to endorsed measures, because there's a great level of granularity, that it could be used for other initiatives but, we just need to be careful that we're not competing or creating standards that couldn't be used more broadly.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay. Thank you, Rosemary.

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

Rosemary, this is Rob. I mean I certainly hope that we're addressing this beyond meaningful use. I mean, excuse me, I think obviously ONC has a quicker path to seeing whatever gets determined as the right approach, get it implemented in meaningful use. But, let's be honest, what we want, this group is engaged in not only meaningful use, but, I mean the people who are on this call, are engaged in things beyond meaningful use and we would want to see it implemented broadly. And the decisions that we make will have great impact, that's essentially what Patty was saying; I absolutely agree with that statement and would hope that we take that to heart. In other words, whatever we do, we do in a way that we expect it to have a broader impact.

Chris Millet, MS – National Quality Forum

And Rob, this is Chris Millet, can I just add on to that? I mean I think we're already seeing that, even work that was focused on just creating measures for meaningful use. We already see some organizations that take those measures and then try to do other things beyond meaningful use with them. So, I know there are a few organizations that tried to take the eMeasures from meaningful use and try to make clinical decision support based on them, even though that's not necessarily part of meaningful use. So, the users of this are also going to take this and run with it as well.

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

So, this is Danny. Is a desired endpoint that we can strive for is it that both quality measure artifacts and CDS artifacts are represented using the same standards? Is that what we're sort of striving for?

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

I think we need to have a discussion and that might be an endpoint, Danny. I think we're here to discuss both of those standards and that might be a conclusion at the end. I don't know what others think. And I want to add that Jim Walker is on the phone as well.

Kevin Larsen, MD – Office of the National Coordinator

This is Kevin Larsen from ONC. One of the things we want to avoid is something that Patty mentioned, which are conflicts that are kind of illogical to a user. So for example, if clinical decision support suggests that you give a medication before a procedure, we would hate to have the way that's represented, because of its sort of technical representation, be different than how the quality measure measures that that same medication was given before that same procedure. And so that misalignment we want to be sure to avoid.

Keith Boone – GE Healthcare – Standards Architect

So, I would go even further – this is Keith Boone – and say that the way that we model the information that's used for clinical decision support or for measurement needs to be the same. Because if you have a guideline that says you should be doing something a certain way, you ought to be able to turn that into a clinical decision support rule and you ought to be able to turn that same thing into a quality measure and if you are not modeling the two things the same way, then you can't do that.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

So, this is Marjorie. Then I would build on that and say then, is the harmonization of the quality data model and the vMR, does that get us to that ...?

Keith Boone – GE Healthcare – Standards Architect

That's one of two things that was discussed at the HL7 working group back in January, that needed to happen, and there also needed to be harmonization of the models used in HeD, in the Health eDecisions work, along with the health quality measure format. And that work is work that's actually in process now in HL7.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay.

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

Yeah. This is Rob. I keep barging in, but just another obvious thing that people I think have in mind, but again my biased statement about the value sets and the data that we expect those models to actually capture and carry. So, we are talking about both of those, whenever we talk about the model, we're also, I think, need to also go so far as to say that we, I'll couch this a little bit in saying in the key areas, we want to also make sure that we're establishing common value sets, common expectations with regards to standard terminologies where that's appropriate.

Rute Martins, MS – The Joint Commission – Associate Project Director

This is Rute Martins for The Joint Commission. Rob, I want to add to that since we've kind of touched CDA as well, and this is something that we weren't as measure developers necessarily aware of, but the existence of value sets in the context of consolidated CDA and how that also impacts the value sets that we're using in measures. So, there are multiple layers of alignment that need to occur here that go beyond vMR and CDM. And then to go back to Matt's point on the expression language, since that's missing from the vMR piece, and as Chris said, there are challenges with the way we're expressing logic with the QDM, I would add that as a third component. So there are the standards themselves, the information model for the data elements, value sets and all that comes with it and then that third component, the expression language. Although it's a separate issue, it still warrants alignment. Going back to Kevin's point that it's not just the data elements, it's how we're pulling this information and timing is certainly a component of that.

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

Right, and kind of everybody again also has, I think, this in mind, that the reason that we're doing this is multifactorial. The vendors all would love to see this, but the clinicians, believe me, are desperate to see this. When you get to the specifics, and we see this often times in the quality assessment stuff because that's been kind of more directly addressed and its impacting clinicians more directly right now. And in that process, we're identifying situations where we do expect care to result in certain things being recorded in the record. And if we do that and that does not align with the sort of things that we also would like, the vendors, the clinicians, that healthcare delivery organizations would like to see implemented in their systems to improve patient care, we've really screwed up. So we want that environment that a clinician and that a patient lives inside to be impacted by our decisions in one way and one way only.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Okay.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

So this is Jim. In terms of any kind of recommendation that the workgroup might make today or in the future, going back to Danny's sort of comments, it seems to me that we would need a crisp, easily understood by people who haven't been in this discussion, statement of the benefits and some kind of estimate of their value, not necessarily financial, although that might well be part of it. And then, I think we were told that the cost of this is unknown, but probably substantial. I would think we would need to come to some kind of agreement on what would need to happen for us to have a better estimate of those costs before we could reasonably recommend anything to anyone.

Keith Boone – GE Healthcare – Standards Architect

Well, when you say the cost of this, and this still being nebulous, I'm thinking back to some of the statements Patty Craig made about this being somewhat challenging and having to go back through and do some remodeling, etcetera.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

I thought she said the costs were probably substantial, but unknown.

Patty Craig – The Joint Commission – Associate Project Director

Yeah, and this is Patty. I guess where I was coming from, I was putting my IT hat on and the fact that until we actually perform the remodeling, we're not going to be able to look at downstream applications to see where what type of costs are going to happen, what type of impact is this going to have to CMS's infrastructure, to the Joint Commission's infrastructure, to EHR vendors, to Cypress. We're just not aware at this point. Until we can see just how much QDM is affected and then what type of downstream ramifications will that have for HQMF and QRDA.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

I would say downstream and midstream. Midstream would be the measure developer's efforts as well, which I can – as a measure developer, I can foresee some challenges there.

Patty Craig – The Joint Commission – Associate Project Director

Yeah, I agree with you there Marjorie.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

So, I'm not against it, I just can't imagine anybody responding to this positively if we can't give them some reasonable good faith, order of magnitude estimates of benefits and costs.

M

I'll still love you Jim.

Keith Boone – GE Healthcare – Standards Architect

So, interesting that we're having this discussion now, this having been I want to say and extremely lively debate at the HL7 working group meeting and several Health eDecisions sessions before and after that, back in January. I think there's been some recognition in the standards development space that these are some issues that need to be worked on. I think it would be great for us to be supportive of those organizations that have already decided that they'd like to address this, to say yes, we're supportive of your efforts to address this and we think that this is necessary. But I'm just wondering how much we as a deliberative body can sit here and sort of sit back and go, oh, well we need more information about costs, etcetera, without talking more to the people who are actually doing the work and have already decided this is work that needs to happen.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

Well, this is Jim again. I mean, if they've decided they're going to do it and they don't need our recommendation to do it, then we don't need to make a recommendation. What's our value add then? All I'm saying is ...

Keith Boone – GE Healthcare – Standards Architect

I think our value add is the recognition that this is something that would be beneficial, if those organizations are ...

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

And you think we know enough to say, this would be more beneficial than any reasonably predictable adverse effects.

Rute Martins, MS – The Joint Commission – Associate Project Director

This is Rute with the Joint Commission.

Keith Boone – GE Healthcare – Standards Architect

I've been involved in the discussions. I can't speak for other people in the group.

Rute Martins, MS – Associate Project Director, The Joint Commission

This is Rute of the Joint Commission. I would just like to throw the question out there of – we're thinking, or you're thinking about the cost of doing this, what is the cost of not doing it?

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

Yeah, that's the benefit side, absolutely. It's just – if we were to add something, echoing other people – it's clearly a critical issue, has big implications, but this wouldn't be the first thing that was a critical issue and had big implications that didn't turn out to work so well. It's just, these things are hard. And at any rate, for us, it seems to me for this group to make some kind of additional recommendation would need to access HL7's benefit cost analysis, for instance, and say, include that as part of our recommendation. Say, we think HL7's benefit risk analysis, benefit cost analysis is valid and justifies our support.

Gene Nelson, DSc, MPH – Dartmouth University

This is Gene Nelson from Dartmouth. I understand your point of view Jim, and recognize, I think, the need to harmonize or unify. I think one rationale underneath that would be that rather than viewing this as function one, decision support, and function two, quality measurement. Oftentimes in well-designed information systems, the decision support has the process quality and outcome quality measures embedded in the decision support, as in ProvenCare or as in the Brent James Clinical Process Model. So, to view these things as actually being, from a design standpoint, beneficially integrated, perhaps is a perspective that we could take and recommend, therefore unification or harmonization is very important. Because as the care is unfolding and the decision support is happening, is it being enacted and do the local and summative measures reflect that, so the one can throw off the other?

Chris Millet, MS – National Quality Forum

Hi, this is Chris. Can I just offer a perspective that relates to cost that I know we've heard in conversation since January? Most of the people involved agree that this is something that's beneficial and probably worth the cost, even if we don't know exactly what it is. But the concern that keeps getting brought up is, this is a significant effort and in order to do it properly, we need to ensure we have a lot of the folks who are impacted by it at the table. And that means we need to factor in what is the cost for them to be at the table within the scope of their existing work, like this can't continue necessarily as a purely volunteer-driven effort, because the scope of the work is just too big.

Keith Boone – GE Healthcare – Standards Architect

So who's got the money to step up and do it. Most of the standards work that actually goes on is volunteer-driven.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

And will probably remain that way, in all likelihood.

Keith Boone – GE Healthcare – Standards Architect

I mean I think that actually is the clearest statement about benefit right there is that there are volunteers who are willing to put time and effort into doing this.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

Just as long as we have some kind of confidence that this isn't going to mean that it becomes even harder for small hospitals to manage their business, even in some short term on the way to nirvana, this isn't going to negatively affect small HIEs and practices of 20 docs. If we know that or have some reasonable basis on which to think it, I think we just ought to reference that and say, I mean, in total, I'm willing to posit this is something that needs to be done, that it's insane to have decision support and quality measures not be part of one integrated process, and one integrated set of models and languages. I think it would be useful if we cited somewhere where somebody else had done some kind of back of the envelope even analysis and said, we're confident we're not going to knock some small, relatively resource-constrained group of stakeholders out of the box with this.

MacKenzie Robertson – Office of the National Coordinator

Yeah Jim, I think that's a fair statement. And also thinking about cost, not all cost is monetary. There are other costs as well, and so it's the cost of making the change. And I guess what you're looking at is, it's the cost benefit analysis and what's the benefit on the other end that outweighs the overall cost.

MacKenzie Robertson – Office of the National Coordinator

So this is MacKenzie. I'll just add my point of view on this. It seems like unless we have a clear direction from ONC on exactly what the workgroup should be looking at, if we're not sure the direction the workgroup would want to take, if this is something that we'd want to make a recommendation on in the future. Perhaps at this point we've had the listening session and we've discussed the issue enough that we discuss it here internally at ONC with Jim and Marjorie, the workgroup chairs. And if this is something that the workgroup should take on and prepare formal recommendations to present back to the HIT Standards Committee, to transmit to ONC, we can make it as part of the March 27th Standards Committee meeting agenda and discuss it there. Because just as a matter of process, the workgroup can't prepare any recommendations directly, they present back to the Standards Committee for the Standards Committee to make recommendations.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

Yeah. Absolutely. And maybe part of the – we sort of scheduled this listening session, which I think has been very successful, understanding that we really would need a clear set of questions for the group to answer, to be effective. And so, maybe that is the next step, is to say, we've done this, there's clearly a feeling that this is likely to be the best available solution to a critically important problem, what specifically do you want the group to comment on?

MacKenzie Robertson – Office of the National Coordinator

So Julia, I know I sent you an email asking just to do kind of exactly what Jim said, if we want to summarize what the ... before the workgroup now and what they're discussing, so we can discuss it at the Standards Committee meeting and within ONC as well. Because we'll have to go to public comment now and then we can plan, if this is something the workgroup is going to take on, we can do a deeper dive.

Julia Skapik, MD, MPH – Office of the National Coordinator

Sure I've got six pages of notes here and I'll work with Jim and Marjorie to ...

MacKenzie Robertson – Office of the National Coordinator

Okay. So, before I open for public comment, I just want to make sure there weren't any more – I just want to make sure, Marjorie and Jim, that you're ready to go to public comment.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Yes, I'm ready.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

Ready.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

All right. Operator, can you please open the lines for public comment?

Caitlin Collins – Project Coordinator, Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

MacKenzie Robertson – Office of the National Coordinator

Okay. Thank you. And so we'll follow up over email on whether or not this is something the workgroup will take on, and just so everyone knows, the next scheduled Clinical Quality Workgroup meeting is for April Fool's Day, April 1st at 12 p.m.

Marjorie Rallins, DPM – American Medical Association – Director, Clinical Informatics

Thank you.

James Walker, MD, FACP – Geisinger Health System – Chief Health Information Officer

Thank you.