

**HIT Standards Committee
Clinical Quality Workgroup
Transcript
November 14, 2013**

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Good afternoon everyone, this is a meeting of the Health IT Standards Committee 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 the meeting is being transcribed and recorded. I'd also like to remind everyone if you are not the one speaking, please mute your lines. I'll now take roll. Marjorie Rallins?

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

Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Danny Rosenthal?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

David Baker? Keith Boone?

Keith Boone – System Architect – GE Healthcare

Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Anne Castro? Chris Chute? Jason Colquitt? John Derr? Bob Dolin? Floyd Eisenberg? Rosemary Kennedy?

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

Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

David Lansky? Brian Levy? Rob McClure? I know Rob's there. Galen Murdock?

Galen Murdock – Veracity Solutions

Present.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Gene Nelson?

Gene Nelson, DSc, MPH – Dartmouth University

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Philip Renner?

Philip Renner, MBA – Kaiser Permanente

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Eric Rose?

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

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Joachim Roski? Randy Woodward? Kate Goodrich? Kim Schwartz? And I believe Julia Skapik you're on the line?

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

That's correct, thank you Michelle.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yup, and with that I'm going to turn it over to Marjorie and Danny.

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

Okay. Good afternoon everyone. Thank you Michelle. This is a continuation of our discussion that we had last week, which we thought was very productive. At that meeting last week, we talked about the HQMF, Bob Dolin gave us a presentation, and we were having that discussion because we came to, I believe, some kind of consensus that part of our charge was to focus on some standards for Meaningful Use Stage 2 and we landed on addressing issues with HQMF first. We also felt we needed to get some background information on HQMF, and Bob Dolin gave us that presentation.

We also felt that we needed to get – learn more and dive a little deeper about HQMF and we're going to do some of that this week. We're also going to – we also asked you to submit to us some areas where you think there are some problems with HQMF R1, and we did receive some feedback. Eric Rose, thank you very much for forwarding some things to us. Julia also provided some information. And we thought this week we'd start looking at those issues and sort of identify where some of the gaps are so that we can continue this discussion. And Danny will sort of walk us through the process of evaluating some of those gaps.

Keith Boone – System Architect – GE Healthcare

And this is Keith. We, I thought were also going to look at the principles work as well.

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

That's right; I'm going a bit too quickly. So thank you very much Keith. One of the things that we need to talk about is the principles, because we weren't able to do that last week and we'll start off with that. Because the principles will then help us evaluate the standards and walk through the gap analysis and at some point, help us move our recommendations forward. So with that, Keith are you ready?

Keith Boone – System Architect – GE Healthcare

I certainly am ready.

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

Okay. Did you forward something over to us?

Keith Boone – System Architect – GE Healthcare

I sent slides last night at like 2 in the morning.

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

Oh, okay.

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

Do you have them Michelle?

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

Michelle, are you there?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Sorry, I was muted. No, I did not receive any slides.

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

I'm sending it right now, sorry.

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

We apologize.

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

So you and Caitlin are getting them right now, if you can pop it up when you get a chance. I would say we can let Keith go ahead and get started.

Keith Boone – System Architect – GE Healthcare

Okay. So, let me just tell you a little bit about what I did with the slides, and then when we have a chance to pop them up, I can just get into some of the details. So what I did was I actually went through the entire deck last night and consolidated what appeared on just about every slide into some higher level principles. So there were a number of different things that talked about, for example, maturity or well established standards or widely recognized or things of that nature. And so what I did was I just consolidated pretty much everything that showed up and it consolidated up really well. It consolidated into about 10 points. And so when we have those to show, I can actually go through that particular list, assuming that can show up in just a moment or two. And then I have one –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I'm sorry Keith, can I just interrupt – Julia, I haven't received those slides yet. Sorry Keith.

Keith Boone – System Architect – GE Healthcare

No problem. I can also go to my mail and look at my sent items. So that went to Marjorie, Danny and Julia and so I need to forward that to you and your email address is –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

It's not an easy one, but Michelle with two "L's" dot Consolazio –

Keith Boone – System Architect – GE Healthcare

Oh, I got it.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, good.

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

All right –

Keith Boone – System Architect – GE Healthcare

So I'll –

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

Go ahead.

Keith Boone – System Architect – GE Healthcare

I love autocomplete. So, that just – from me.

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

So keep going Keith.

Keith Boone – System Architect – GE Healthcare

Okay. So I'll go on and we'll pop the first slide up and I'll just enumerate them. So, the first item is, does the standard fit into whatever our existing and/or planned architecture in terms of meaningful use and the various standards and they're all fitting together. The next one is does the standard actually meet identified program goals and requirements? So in our particular case we're looking around goals and requirements around clinical quality measurement, clinical decision support and what those goals are. Is the standard itself either well suited to and/or designed for the specific purpose for which we're trying to identify standards? Or are we trying to force fit something? Right, so the idea of the principle is that we want something that's really – designed specifically for the purpose for which we're trying to use it, or is a close fit. An example – for example, in the close fit category, one of the things that we wound up doing with HQMF in the Query Health project was actually seeing that the way that HQMF was responding with answers to questions about counts of things. Because if that actually was really the same kind of thing that Query Health was doing, even though query health wasn't calling the things quality measures, they were talking about research questions. But their research questions fit fairly well into some of the similar notions that fit into quality measures. So that would be sort of the close fit. And when we talk about designed purpose design, like we were talking about clinical summaries, the CDA consolidation effort, CCDA, was on purpose design to meet those specific goals.

Next, is this something that's a well-recognized, well-established or mature standard? And so widely recognized, I guess was the word. So when we look at that particular criteria, there are some interesting questions about that, because a lot of the work that's happening in the standards space is happening sort of in response to Policy and/or Standards Committee sort of direction about places we want to go. So the standards haven't necessarily been around that long, so it's hard to say necessarily that they're well established and are mature. But in the case of, for example, Consolidated CDA, that's actually building off of a base set of standards that are well established and mature. And Consolidated CDA is something that everybody knows about because there's been a lot of engagement and involvement in the development thereof. So, recognition of a standard doesn't necessarily mean that it's been around a long time, but at least it got some good recognition, people understand what it is and what it's intended to support.

Does it have or is it expected to have in a short period of time, implementation, adoption and use? Right, so when CCDA first came out, well of course there really weren't a whole lot of implementation, but it was certainly expected that it should be, maybe not an easy lift, but a lift that people were already working on to move into supporting that standard. Is the standard testable and has it been tested? So testability is really a – is for components, criteria, are there tools to test conformance and verify that somebody knows the – message or communication that complies with the requirements of the standard. And then has there been any testing in various environments, and – has there been pilot testing, has there been a real world testing, that goes along with it.

Does the standard have SDO support? So is this something that is developed by a standards development organization and does that standards development organization meet the sort of the existing NIST and OMB circular A119 criteria for openness and balance and all of the other good things about standards development organizations including the consensus development process. So does it have that level of support or is this something that a group got together and put together and said, well this could solve the problem, but then we're stuck with the issue of, how do we maintain this? And as we look at, for example, right now the Direct project and that set of specifications, unfortunately that doesn't have an SDO home.

So there's still a little bit of ongoing maintenance that's happening with that, that's sort of in the S&I Framework to some degree or maybe with some of the implementers. But it doesn't really have an SDO home at the moment. And so that's not an ideal situation, because if you need to do maintenance and you really don't have the right kind of resources available to readily and quickly do that maintenance, if somebody finds a bug and you need to go make a fix, you just sort of need that availability and capability to support that.

Is it something that's readily available without encumbrances? And, that doesn't necessarily mean free, although that's sort of the ideal, when it's something that's free, but there are a number of standards out there that you still have to pay to use. It's not true at HL7 anymore, but easier if something that's readily accessible, not too much of a burden for implementers to use and is it – does it exist without specific patent restrictions or other sort of encumbrances that would make it hard for implementers, and especially those like in small businesses, to be able to be using and support.

Another area is, is it of low complexity? And by low complexity I mean, it's got enough complexity to support the requirements, but not more complexity than is justified by those requirements. And the idea behind low complexity is that it makes it easy to use, it makes it easy to explain to non-technical people and makes it possible for them to sort of look at the output and say, yeah, I understand this or I understand this at a high enough level that I'm ready to make some decisions about it. And that also gets into one of the issues of, over the wire sparsity, so the complaint about TTDA not being – it's over the wire sparse as it could possibly be really as it boils down to. There's more complexity involved in that than is absolutely necessary and so, we're looking for that complexity.

And then finally, have we – or proved it? Is it extensible so that there are places where if there's something in the standard that's missing, for which we have some requirements, is there a way we can extend or build from it so that we're not totally wired in to only what the standard says it does and can't add some extra piece of information that might be needed according to our specific requirements. So and case in point in CCDA, the standard has the capability to support race and ethnicity, but under US OMB guidelines, you can have multiple races. So because the standards extensible, there's a place to say, well here's how you can capture additional code supporting documentation of race in the clinical document.

Have we got the slides yet or are we still waiting on them?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

The slides are up.

Julia Skapik, MD, MPH – Office of the National Coordinator
(Indiscernible)

Keith Boone – System Architect – GE Healthcare

Okay, yeah. So go ahead and move to the next slide. So on this next slide, so in terms of doing an evaluation, as we're evaluating, we have a number of questions to ask. And one of the first ones that we would be asking is, does this fit into our existing or planned architecture? But the \$64,000 question that we have, and I say we, that's in terms of actually the HIT Standards Committee as a whole, as what is our architecture? We don't actually have anything other than an implicit architecture specified by meaningful use, and it's – umm, I won't say a straightforward job, but it's an engineering job to actually be able to pull out and rationalize an architecture around what we currently have.

And then in terms of program goals and requirements, what are we trying to do? We need to be able to ask the question, what are we trying to do in the selection of a particular standard so that we can identify goodness of fit, but that mean you can also identify and ask the question, well does our architecture need to change to support that capability? So as we look at, for example, standards for clinical decision support for which we don't have anything at this stage, what's our – what's a high conceptual level, what's the architecture that we're looking at to support that capability? And do we need to maybe add something to what's already there in order to be able to make better judgments about the fitness of the standard?

And then, is this standard designed to do what we're looking for? And if it's not designed to do what we're looking for, why it's still a good fit. So that's sort of the HQMF application to Query Health, why is it still a good fit, well because even though it wasn't designed to do what we're trying to do, it's answering the same kinds of questions. Whereas we could look at other standards and we can say, well this isn't really designed to do what we're trying to do, it's a very generalized thing and we're going to have to apply a whole bunch of rules to support that, maybe that's not such a good fit.

On the maturity side, we also need to understand that not everything is going to be mature. And so from a sort of a principles perspective, we need to step back one level first and say, okay, so what kind of risks are we willing to take? What is it that we are willing to risk in terms of what we'd sort of see as the expected return on the use of the standard? And there are a couple of ways that we can look at the maturity, in terms of assessment of this. If this is something new, does it build on previous knowledge or is this just completely de novo, not building on something that we've already done. If it's something like CCDA, where it's building on existing knowledge of what we did with HITSP C32 and sort of trying to resolve a bunch of the issues that we already knew because of existing deployment experience. That's not the same as if we were going to go with a completely new, de novo built standard that we don't have that previous experience with.

Has it ever been used in a real world environment? Is this something that people are using today maybe in isolated smaller cases? So I think, I know Doug's actually, Doug Fridsma's got some slides where he talks about local pilots, regional sort of deployments and then national level deployments, so we can look at, well what's the size of that environment and how well tested was it in that environment? And has it been tested? And can I get this today, is this something that's publically available that – are there implementations that are out there? Do you have people out there just all – open source implementation. (Indiscernible)

And then another step back from this is, well okay, how well do I trust the organization and processes that went into the development of this particular standard, if it's not that mature and how successful have they been in the past in producing materials that we're currently using? So if this is a brand new standard developed by a completely brand new SDO, that's potentially more risky than if this is an existing standard that sort of fits along the lines of other standards of a similar nature, but have been developed by an SDO that's been around for a decade or more. And so that gets into who maintains the standards? It helps to assess sort of the riskiness of adoption based on where it is in its cycle of maturity. And understanding that while the ideal is that we'd love to adopt stuff that everybody's been using, that's been around for 10 years. It isn't always necessarily the case that the standards that we want to apply for meaningful use are things that necessarily meet that category because if we've had them already, we'd probably already have been using them.

And then is it easily and inexpensively implemented? This is the two guys in the garage test, can two – two guys, two gals, two people or can one or two or a few people who are maybe building some innovative piece of new technology be able to access this and implement it on that technology. Or does it really require a lot of resources and a lot of experience and maybe a degree in HL7-ese or DICOM-ese or whatever, to be able to understand it. The test I always look at is, can I take somebody that's been through an AA degree in programming and has a few years of experience in healthcare IT environment or healthcare itself, and can they maybe do something productive – maybe not implementing the whole thing, but are they able to contribute to being able to use this standard? Because if everybody who's going to be required to do the development has to have a Master's Degree in Informatics to be able to implement it, then the ability to roll it out isn't going to be as easy as if it's something that, well, you can just go to the lab and read this page here and there are some examples over here and you can write some code and get something working in a day or two or a week or two.

And then lastly, is it future-proof and adaptable to change? And part of the future proofing is, is there somebody to take care of it? And does it have some sort of extensible capabilities or a good process to be able to adapt and change that standard, so as we're finding new issues or we're finding new capabilities that we'd like to see. That there's some mechanism by which we can advance the standards work to be able to support new capabilities in not just Meaningful Use Stage 3, but Stage 4 and fill in the blanks. So, those are the kinds of questions to ask and if we go back to the previous page –

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

The one after that, menu.

Keith Boone – System Architect – GE Healthcare

Yeah, this one. If we go back, these – this is sort of the 10 high level principles that I think we're looking for in standards selection. And I think this works fairly well, not just for this workgroup, the Clinical Quality Workgroup, but is actually something that we should be looking at at the level of the Standards Committee itself, of being able to apply this sort of – these sorts of principles to all of the standards selections. And I think the one sort of key outstanding message of all of this is, that we need to get an understanding of what our standards architecture is for meaningful use and where we see it going.

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

Great. Keith, this is Danny. Keeping an eye on the time, thank you for walking us through this and summarizing your presentation into this, nice, easily consumable slide over here. We have an hour scheduled to talk through – if you're not speaking, could you please mute your phone, por favor. Muchas gracias. So what I'd like to do is, we have an hour – to talk through gaps, or potential gaps in specific examples of HQMF. Before we do that, I wanted to open up and see if people have comments about Keith's presentation and specifically looking at the slide in front of us, are there any additional guiding principles we should have listed on this particular slide?

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

Danny, this is Eric Rose.

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

Hey, how are you today, Eric?

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

Good thanks. How are you? I had a question, Keith – I'm sorry, there's some weirdness going on with my phone. Keith, if you could go back one slide, I was a little unsure about the reference to architecture and I had a quick comment and then maybe you could expand on that a little bit. But, I would think that – I assume that by architecture you mean the sort of technical and information sort of environment into which any proposed standard for quality measurement or standards would have to be integrated. And its – I would think that the only thing we can assume as far as architecture is; a) whatever is specified in current require – or planned requirements for certified EHR technology and b) probably we can make reasonable assumptions based on what we know to be out there. I mean, like for instance, the ePrescribing standards were probably selected based on the fact that, among other things, it was known that lots and lots of retail pharmacies in the United States can accept NCPDP scripts transactions. And so that helped, I think – so, I just want to confirm that that's what you mean by architecture. Because I was just a little concerned, there might be different meanings behind that.

Keith Boone – System Architect – GE Healthcare

So, no, that's exactly the kind of thing that I mean by architecture. It's a high-level view of – so if we take a look at what's in meaningful use, we have a basic information model, it's the meaningful use common data set. That, at least in some of the quality – that's one part of the information model and then there's another part of the information model that fits into the value sets. So, when we ask about the architecture, we know that's our information model, so those – this standard that we're looking at, is that something that can work with 17 data elements that are in the common MU data set and is it something that fits – can support use of the values out of those already extant value sets.

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

Okay.

Keith Boone – System Architect – GE Healthcare

And so how does it fit into that particular space? So it's not – it's not getting deep into a very detailed technical implementation architecture at all, it's more high-level, conceptual – architectures around being able to maybe do push transactions for delivery of information to patients. And we also have some ways to support pull and maybe there are some technical considerations around, we'd like to support REST, kinds of questions, not much deeper than that.

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

So, and of whom were you proposing that we ask this question?

Keith Boone – System Architect – GE Healthcare

I think this – I think the question of actually being able to address what is our architecture could go a couple of different places. I think one of the places that it goes is, I think we just provide some feedback to the Standards Committee itself to say, so it's important for us to understand our architecture and we really don't have a good story to tell around that. Can you start a work stream to address that? At some level I think the necessary expertise in that probably exists in NwHIN Power Team and the Security and Privacy infrastructure workgroups, because most of its probably going to be in sort of the generalized infrastructure that maybe the power team could address. But when you get into the security and privacy space, there is some architecture around that that's going to require that level of expertise. And I don't see this as being a huge, long endeavor either, I think it's more, let's capture what we know and be able to – I'd love to be able to say, here's the two slides that sort of explain the meaningful use standard architecture at a high level in a block diagram.

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

Um hmm.

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

So this is Marjorie and as – in listening to this discussion, I'd like to make another suggestion. And that is, these questions, I surmise, are the summary of the types of questions that we'll use or that becomes our – these questions essentially become our evaluation criteria to evaluate whatever standards we want to put forward in front of the HIT Standards Committee.

Keith Boone – System Architect – GE Healthcare

That is exactly it, yes.

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

Excuse me?

Keith Boone – System Architect – GE Healthcare

That is exactly their intent.

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

Yup. And so knowing that, I would say, I think as a group that we need to be solid on our criteria. And just like Eric asked a question about architecture, I think we as a group need to come to consensus that this is the appropriate set of questions. I think, personally I think they're a good set of questions, but I'd like to ask others if they have some additional input. And my question – I have a question myself, and that relates to what are we trying to do? I think that might need some clarification, does it just speak to the architecture, when we say, what are we trying to do? Is that the standard itself or what is it that we're trying to achieve using the standard? That question might need some clarification and maybe Keith, you could start with that, and I would certainly ask if there are other questions – other comments that others in the group have on this list, please chime in, because I think we really need to make this a solid pass. So with that, Keith, what are we trying to do? I'd like you're additional thoughts on that.

Keith Boone – System Architect – GE Healthcare

Umm, so to be fair, from my perspective, the ask that I heard was identifying standards to support query measurement and clinical decision support for Meaningful Use Stage 3. And my particular context is going to be heavily weighted by the development efforts that I've been involved in, in HL7 and elsewhere, in that particular context. But, it's what are the right standards to use to express questions about what has been done versus what should have been done? What are the right standards to express what should be done based on what we currently know about the patient? And so those two questions are actually prospective and retrospective views of what basically boils down to providing care. And the prospective view is what we call clinical decision support, and the retrospective view is what we call quality measurement. And how do we fit those pieces together in a way that makes sense, so that we're not trying to do – ask the question about did we provide quality care in a way that's fundamentally different from what do we need to do to provide quality care.

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

Okay, so that gives me some clarity. So this question, what are we trying to do says to me, do we understand what we're trying to do with the standard, right –

Keith Boone – System Architect – GE Healthcare

Yes.

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

– and we've articulated that in the context of quality care. Go ahead Danny.

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

And so I was just thinking as we're in – it's in a spectrum, right? And I'm wondering if the spectrum is, have standards where our decision support and our quality measurement are like conjoined twins, right, and they sort of function together, two sides of the same coin. On the other end of the spectrum is the very, very practical, these are the 50 measures that we want to be able to operationalize for MU Stage 3, one of which may be a risk adjustment measure, one of which may be area under the curve or a time in therapeutic range, right? So those are two ends of the spectrum. How do we decide or make recommendations as far as what our targets really should be to answer the question, what are we trying to do? Is it just to meet the minimum requirement so that we can have a standard that supports the bare minimum number of measures that the folks are interested in measuring for MU Stage 3? Or is our task really aspirational, saying do we get it to that final end stage of the quality measurement report so folks, how do we determine this?

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

This is Eric, I'd like to propose one potential way to approach that. I think this could end up being a very prolonged process if we – or, let me put it differently. I think we may make this a less prolonged process if we kind of – there are some things that we can probably address pretty quickly by looking at just what's available now. So for instance, we could – and of course, this workgroup is not going to develop standards, we will identify – I think that we don't have the capability. But what we can do is identify the available standards, assess their strengths, weaknesses, suitability to various use cases and identify areas where further standards developments can – are needed and then in turn, ONC can work with the SDOs to address those gaps. So I think that the – it's probably, I don't think this is necessarily a slam dunk, but it's probably the case that there really isn't a standard, a set of standards that allows you to just represent a quality concept once and then use it for clinical decision support and for retrospective quality measurement. So that – that would honestly go into the, this needs to be built pile, at least I think it's very likely.

And then there's the other area I think I hear from the Policy Committee and the Standards Committee is that there's a lot of interest in expanding the array of types of – expanding the breadth of a) types of measures that can be handled beyond just proportion measures and scalar. Sort of like mean time measures, like things like area under the curve, etcetera. And so addressing – we can anticipate that that's something of interest and we can assess the ability of the different versions of HQMF and associated standards to meet that. And then the third is the interest in additional types of data beyond the types of data that have been included in standards that quality measures so far. And so I guess I'm not sure these are questions that we need to ask, I think the answers are kind of there, at least, I mean – or at least some of the answers are there, in front of us.

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

So this is Julia Skapik, I think actually a lot of the questions being raised are questions that everyone would definitely like the answers to. I think that in terms of the immediate goals, we thought to focus on what we currently have in an evaluation of whether or not what we have is adequate, if now, how is it inadequate? If it's inadequate, how could we get to something adequate using this standard, before we move on to sort of looking at every standard out there and how it might be better if we grew the whole thing up. So I agree that those questions are all questions that the Standards Committee would like to hear the answers to. But I think we could start today on some of what we have here, which are examples of how the standard we have right now, HQMF R1 is inadequate to express the things we need to express in a way that's either effective or reliable or efficient. And so I was actually going to, Danny just stepped out for a quick moment, but he asked if Eric, did you want to go ahead and start with the attachments that you sent me – CMS 125?

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

Oh, sure. I sent that?

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

So, just to put some things into context –

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

Continue Marjorie.

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

What I think the next step is – I guess I wanted to make sure that we were in agreement on the types of questions that we wanted to ask, as a process, to make sure that when we put forward our recommendations, we have a solid set that – and we use the same criteria, where relevant, to whatever standard we evaluate en route. I guess the sense I'm hearing is yes, we're ready to move forward with that.

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

Does anyone object to any specific things that were raised in the general principles?

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

Well, hearing none, I think what the next thing that we wanted to do then was begin to look at some of the gaps in HQMF, this is continuing the discussion from last week. And Eric, thank you again for forwarding some of your issues with a measure as it relates to HQMF. And with that, Julia, I think we can go ahead and move Eric forward.

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

– a little bit there. Eric, do you want to go ahead and start? I think you had the...

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

Sure, but I'm sorry, you referenced an attachment and I'm looking at the things that were sent. Is there something you can display, because I'm not finding what you're referring to. I can pull the email that I think I sent – so, yeah, I found the email and I could just talk to it, if there's – if you don't have that in a document that you can display.

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

I think I actually did send it over, would you read the title of that so that Altarum can –

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

Well the – so I sent an email just titled, HITSC Clinical Quality Workgroup discussion of CQM standards and the attachment I sent was simply the HTML rendering of the – of eMeasure 125, breast cancer screening, but –

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

Yes, we should have that, so if they can pull it up now, if you want to use that to show –

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

Okay, sure.

Caitlin Collins – Project Coordinator, Altarum Institute

I'm sorry, which document is that>

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

125 –

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

Yeah, I'm don't – I'm not sure it got sent out.

Caitlin Collins – Project Coordinator, Altarum Institute

We can't sent HTML files to every – we can't display that. Give me one second, I might be able to do that.

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

Okay, well it's – I mean, it's – I can talk to it anyway.

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

(Indiscernible)

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

So I had just thought, well, while they're getting that set up, I can kind of talk about this. So, I had offered, certainly not any – by any stretch of the imagination an exhaustive list of challenges that seem to be present for organizations trying to deal with the quality measurement requirements under MU 2. And, okay, there's the document. And so this is stuff that I've kind of stumbled upon by accident, but it's out there, for what it's worth. And the second caveat, before I get into details is, it's certainly not clear to me by any means that these are – I wouldn't necessarily characterize these as issues with HQMF, these are challenges in doing the meaningful use clinical quality measurement reporting and capturing data and analyzing data and so forth. So the cri – I think the way I was proposing that this be considered is when we look at what standards we wish to recommend that one of the things we want to consider is, is there an opportunity to mitigate these issues with recommending one approach versus another. So that's kind of context.

So one of them was just, if you scroll down to the bottom of this document, so this is something that you can download freely off the USHIK website, and this is just an HTML rendering of the – I believe of the HQMF files. So the HQMF file is natively in XML and it represents the logic for – and metadata for a single clinical quality measure, in this case it's breast cancer screening for women. So the population criteria is written – is expressed there kind of as pseudo-code and it shows you what the sort of inclusion and exclusion criteria are for the numerator and denominator populations, because this is a proportion measure. The proportion of patients who should get breast cancer screening that did get breast cancer screening, that's kind of the gist of it.

So what's interesting there is that if you look at – under population criteria, if you look at the third bolded bullet from the top that says denominator exclusions, and the second sub-bullet of that where it says, or count equals two of procedure performed unilateral mastectomy. What this is saying is that you shouldn't include a patient in the denominator population for this quality measure if she's had two unilateral mastectomies because by definition, she doesn't need breast cancer screening, so she shouldn't be counted as one of the denominator population. So – which makes perfect sense and is a perfectly legitimate thing to have as part of the logic of the quality measure.

And it's just really, really challenging to get that data out of EHRs because there usually – no EHR that I've ever seen has an explicit way of documenting that a patient has had two instances of a procedure that can be done on either side of the body, one on one side and one on the other. So that's just – if I were an EHR vendor, I would be sort of – that would present a challenge to me in terms of how do I just write the logic for the quality measure calculation engine to determine that reliably.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Eric, Eric, this is Danny. Sorry to interrupt. I – let me put something before you and ask for your feedback on this, okay? Because it think this is a wonderful example and looking at forecasting for the other examples that people have sent to us, I think that the different examples of potential gaps I think will fall into one of three buckets, right? One bucket is sort of complexity around the measure content irrespective of what standard is used to represent that content –

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

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
– this is – so I call that almost measure content issue.

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

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Another one is a logic issue, right, where doing something like a risk adjustment is just very clunky the way that the logic is empowered in the measure. And the last one I classify as a QDM issue, right, so it was there's no real easy way to say, left-sided blahbity blah, right? So if you had to sort of classify this issue that you're running into right now, is it a measure content issue? Is it a logic issue? Or is it a QDM issue? Or none of the above and additionally.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
Right, well, it's – I would characterize it as a measures logic issue, but the specific issue is that it's difficulty binding the type of logic in the measure to the data model of most EHRs. So, it's not that the logic itself is –

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

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
– would challenge a programmer to write code around it, the logic is simple Boolean logic. But – so, it's – but really I think it's that the logic imp – the logic presumes a certain – the data is such that it can be balanced to that logic and it may – the logic to data binding is the problem, if you will. So, and bucketing these is important because the issue is not this particular – I mean, this specific issue in and of itself is not a big deal, it's an exemplar of a larger category. So there –

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

Keith Boone – System Architect – GE Healthcare

So there is a – I'm sorry, this is Keith. So there's an issue, and we had this problem with this particular measure, there's an issue in terms of the fact that a measure cannot be unambiguously evaluated when it's specified in a way that is imprecise. And in this particular case, it's not that the underlying standards lack the capability to support the precision as much as the measure wasn't at that level of precision and also it's highly likely that the information systems don't necessarily capture the data at the level of precision that would allow you to make that assessment.

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

Right.

Keith Boone – System Architect – GE Healthcare

Because – and it's not just left, right, bilaterality, how many biopsies can you have on your body?

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

Right.

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

Lots.

Keith Boone – System Architect – GE Healthcare

Yeah. So, it goes beyond just simple left right.

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

This is Danny again. Eric, so and maybe there's an additional category which is not really a manifestation of the measure of itself, but how data are represented in the EHR and that is – that's a big issue but I'm not sure of a way just to tackle from a quality measurement perspective.

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

Right, so the problem is not that HQMF necessarily can support this complexity, because if somebody wished to use HQMF internally, say within an enterprise, where the data model is known, it might be a perfectly appropriate thing to do. So the problem is that the measure developers and measure stewards are not constrained in their use – they may use any of the capabilities of HQMF, even those that are not – that take it beyond a plug and play, something that would be treated in a plug and play fashion.

So, the second issue that I had brought up, if we can talk about that, dealt with value sets. And there are lots of issues of value sets, I enumerated four of them and there's nothing to show on the screen for this, but just to talk about. One is just that the value sets are imperfect, partly because they're under the control of the measure stewards and so – who, I think do the best that they can and sometimes have codes that are – that refer to, in some cases, veterinary conditions, they just leave in by mistake. Codes and value sets that just don't – aren't of the same semantic type as the data element to which they correspond. So for instance, one of the things – one of the SNOMED codes that was included in a value set of reasons to – reasons not to put a patient on anticoagulation was the SNOMED code for – the title of the SNOMED code was support. And it was in the procedure hierarchy of SNOMED, and presumably meant provide some kind of support to the patient. But actually, what – it's pretty clear the measure developer thought that they were getting with that SNOMED code was the idea of inadequate psychosocial support at home, being a legitimate reason not to give a patient a medication that requires lots of precautions and intensive monitoring and so forth. At least, that's what a lot of people think.

So anyway, the value sets are imperfect that was the first thing. The second thing is that because the value sets are imperfect, they get updated, which is nice, because it provides an opportunity to fix issues. But the – but it also presents a challenge to anyone who's trying to align their data capture processes with ensuring that they're capturing data in a way that it will appropriately include or exclude patients from CQM. So, if it's a moving target and they can be updated without prior notice at any time, and I think it's happened three times since the first time the CQM value sets were published.

The third is just that there is a huge – there seem to be a huge number of value sets with perhaps some redundancy and so that again adds to the complexity of any organization who's trying to figure out how to ensure – an EP or an EH doesn't have to be able to capture every single code that would go into a value set. But they do have to be able to capture data such that when particular patient's clinical reality applies to the – to a particular quality data element in a particular quality measure, that –

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

Right. So Eric, this is Marjorie, not meaning to cut you off, but we are sensitive to time and I guess we would – we or I would ask the question. I think the value set issue, how does that relate to the actual use and readiness of the standard itself? I mean, what I'm hearing is so the quality issue that –

Keith Boone – System Architect – GE Healthcare

So, this is Keith. Value sets are crafted by organizations that are SDO-like or which are SDOs. Okay, so they're crafted by organizations which either go through a consensus process or at the very least, a vetting process. And I think in some of these cases, when we start talking about value sets that does get into the standard selection process. We have a value set for smoking status in Meaningful Use Stage 2, which oh by the way, isn't at all aligned with the value sets for tobacco use, which have to be used to support clinical quality measures. And so this is the issue of does this fit into our sort of existing architecture and standards that we've already selected sort of question. So it's a very, I think, pertinent question in that space. With that, I do have to sign off. Unfortunately, I've got to go to class tonight, and class from – the HITSC – Workgroup.

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

So Keith, this is Rob, hold on a second Kev. So a couple of things. My understanding of what we were doing was trying to get a sense of what this committee might actually propose, it's sponsoring committee, the HITSC, in terms of – this is going to be actually even more global than any of you even want, but nonetheless, fitness of purpose for our existing standards that describe quality measures for moving forward. So, presumably Meaningful Use 3, i.e. in simple terms, do we agree that moving forward with HQMF. In fact, I think the real question is, do we, I mean because I don't think anybody alive wants to see HQMF R1 go forward. So, I don't think we have to answer that question.

The question is, do we want to go forward with HQMF 2.5 or potentially one of the other – that we saw discussed, that Bob presented. Or do we feel that there's dramatic issues sufficient enough to propose something else occur. I really – I mean, I think the sort of stuff that's been presented so far is really informative, but I think it's ridiculous to think that we can go back and say, okay, let's just throw everything out and start over, number one. But first, I think we need to confirm that that's really the question and then we need to frame that question in a way that it can be answered in some reasonable time period.

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

Well, this is Eric. I think it's – I can address that comment and also Marjorie's question maybe with one very brief comment.

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

Sure.

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

So it's – I don't think it's just about endorsing one standard or another, although I think that that is an important part of what we need to do, but there are different ways in which this – different requirements around particular standards and how they must be used that we can advise in favor or against. And one of the things that I was going to propose is that we can bypass a lot of the challenges about value sets by just saying that if an EP or an EH chooses to capture the high-level concept to which a value set corresponds, then it should be possible for them to do so. So, for instance –

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

Yeah. And Eric, this was an example, you gave an example of identifying women who are at high risk, women who are sexually active, and the measure developer – and our – this is the way that a kind of a

concept sort of gets forwarded into the measure – the measure developer says, well what’s currently available in EHRs? And people don’t often capture the discrete concept of a woman who’s sexually active or a man who’s sexually active, so what they do is they use proxy things that – like, they’ve been tested for HPV. They’ve – and they will use labs and procedures and diagnostic codes to make the – so I would say that that is a measure content issue and nothing to do with the standard, meaning, the measure developer can say, yeah, sure sexually active is a –

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

Well I would argue with respect that it can be also a measure implementation issue so currently the requirements under – the certification requirement is you have to output a CDA – sorry, a QRDA level 3, if I’m not mistaken, file that basically makes it technically impossible for the CQM calculation engine to accept a piece of data that just says patient is sexually active and be compliant with 2014 EHR certification criteria. So all I’m saying is that how the specific requirements are written can close or open opportunities to work around some of the shortcomings in value sets. And so those – so it’s not a flaw in the standard, it’s not even necessarily a flaw in the content, it’s a flaw in the regulation that indicates that spec – how specifically the standard must be implemented.

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

So that’s a really good point that I think we can highlight and maybe put in a parking lot, but I don’t know if that precludes us from moving forward with our recommendations as they relate to standards. Does that make –

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

Agreed.

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

I think that’s very valuable information. Okay.

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

Right, so whether, for example I would agree or disagree and I won’t get into that. I would – I agree – I mean with your specific thing Eric, about that particular example. But I do agree with Marjorie in that we still have the challenge, which is even if there are certain elements of this process that are difficult to implement. Because of the expectations that don’t line up in terms of what people want to see in a quality measure versus what actually is captured in the workflow and all that sort of stuff.

There are things that do line up, we presume, and the question facing us is, I guess maybe two-fold, and I think this is partly your issue, which is do we suggest, given that we have some way of reviewing functionality of existing kind of measure constructs and actually QRD. So measure both in terms of communicating the measure and then communicating the information about a patient back to meet the measure. Do we have enough information to be able to say, yes if we were to constrain the world, let’s say, so that for example you don’t require complex kinds of things in quality measures that cannot be successfully met using our existing standards, maybe those existing standards can be implemented.

Or – so, that’s one way to approach this. In other words, and I have certainly felt this way that many of the kinds of measures that people are interested in and looking at are relatively complex and the standards both, I’d say in terms of how that kind of complexity is communicated, i.e. HQMF. And also, the kind of data that needs to be captured in a system to represent that i.e. the sort of thing that you were just talking about, go beyond what we can currently do effectively. And so we either have to change the standard so that it can meet these complexities or we have to constrain what we say can be accomplished using the existing standards that we do have and somehow kind of in a sense, split the world. You say, okay, we can only use these CQMs to do these things and all of those other things that we want to do need to be done either in a more advanced way that we’re still figuring out or need to be done in a, for example, paper-based way that we’re currently doing. So, what I just said, Eric, does that still align with your concerns?

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

Yeah.

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

Solution.

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

I think so, I think so, yeah.

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

Okay.

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

So, and you know Ro – I think that our recommendations can actually span both of those, right? If we stay with our current standards, we will not be able to do these following things that may be of interest. And if you want to do those things, here's what our recommendations are and need to happen and by when in order to meet those –

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

I know – I mean, we know that there's a tremendous pull from CMS and other entities to do these really complex things, because that's where they're focused right now. But perhaps one recommendation that we have is to say, let's be more concrete about what we can accomplish with our current specifications, with current HQMF let's say R2, R2.5 and be very accurate about saying, these kinds of standards can work here. And I agree, and meet Eric's concerns about let's not force standards into that space that demand yet another black box get stuck in a nurse's cube to go and document something that is not traditionally documented. And then begin to think about, okay, do we rethink things in a more dramatic way to do these more complex activities.

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

Gotcha. So – time, we have five minutes left, right? So I think what we could potentially do is talk maybe for five minutes about what are those sort of complex things Rob that are being asked of, right? And so on the agenda, some of the examples that are listed there are, and these needs that are not available that have been proposed for potential Meaningful Use 3 content. One of them is risk adjustment and another one is – CMS 179 a complex calculation –

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

Yeah, can we pull up one of those?

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

That's the one for the area under the curve or time in the therapeutic range. So those can be examples, correct?

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

Right.

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

Right.

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

Yeah, I mean to some extent it's an orthogonal view, I mean –

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

The slide set is actually an overview of what sorts of risk adjustments they're looking for and what they perceive some of the HQMF –

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

And is that one of the –

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

It is. I think it's called slide presentation.

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

So let me respond to that, I thi – yes, it is. But I think to some extent this is a – there's a bit of a blunt instrument here. It could be that certain quality measures are simplistic enough, even though there are continuous variables on measures or they're ROC measures, but the kinds of things that they're actually asking of EHRs and the sort of representational complexity is pretty simple, that they could still be – we could make that leap. The problem is that we've got another layer of complexity that again, Eric's right, and that's – in that even though we might be able to say it simply, it's not collected simply. And I think we have to have an – the one thing – one of the things that this committee could look at is –

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

Cost of the –

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

– can we actually look at EHR data collection complexity and somehow measure that in air quotes, in a way that we could say, these things we recommend not be a part of the quality measure process. And doing that isn't necessarily making the HQMF more complex, but it's making the process more complex and people when they get that, like Eric has done, is saying the measure complexity is too high and so the HQMF isn't working. I'm not blaming you on this one Eric –

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

Yeah, right.

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

– but in fact, it's not the HQMF that's a problem. And so perhaps we need to also help separate out that level of complexity so that we can still do HQMF and maybe even enhance HQMF a little bit, but stay simple on the EHR impact side, on the provider impact side, so that that slight change in HQMF or whatever the measure model is, is still doable. I mean – do you see what I'm saying?

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

Yeah.

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

I think there's that – there's an orthogonal look at this that is painting the whole process with a negative brush.

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

So, we have two minutes left before we're opening up for public comment. I'm not going to have time to go through this, and going to put this on our next phone call. But maybe we can talk about these thoughts. Anyone on the line have additional thoughts in response to the conversation? Rosemary, Eric, Keith, you guys still on?

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

Yup, still on.

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

– now we're blending over onto the – into the sort of data capture measure content side, right?

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

Yeah and I think –

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

Okay. So we don't have any additional thoughts then. Do you know how many slides there are Julia?

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

It's, I don't know, maybe 12.

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

Wow, we don't really have time for that.

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

I can just explain why I attached the stuff that I attached and just let them look at that on their own.

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

And then we'll talk about it – .

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

So I was just going to mention the attachments so people would have another chance to review them. So these – the first set of slides here that we're being shown are slides about how one would generate a risk model and how one would apply HQMF quality measures with the risk model, talks a little bit about potential problems that could come up and then issues with QRDA for data submission and risk-adjusted measures. This is very important to CMS because a number up their value-based programs rely on risk adjustment so that they can make comparisons across different care settings.

The attachment CMS179 and I believe I had attached the HTML as well in the original set of documents. That measure does the area under the curve calculation, so what was required for that to be published in Stage 2 was to create this SQL appendage. And the expectation was that anyone implementing it would have to go in and by hand, also code in the SQL piece, just the HQMF alone is not enough to satisfy the measure. And yet we are still asking for the output to reflect something that can't be – (indiscernible). And then finally, CMS188 and the HTML was there as well, is a measure that has dozens of pages of XML output because of the level of complexity and the way that it's specified, partly due to some of the limitations in the expression language. And you'll see that because of the complexity of that and our need to do manual quality checks on it, it generated 72 reports in the – system on that – that are attached to that measure. Basically because it's so difficult to determine whether or not the expression actually expresses what the intent of the measure is, even after 30 manual reviews.

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

Can I ask, so, has anyone taken 188 and rendered it in HQMF 2.5?

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

In 2.5?

M

Yeah.

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

I don't know, 2.5 doesn't really exist, in 2 maybe.

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

I'm just wondering if at – again, part of what we're being asked to consider, beyond just HQMF, is are the new HQMF, 2.1, I guess would really be, that's supposed to simplify things quite a bit. So, does it take one of the bad ones, can Lantana or somebody take one of the bad ones and say, okay here's how much simpler it is if we were to follow this, and it would be still consistent?

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

So it sounds like the suggestion is, for HQMF, and I know that Lantana has done this for R2 and R1, you'd like to see a comparison next week –

M

Yeah.

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

– of a measure in R2 and a measure in R1?

M

Yeah.

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

Would we also like to try and get an HeD measure, compare that to R1?

M

(Indiscernible)

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

Health eDecision?

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

Would the logic of the measure express – using the HeD formalism for logic?

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

Right, so the GELLO and VMR.

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

Well not GELLO, because GELLO's not part of HeD.

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

That's the expression language that they're using, right?

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

Uh uh. That may be what they're considering for the new thing, but there is no expression language yet for HeD.

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

Okay. Well then, just VMR.

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

Yeah. But anyway, I mean, I – this is – Keith laid out a much broader kind of perspective, which I appreciated, and I'm back to where we are now, which is HQMF. But, yeah, I'd like to see, in order to be able to say something intelligent about the proposals for HQMF, I need to see how it fixes some of the known problems for HQMF 1.

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

– you got that.

Public Comment

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

I believe it is time to open up for public comment. Operator, could you please open up the line?

Ashley Griffin – Management Assistant – Altarum Institute

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.

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

Do we have any questions or operator –

Ashley Griffin – Management Assistant – Altarum Institute

We have no public comments at this time.

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

Okay, so thank you everyone. I think our next call, when's our next call –

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

December 3.

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

– is December 3 and we'll continue this discussion and we'll ask for, who's going to get the examples?

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

I'll do it –

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

Julia's going to touch bases with Lantana to get us the comparison between R1 and R2.

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

Yeah, and the Health eDecision –

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

(Indiscernible) Hopefully we can get that out in time for you to review it, so that everyone –

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

We'll send it out before Thanksgiving.

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

Oh, great Thanksgiving reading. So, anyway, we'll continue the discussion on December 3. We appreciate your time and look forward to talking to you then. Thank you.

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

Thank you.

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

Thank you.