

**HIT Standards Committee
Clinical Quality Workgroup
Transcript
January 30, 2014**

Presentation

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Thank you very much. Good afternoon everyone, this is Christianne Williams from the Office of the National Coordinator. This is a meeting of the Health IT Standards 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, this meeting is being transcribed and recorded so please state your name before speaking. Also, if you're not the one speaking, please mute your line. I will now take roll. Danny Rosenthal?

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

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Marjorie Rallins?

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

Present.

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Anne Castro? Bob Dolin? Brian Levy?

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

Yes, present.

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Christopher Chute? David Baker? David Lansky? Eric Rose?

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

Here.

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Flo – I'm sorry, excuse me, Floyd Eisenberg? Galen Murdock? Gene Nelson? Jason Colquitt? Joachim Roski, hopefully I said your name right? John Derr? Keith Boone? Philip Renner? Randy Woodward? Robert McClure?

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

Present.

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Thank you. Rosemary Kennedy?

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

Present.

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Kate Goodric? Kim Schwartz? And are there any ONC staffers on the line?

Julia Skapik, MD, MPH – Office of the National Coordinator for Health Information Technology

This is Julia Skapik.

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Hi, thank you.

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

Alicia Morton.

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Thank you Alicia.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Hi, this is Julie Crouse.

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Thank you Julie. All right Danny and Marjorie, I turn it over to you.

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

Great, thank you very much. So right now, we are on slide 2, which is the agenda for today. So for the first part of the agenda today will be going back and reviewing and coming to agreement on the principles for when a standard is ready for primetime. So, we'll be spending approximately an hour on this and I'll be walking us through this conversation. After that, we'll be going – talking a little bit about next steps. So go ahead and next slide please.

So we, based on a couple of suggestions, we've shuffled around the slides just a little bit, but all of the same content is also in the slide deck that was sent out to you today earlier. So if you're not watching the web meeting right now, please turn to slide 5, that has on it a grid and the title is CQ Standards: Ready for Primetime? So what we did was we took Keith's two consolidated slides and even further consolidated them to a single slide and what we're trying to do today is to, as a group, agree to these principles for when a standard is ready for primetime. So let me just walk you through this just a little bit.

On your left side, you'll see the principle checklist. We just grouped them together into some folksy, friendly language that sort of describes each of the clusters of principles. So, the principle – the standard's ready if it gets the job done, if it's tried and true, if it's forward looking, if it plays well with others and is not too difficult. Then on the right side are the guiding questions that Keith proposed to us when he presented his consolidated list, and the questions on the right are the questions we should be thinking about when we're going through the checklist on the left.

So I'll give you an example of this, right. The first two checkpoints are does the standard get the job done? Does it meet the program goals and requirements? And is it well suited and/or designed for the purpose? The guiding question there is, what are we trying to do and is the standard designed to do that? Back to the left, next category is well, is the standard tried and true? Has it been testable, has it been tested? Has it been implemented or is it intended to be implemented, adopted and used? Is it recognized, well established and mature? And the questions – the guiding questions there are, well, for each one of those considers what are the risks that we're willing to take on its maturity? If it's new, does it build on previous knowledge? Has it ever been used in the real world environment? Has it been tested? And can I get it today?

The next cluster is, is the standard forward looking and the two checkpoints there are, and is it extensible. And does it have SDO support, meaning, will it be supported in the future, i.e. forward looking. And so for those two points, is it future-proof and adaptable to change? And then, who maintains it? The next cluster is, does it play well with others, and this is just a similar checkpoint that, does it fit into the existing planned architecture? And this also touches on the burden to the vendors and the end-users for implementing the standard, if it does not play well with others. And the guiding question there is, fitting into the architecture, well, what's the architecture that you're trying to fit into?

And then lastly, is it not too difficult, meaning is it readily available without encumbrances? And is it low complexity? Obviously, these are relative. The guiding question there is, is it easily and inexpensively implemented? So this is the – these are the principles on the left and the guiding questions on the right and we'll be talking a lot more about this on the call today, I just wanted to show this consolidated list, and we'll be coming back to this in a couple of slides. Next slide please.

So some of the considerations that we should be thinking of is, of those checklist items when we're coming to agreement on these principles is, what is a must have versus what's a nice to have for a standard? When is "good enough" actually good enough? How do we balance the risk of prematurity with the possibility of success and the need for standard? Are we missing other considerations in our checklist, such as where does gestalt fit into this? And what if a standard is sort of on the cusp of readiness, what would our recommendations be to get that standard that may be needed over that cusp? These are just things that we should be keeping in the back of our mind. Next slide please.

So what I was thinking we could do as a group on today's phone call is to – these are gaps that were identified on prior conversation. And what we could do is, we could step through each one of these gaps, and these just happen to be gaps around clinical quality measures, and here I'm listing what some people have proposed as potential solutions. Clearly this framework should extend to other clinical quality standards, not necessarily just HQMF. But as we're walking through these three examples over here, does the checklist that we have, does it really address the readiness of a standard to meet a particular need. So in the subsequent slides, what we'll be doing is we'll be talking about each gap, and then we'll go through the checklist. And we're just going to have a nice conversation and make sure that the kinds of things that we are talking about fit and belong into the checklist and that the checklist is actually sufficient for our purposes of identifying something is ready for primetime. So, next slide please.

So for those of you that have the printout, turn back to slide number 5, which has the checklist. And before we jump into the conversation here talking about one of the gaps is, there needs to be risk adjustment – the ability for quality measures to handle risk-adjusted outcome measures. And we can talk through the principles on the left over here in the context of that gap, with the potential solution of HQMF R2. So before we start the conversation, just want to open it up to any comments and questions.

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 Eric.

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

Hi, just looks really good and is very clear, appreciate that. I think the only question folks who are unfamiliar with the discussion might have with this might be around the use of the phrase "our architecture." And it might be good to clarify whether that refers to the architecture of health IT that's currently in place, deployed in the United States or does it refer to something internal to the federal government or to CMS or what have you.

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

Okay, great. We will talk about that as we go through each of the gaps, okay.

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

Good.

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

So Danny, this is Rob McClure, can you hear me all right? I'm not on a good connection.

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

Yeas, I can hear you.

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

Okay. So the one thing I don't really see clearly identified in the matrix that you've created, and I'm not suggesting what I'm about to say is easy, but the idea that in choosing standards and let's say – well, maybe it's just choosing standards, but, in how we implement or expect the level of complexity of the expected use. I wonder if we can suggest that even though a standard can support complex utilization, that we don't encourage kind of exercising the full level of complexity that the standard might support. And so to get that kind of crystal clear, we could kind of also say something that's probably a little bit too stark, but if we were to say, we would encourage the use of quality measures that are simpler, even though the standard might be trying to kind of support more complex quality measures, as an incremental process. And we've talked about this in the past, this idea of focusing the expected implementation in areas that don't cover the breadth of what we want to reach in terms of quality assessments, but are easily attainable in the near term, as we learn more about how people might implement a particular standard that does have more complexity available. Do you see what I'm saying?

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

Rob, can you give me an example of that?

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

Well, so the idea that we would – part of what's currently being investigated are enhancements to the HQMF and to the QDM to support continuous variable quality measures, for example.

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

Um hmm.

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

And already the kinds of quality measures that we're currently implementing require pretty complex documentation of workflow activities. And to be clear, those issues that those quality measures are assessing are critical and important things, but the – even though the standard can support the ability to describe these quality measures, the system's ability to adequately capture those workflow items is suspect. And so – and I'm not saying I know how – by what metric we would be able to identify quality measures that don't push the envelope too far. And I also strongly don't recommend that we don't push the envelope some, but again, if all we do is say, well that standard is actually stable and it is being implemented, therefore anything you can do with that standard is something we should encourage. I think that, at times, is pushing us too quickly to try and get these really complex quality measures that require in particular, complex workflow issues to be documented in ways that we don't have current vocabulary standards to support. And we don't understand the implication to workflow. So, I know that this is a nuanced thing I'm bringing up, but I wonder somehow if we can begin to assess what things we know people should be able to accomplish, given current standards and current EHR functionality and current acceptance of these activities by clinicians versus even with the same exact standard, based what it currently can do. Where we would say, we need to do more – we need to kind of gradually push these more complex data documentation issues and that sort of thing, over the course of a longer period of time. Did that explain it?

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

Yeah. Sure, so Rob, it – let me see if I und – I can say that back to you. So we don't want to encourage and push standards that may over-engineer and go beyond solving the existing needs and at the same time, risk making things more complex to implement. How do we sort of balance that? And I think this really gets to the first cluster and the bottom cluster, to get the job done, yet it's not too difficult, right? So is that defined by us, Rob or is that defined by the policy group that says these are the things that we're trying to accomplish, the standards group.

Keith Boone – System Architect – GE Healthcare

Joining late, but I want to jump in real quick and say I think there's two aspects to that. One is, I think that our workgroup in this space can do a sort of a high level assessment as to, does this get the job done and can it work and what's our assessment of the ease? And I think that that will have to be – and reviewed by the HIT Standards FACA in terms of that. And then there will also be feedback through the process, where people can, once there's a recommendation out, people will be able to provide feedback on whether that's really a good assessment or not. So I think that we should take a crack at it, we're not the final arbiter, but we should certainly help with what our thinking is on it.

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

Great. Other thoughts from the group?

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

This is Rob. So just to add to your very first question, I actually got interrupted so I didn't hear all of what Keith had to say. But, you were asking whether this is us or the HIT PC Committee, the Policy Committee –

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

Yeah.

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

– and yeah, I think this is actually more of a policy question, but, in order to make good policy, you have to have good guidance and what I'm asking us, and I'll tell you, I don't have the answer to this and this may be impossible to answer. But, can we give standards level guidance that says, look one, these standards are new and they are slowly being implemented and the complexity that the standards appropriately are pushing to support may go beyond what the Policy Committee should ask to be implemented in the first – does that answer the question?

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

Yeah, it does. Other folk's thoughts on this?

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

I think technically – this is Eric. I think technically it'll be very difficult. First of all, I agree with Rob's point wholeheartedly. Technically I think it'll be very difficult to identify a set of constraints on a standard that allows a broad array of quality measure details to be represented and it's also something that is probably important to do. As far as identifying where the specifics are tricky to implement – there may be, to some degree a natural experiment that's occurred with the fact that the current meaningful use quality measures have been made available in HQMF format, not that I believe it's not HQMF's version release 2, I think it's an earlier one. But EHR vendors may be able to give useful guidance about what were the aspects of those quality measures that would have been difficult to implement in a plug-and-play fashion, it that were – if that had been necessary.

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

Great. Thanks Eric. Maybe what we can do is run through a couple of the examples and it sounds like a conversation that we've been having thus far aligns fairly well with the principles that Keith has aligned, and, I mean, the topics are certainly fitting into each of these buckets. So why don't we just start in a few minutes going through this first gap, and this is just an example that has come up again and again is the need to do risk-adjusted outcome measures. So, let's just run through this together as a group and we can use a potential solution of HQMF R2, okay?

So first question to the group is does HQMF R2 get the job done when it comes to enabling measures with risk-adjusted outcomes? Number 1, does it meet the program goals and requirements? Number 2, is it well suited and/or designed for the purpose?

Keith Boone – System Architect – GE Healthcare

So this is Keith. You focused your first question on risk-adjusted outcomes –

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

Correct.

Keith Boone – System Architect – GE Healthcare

– and, it's not clear to me what the context is of that in terms of the job. Because when you say, does HQMF R2 get the job done with respect to risk-adjusted outcomes; I don't know what "the job" is. If the question is, does HQMF R2 allow a system to measure quality performance indicators and can people use that to assess outcomes against a risk-adjusted result, I'd answer it one way. But if the question was does HQMF R2 allow you to assess whether somebody has a risk-adjusted result that's within a certain range, or something like that; I'd have to think harder about it. I think the answer would still be yes, but I'd have to think a lot harder about it. So I'd like a little bit more clarification on that point.

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

Got it, got it. And does someone on the call, can someone sort of comment from a policy perspective on what the anticipated need is for risk-adjusted outcome measures? And does anyone have a specific measure in mind. So was this taken from – and I know that Floyd is on mute and he's unable to speak, and I'm sure Floyd has an answer to this question. Does anyone from the ONC side have any particular measure in mind for risk-adjusted outcomes?

Christianne Williams – Business Analyst – Office of the National Coordinator for Health Information Technology

Julia Skapik or Marc Hadley, are you on the line by chance?

Julia Skapik, MD, MPH – Office of the National Coordinator for Health Information Technology

Yeah, this is Julia I'm on the line. We have some stuff for Meaningful Use 3 that's under development. For Meaningful Use 2, we ended up usually stratifying rather than doing real – the real kind of risk adjustment that we would want to. So I guess the question is, what example would you rather see and do you want us to bring some of those to you next time? I mean I can pull something up now if we decide what kind of measure we want.

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

Just pull anything out, I mean, these aren't – these are just meant to sort of stimulate conversation and are these questions the right questions to be asking. Keith's point is, I mean I think this is an excellent point Keith, I'm not sure if you intended this, but the point is, we need high specificity to identify if a standard fits the particular need.

Julia Skapik, MD, MPH – Office of the National Coordinator for Health Information Technology

Okay, give me a couple of minutes.

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

Yeah, good, okay. So why don't we move on to the next slide, actually, why don't we go ahead and skip ahead two slides, and we're going to move on to – there you go, that's the perfect one. Okay, so here we have specific measures now. The gap that was identified is complex calculation and two specific examples that members of our workgroup have brought forward was number 1, CMS 188, initial antibiotics for community-acquired pneumonia. And the second measure was CMS 179, time within the therapeutic range of warfarin. So, potential solution for this is HQMF R2.(blank). So can someone on the phone sort of say, hey, I know a version of HQMF that can do this, and then we can walk through the checklist on the left.

Keith Boone – System Architect – GE Healthcare

Okay so I – I'm sorry, you were breaking up when you said – it's the sentence when you explained what it is that you were trying to solve, which was the thing I was opening to listen for.

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

Oh, so we need a standard to help us represent two measures that folks in our group have identified as gaps in the past. The first one is initial antibiotics for community-acquired pneumonia and the second one is time within a therapeutic range for warfarin.

Keith Boone – System Architect – GE Healthcare

Okay. So, okay, so I got the two measures now and I can actually answer the question, based on those two measures.

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

Perfect. So is – I'll just put it out there, can HQMF R2 address this gap?

Keith Boone – System Architect – GE Healthcare

So on initial antibiotics, HQMF R2 alone can, just as its been specified as the standard, can address it because you can identify the pre-conditions for when initial antibiotics be given and detect whether they have been given and you can do the counts. And so you can produce the quality measure that says, so many patients out of so many patients got initial antibiotics – so many patients who needed to get them over the number of patients who should have had them. On the – and you can identify patients who shouldn't have gotten antibiotics for one reason or another, because they were allergic or whatever, so you can deal with the exceptions and that sort of thing.

For the – in the necessary range, in the therapeutic range for warfarin, you would need HQMF R2. However, you would need to go a little bit further and say, I need to use the QDM implementation guide of HQMF R2 plus the expression language appendix that's supposed to come with that, to – I think, to be able to express in therapeutic range. And that's because what you actually have to do is identify days when warfarin is in therapeutic range and the challenge is that you actually have to get two adjacent days, look at the results, compute a slope and figure out how many days of in therapeutic range does that mean.

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

Great, ah Keith –

Keith Boone – System Architect – GE Healthcare

And so that's a challenging measure to compute, you need a little bit more than HQMF R2 plus that little bit more is capable of doing it. It will be easier in HQMF R2.1.

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

Got it. So Keith, can you actually say one more time what those – that cluster of standards was, so you mentioned at the end there, it'll be easier to do in HQMF 2.1, but in HQMF 2, 2.0 I guess, what was the other standard?

Keith Boone – System Architect – GE Healthcare

There's the QDM-based HQMF implementation guide. So let me just step back a second and say, there's actually in the meaningful use rules, you identify a standard and you can identify an implementation guide.

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

Yup.

Keith Boone – System Architect – GE Healthcare

So HQMF R2 would be the base standard and the implementation guide would likely be, in any case, the QDM-based implementation guide, which has in the form of appendix that enables some more complex calculation to be performed and computed over.

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

Um hmm.

Keith Boone – System Architect – GE Healthcare

And so if the question was about is that stack sufficient, that stack is, in fact, sufficient.

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

Got it. So then why don't we have a conversation about those two potential solutions and we'll go through the checklist on the left, right? So the first one that I'm hearing is, HQMF R2 plus the QDM implementation guide. So, first question, does it get – .

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

I'm sorry, there's somebody who has a lot of background noise. If you aren't speaking, if you could please mute.

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

Yeah, that was me – I apologize for the static on my line, I did have a quick clarifying question if that's okay Danny.

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

Sure.

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

So was that Keith who was speaking before me?

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

Yes.

Keith Boone – System Architect – GE Healthcare

Yes.

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

So Keith, one thing, you may already be aware of this is that with warfarin treatment, the target range is – may be individualized per patient, and so can HQMF R2 with the other object that you referred to, can that support that individualization? So for patient “A” the target range may be “XY,” for patient “B” it may be “AB.”

Keith Boone – System Architect – GE Healthcare

I am aware of that and that's one of the things – that's another one of the things that makes target range difficult.

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

Thank you.

Keith Boone – System Architect – GE Healthcare

So you can establish for a patient what the target range is, and I don't know how that's based, but I'm presuming that's based on height, weight, age kind of material.

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

It's actually individualized per patient so it's not inferable necessarily from any other information –

Keith Boone – System Architect – GE Healthcare

Okay.

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

– it's got to be a data object in its own right.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd –

Keith Boone – System Architect – GE Healthcare

So I used to – go ahead Floyd.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Oh, thank you, I can finally speak. I've been trying for a while. So I think there's – I think this is good conversation, but we're into the depths of this particular measure, which of course is an example. I think there are basically three areas that are going on for clarification that are components of HQMF, whichever version you want to talk to, potential components. One is expression language, and what we're talking about now is can we express what we want to say. And I think there – it would be really helpful, probably offline from this call, to do an evaluation, is the expression language discussion that's going on in HL7, and hopefully will be an approved ballot maybe by May, sufficient to deal with the particular measures that are here. Because it is challenging but it sounds like it needs to be an offline real analysis.

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

Um hmm. And Floyd, you mentioned three things, you mentioned expression language and what were the other two?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Yeah, so actually, it's four things that are going on. One is HQMF R2 is published, there is work going on to add to that, the draft standard for trial use, called HQMF R2.1 –

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

Uh huh.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

– and the full extent of that I'm not completely aware, maybe someone else can talk to it, and that – so it's being enhanced. The content pieces for potentially HQMF or Health eDecisions as things move forward, are – will include three things, one is metadata, that's the header information, so there's a standard way to describe that across all quality artifacts. The second is expression language, how can we say the calculations that we're talking about here, how complex can they be? And the third item is the data model. As many know, the measures have used what's called the quality data model, the – in HED the rules have used virtual medical record. And so this is a discussion about – at HL7, about trying to align those with existing models so that there's a standard new way to express things that everyone can use. The challenge is that is work that's still going on.

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

Um hmm.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

But I think it's important to know about those four efforts.

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

Thank you Floyd. So, when we're thinking about metadata expression language and data model as the – as components of the standard, and if we're just using this as purely an example, let's just say hypothetically R2.1, I'm just going to throw it out there. For R2.1, can we go down this checklist and can we say yes or no to all of these and then be comfortable with our decision in saying, R2.1 is ready for primetime or not ready for primetime when it comes to these two examples of complex calculation? Okay, so let's –

Keith Boone – System Architect – GE Healthcare

In six months I could answer the questions. But I could not do that today, I would have to say no.

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

Got it, and I'm sorry, who was that speaking?

Keith Boone – System Architect – GE Healthcare

This is Keith.

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

Okay –

Keith Boone – System Architect – GE Healthcare

And the reason I would have to say no is because R2.1 doesn't exist as anything other than a project that is in flight and so no, it's not ready.

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

Got it, so not ready – so then –

Keith Boone – System Architect – GE Healthcare

It's not ready at this time.

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

Got it, so it sounds like under tried and true, we wouldn't be able to check that box.

Keith Boone – System Architect – GE Healthcare

Yup.

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

So, if we backpedal a little bit and we go down to R2.0, first check box, and this is open to the whole group to answer, does it get the job done when it comes to these specific examples. Keith has said yes, it can do both initial antibiotics and it can also do the warfarin time in the therapeutic range, if we have the additional QDM implementation guide explaining things a little bit more.

(Indiscernible)

Keith Boone – System Architect – GE Healthcare

So I want to explore the statement about warfarin in therapeutic range, because I'm about to retract a little bit on that. One of the previous speakers had mentioned that what's a therapeutic range –

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

Yes, that was – this is Eric Rose that was me.

Keith Boone – System Architect – GE Healthcare

– is not something that can be inferred; so I will say that if this is not something that can be inferred, that my understanding of current practice is that the therapeutic range of warfarin for a patient is not necessarily going to be captured in the EHR. And so you will not be able to compute this measure for warfarin and therapeutic range, and even HQMF R2.1 would not be able to compute that measure, if in fact what you have to do is have a look up for the patient on what is their therapeutic range. And it becomes even more challenging because if you have to have a look up, then therapeutic range could be changed over time. So if you said warfarin between the ranges of this and that for patients of – with this set of criteria, it can be done. But if you can't make inference, then it can't be done, even in HQMF R2.1.

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

Okay. Thank you.

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

So this is Rob. I'm confused a little bit, and again, I think this is to some extent what Floyd was saying in that we're dealing – we're diving down into something very specific potentially to a particular measure. I mean granted a clinician may decide what they want as the INR, war – you don't do tests for warfarin metabolites, you do a test for its effect and that's what's in the measure, so – I'm pretty sure. So it's probably looking at something like INR. And there are guidelines about what your INR should be, now granted, in a particular patient for a particular use case, they could easily be different. And so what I might want for my patient in a particular situation, I think would fall into a range that anybody would say, yeah, that's probably what you'd want. But I might want a very specific number, and that's in that range and it's not – if they're someplace else in that range, I might not be happy. But we're talking about quality measures, we're not talking about clinical – directing clinical care here. So, I think in this particular very detailed situation, I think HQMF 2.0 would work. Now, I don't know if it was Eric who said that these aren't possible and maybe again, as Floyd said, we need to have a conversation offline about that. But I think that looking for quality measures that are attempting to identify whether a laboratory measurement is going to fall within a standardized range, which I believe most of – those two measures probably are looking for, then Keith, then wouldn't you agree that HQMF 2.0 can do that?

Keith Boone – System Architect – GE Healthcare

I would absolutely agree that.

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

Yeah, so – now again, there may be something specific about these measures that fall outside, but that statement of if you can externally define a range that should be true for any patient, remember we're talking about quality measures, then it should function – HQMF 2.0 will work and I think many measures that would work for.

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

Right. So, and just keeping an eye on time, it sounds like for that first bullet point over here, that having the bullet point of get the job done, specifically meet the program goals and requirements and is well-suited and designed for the purpose. It sounds like people feel that these two check boxes are appropriate check boxes when evaluating whether a standard is ready for primetime with the caveat that the program goals and requirements must be explicit. So, if there are no objections to that, I'd like to move on to the second classification or the second category of principles around whether the standard is tried and true. So are there any objections to the prior statement that I made where Keith's suggestions of those two check boxes for getting the job done are valid for the purposes of our standards readiness? Great.

So let's move on now to the second classification or category, which are questions around is a standard tried and true? Is it testable and –

Keith Boone – System Architect – GE Healthcare

Can you explain what that means?

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

Yeah, yeah, sure. Basically I just put a category, a cluster around those three bullet points. If it –

Keith Boone – System Architect – GE Healthcare

I'm sorry, I'm not able to see the screen.

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

Oh, I'm sorry, so the three bullet points I think Keith, that's you talking there, the three bullet points that you proposed under this category were is it testable and tested? You also said has or is expected to have implementation, adoption and use. And thirdly, widely recognized, well established and mature.

Keith Boone – System Architect – GE Healthcare

Thank you.

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

All three of those sort of fit under the bucket of its tried and true.

Keith Boone – System Architect – GE Healthcare

Okay.

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

So, it sounds like the conversation we were having was HQMF R2.0 versus R2.1, whenever that comes out. Thinking about complex calculations and weighing our 2.0 versus 2.1, for these questions around is this – is a standard tried and true, do these three check boxes, are they reasonable things for us to be asking for standard readiness. Let's go check box by check box. Is it reasonable for us to ask is it testable and has it been tested?

Keith Boone – System Architect – GE Healthcare

Yes, because I'm rejecting 2.1 because it is specifically not testable and tested and hasn't been implemented, because it's still a work in progress.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So, this is Floyd. The question is, is 2.0, while it may be testable and may be tested in some place, and is it implemented? And has it really been tested?

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

Right.

Keith Boone – System Architect – GE Healthcare

So I can answer in the affirmative that – are implemented.

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

Okay, so then I think by logical extension, if we go down to the next bullet point, is it widely recognized, well established and mature?

Keith Boone – System Architect – GE Healthcare

So I would say 2.0 is widely recognized, not mature, so it doesn't get a high – it doesn't get a complete – it doesn't get a check here.

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

Yup, yup.

Keith Boone – System Architect – GE Healthcare

It's I think it's –

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd, I think you could argue about widely recognized, but by some in the field maybe, but I don't know about everyone, so agreed it doesn't get a check box though.

Keith Boone – System Architect – GE Healthcare

So it doesn't – I would put – on a scale of 1-3, I would give it a 1 or a 2.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Hmm.

Keith Boone – System Architect – GE Healthcare

CDA is widely recognized and widely implemented.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So I guess the question is, are we all voting on how to scale this or are we taking this single voice to grade it?

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

Wait, will you ask that one more time.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

I just want to know, anyone of us can speak up and I'm not saying this to be negative, but are we agreeing as a group how we grade this?

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

Yes, we are.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Thanks.

W

It should be based upon consensus, so we heard one pers – every person's opinion needs to be shared if possible, so that we can come to a majority.

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

And just to clarify that, the purpose of this conversation is not to determine R2.0 versus 2.1 versus 5.7, the purpose of this is, does this principles checklist hold, are we asking the right questions for when we do have to make that determination.

Keith Boone – System Architect – GE Healthcare

So we're doing this, so Floyd, we're doing this as an example rather than as a real evaluation that we're going to move forward with.

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

Exactly.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

That helps a lot.

Keith Boone – System Architect – GE Healthcare

Whether the principles work.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

No, it's just important to make sure we all understand that. Thank you.

Keith Boone – System Architect – GE Healthcare

Okay. Good. Yeah, yeah, yeah, because I agree, don't just listen to me I can be wrong sometimes.

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

So other folks, do these questions about a standard being tried and true, do they hold? Is it testable? Has it been implemented? Is it widely recognized, well established and mature? Other thoughts.

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

This is Rob. I mean I think they are the right questions and I think that right now, they require subjective decisions, to some degree, right. And that's part of why we exist is to add that flavor, the 2.0 is new and this isn't the sort of thing that everybody feels like they have to do next week in order to get paid. So, it's going to be adopted slowly and by organizations that have – oh, are leading edge and have a lot of interest in trying to see how these things can help clinical care. So, to some extent it's good to know, actually, not to some extent, it's great to know that GE has implemented some of these things. It would be really wonderful to know if there were more that had done that, because obviously –

Keith Boone – System Architect – GE Healthcare

It's just that –

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

– Keith's organization is a unique entity, they have Keith.

Keith Boone – System Architect – GE Healthcare

Clarifying comment, we are implemented. I'm not saying which products, because we haven't announced any products that are currently available on the market, I'm just telling you, we're implemented.

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

Right. And that's – and so I think then we as a group have to decide, and I think that's a good example of where we are, we have someone who's deeply involved and there's an organization that's following through, as it should, that's wonderful. Is that sufficient? I'm – I mean as much as that – I want to push that forward, I worry, and that's why I made my first comment, somehow we have to figure out a way of pushing everybody forward, but not demanding that everybody be the bleeding edge. I don't know how to do that exactly. That's our dilemma.

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

So, I'm not hearing a lot of pushback to these three questions at assessing whether it's tried and true and Rob, your point that a lot of our answers are going to be subjective for this is very well taken. Any other comments on the category of tried and true? Okay. So the next category, and we are two out of five done, so we are getting there and we have another – we have until 2:10 to wrap this up, so another 15 minutes or so. The third category is around if the standard is forward-looking. So this is, is the standard – so the standard as it is, is it extensible and does it have SDO support? So if it's great for right now, but it can't be extended and no one's supporting it to take it to – to extend it in the future and develop it, then it's not very forward-looking, right. But if it is extensible and if it does have good SDO support, it's not simply orphaned, those are all good things. So in the bucket of forward-looking, extensible and having SDO support, what are people's thoughts on this?

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd with a comment. I like the concept of this element, my concern is, to answer the question of SDO support, the fact that there's ongoing work is very helpful. Often the work only maintains the – is only maintained with support if organizations have interest and want to fund people to create those standards. So, there's – it's a little bit of a fuzzy answer and I just want to be cautious that we don't assume because there's work going on, it will always go on.

Keith Boone – System Architect – GE Healthcare

Yeah. So let me – this is Keith again. Let me clarify on the “has SDO support.” I actually appreciate that question because if we take an example of Direct and we say, extensible. Absolutely. Does Direct have SDO support, well, if there are changes that need to be made to the Direct specification, that’s actually going to have to come back through S&I Framework, which is not an SDO, and maybe they’re going to have to find a home for it. It doesn’t have a home right now, other than through ONC, which is not an SDO either. So, it’s a helpful clarifying question one that, if you were to look at CCOW and ask that, well is it extensible, yeah, it’s extensible it’s arguably extensible. Does it have SDO support? SDO support for CCOW has been waning for some number of years because there’s been no demand to advance the standard any further. And there’s not been a whole lot of interest, so, I’d have to answer that one “no.” I think that would be informative if CCOW were a potential answer to a problem we were trying to solve. So I like the question, because to me, and actually the issue with these questions is a “yes” or a “no” is not an absolute thumbs up or thumbs down. You don’t have to get a perfect score, but from an assessment perspective, this is a good way to do an assessment of – and actually as – now that I have the slides up, the – I also like the way you organized them into sort of the top level versus the bottom level detail. Because the bottom level detail informs the top level.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd. In response, I agree and I think that’s good. I do think that bleeding into this is that issue of, even if there’s no support, financially specifically, if organizations are using it all over the place and every – and there’s a common issue with it, there will be support to go back and fix it. If they’re not using it, it can still get supported with outside funding, but – so there’s a little bit of bleeding into this the how much is it used. And it’s just a little – it’s not totally separated from that.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System So, any other thoughts on the extensibility of the standard, the future-proof and adaptable to change? If some people are saying that is a – that would be a great thing to have, but it may not always be present and yet a standard may still pass our principle checklist. Any other thoughts on extensibility?

Keith Boone – System Architect – GE Healthcare

I think extensibility is an important criteria. The number of times that I’ve seen where you need to be able to adapt or add a layer or do something that goes outside the boundaries, if we could never have supported multiple race codes in CDA because it didn’t have extensibility, it would be completely inappropriate under both law and regulation to cite it. Because we couldn’t actually capture mandated data that needed to be captured, so I think it’s – extensibility is important. The – actually, looking at everything here, I think all of these questions are important, but I think the weighting on them, I think you’re “must have,” “nice to have” scale on the left is a gray scale, it’s not on on/off switch.

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

Yeah, absolutely, Keith.

Keith Boone – System Architect – GE Healthcare

So you prioritized – I think you prioritized these well, you’ve classified them well. I think extensibility is more important than has SDO support. Yeah, I – this is a really nice slide.

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

So, we have two categories left, so we have “plays well with others” and “not too difficult.” So plays well with others is, does the standard fit into the existing planned architecture, and on our last phone call, or maybe it was two phone calls ago, we spent a long time talking about, what is architecture. And not to drum up that conversation, the focus here is, does asking this question of does the standard play well with other standards, and Floyd, you were talking about the three layers of data expression language – data model, it would be great if the expression language played nicely with other standards that are using a similar expression language. So the question to the group is, is this criteria, fits into the existing planned architecture, is this an important thing for us to consider when looking at the readiness of a standard? And the answer can be yes.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd, I'll say yes. I don't have much to add to that.

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

Danny, can you clarify what is meant by architecture here? Are we talking about just what's kind of intends to be solved in US care delivery organizations or –

Keith Boone – System Architect – GE Healthcare

When I initially posed – this is Keith again. When I initially posed the question about what is our architecture, it was posed in the context of what is the architecture for meaningful use. So, not systems installed for care delivery, but architecture that meaningful use implies in the context of – what am I trying to say –

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

Of certified EHR technology?

Keith Boone – System Architect – GE Healthcare

Yeah.

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

Yeah, okay. Thanks, that makes sense.

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

Eric, does that help answer your question?

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

Yes, it does, thanks. And yes, I think it's a reasonable – I think so by architecture we mean architecture implied by existing CEHRT requirements.

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

And then the last category here is “not too difficult.” And this is, as we're saying on the other ones that are objective, there's a balance here, so under this category is, is a standard readily available without encumbrances and does it have low complexity? Low complexity to one person or vendor may be high complexity to another. So, obviously these have to be taken into relative consideration, but is this something that we should be looking at and does this make sense to have on a principles checklist that we should strive for standards that are readily available and strive for standards that have lower complexity?

Keith Boone – System Architect – GE Healthcare

So I'm sorry Doug Fridsma's being interviewed right now, I know exactly what his answer would be and it would be absolutely. I don't know how many times I've heard him say that the standards need to be only as complex as necessary.

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

Other thoughts on this folks?

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

So, this is Rob. I mean I – obviously, maybe not obviously, but anyway, I agree. But again, there are some subtleties here and again, this is where our subjective kind of advice to the Policy Committee is important in that this highlights the point I was making before. We need standards to be crafted to push the envelope further, so they will be, I think, frequently more complex than what we necessarily will ask everyone to implement.

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

Robert, you said they will be more complex?

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

Yeah, I mean, this is another way of saying the thing that I've been saying all along during the meeting is that the standards community and the community of the bleeding edge technologists that understand how to translate our complex world into implementable architecture and standards that describe that, those things by their very nature, as we encompass more and more of the complexity of life into the standards, will be complex. So, but that being said, the sort of things that we ask the masses to implement, we need to be cautious about demanding that they implement all the standard says in the first pass.

So, the answer to the question, should the standards be – the alignment between the complexity of the standard and the complexity of what actually is – we expect, I'll say the masses again, to implement, I think there will be a disconnect. I think that the standards likely will describe more complexity than we expect people to implement. That's not a disconnect that I think most of us would hopefully disagree with

–

Keith Boone – System Architect – GE Healthcare

So can I, can I –

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

– it's not something I think that Doug would disagree with either. We need to push forward, but we don't expect everybody to be at the front edge of the boat.

Keith Boone – System Architect – GE Healthcare

Okay, so can I connect two statements? So is the standard of low complexity with respect to the parts of it that are – that need to be used to meet program goals and requirements. So around that low complexity, say in the context of the program goals and requirements, is the standard of low complexity? I think that addresses the – what we're asking people to implement of the standard is of sufficiently low complexity for meeting the program goals and requirements that it would get the check. Because I think that's the context that you're looking for around that, Rob. And I want to get confirmation that that's right.

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

Umm –

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

What can – oh, Rob, you answer first and then I want to add to that.

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

Yeah, no, I think you're getting it. I think you're getting it. So go ahead.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

So this is Floyd with a comment related, and maybe there's a caveat and I think I hear this in some of your comments Rob that it's not just the standard that there's a caveat that for programs there needs to be a governance to avoid over-expression and use of the standard in programs. Even though others might find locally the ability to get some value, but not to force that on everyone. So it sounds like there needs to be, even though the standard may allow some things, there needs to be a governance around use of it in the government program.

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

Yeah, that's right and that's why I think Danny was correct in saying what we're doing is providing – we're saying, this standard covers the level of complexity that we need. But, we need to give guidance, and this was my point, to the Policy Committee and say, do not turn around and require quality measures that exercise every nuance of the stand...

NOTE: I believe there is missing voice file for about a minute between the above speaker who ends as above and speaker below, who begins here.

Keith Boone – System Architect – GE Healthcare

– down to its essence in such a way that we can use this as a very easy to use assessment tool. And I really appreciate the amount of work it took to do that, you just made something very hard easy and we talked about that yesterday, about how hard it is to make the complex easy. So I really, really think this is outstanding.

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

Keith, we were just following your excellent lead, so thank you as well. So I think folks that we have consensus on these principles, which is great news. Hearing no other conversation, I think we're going to turn it over now to ONC to carry on with the agenda.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Great. Thank you for that lively discussion. This is Julie Crouse from ONC. I just wanted to throw out a few ideas for potential agenda items that we could schedule for the month of February. The first potential agenda item, and again, we're looking for your feedback and if you have other ideas, we hope you can propose them right now. So the first idea is, in December there was a deep dive on the HQMF R1 and R2 standards that was done. We wanted to get feedback from your group on whether or not it would be helpful to do a deep dive on the Health eDecisions, the clinical decision support standards that have recently been published and that are still being published through the HL7 organization.

And another potential topic is I think that Keith Boone mentioned this earlier is there are several project scope statements and projects that are going through HL7 right now; one of them is the HL7 HQMF 2.1 standard. Would the group like to, mainly for transparency and awareness, be given an update by someone from the HL7 community on kind of the works – and the work in the project that has recently happened and that's in the pipeline? And the project at a high level is being described as a harmonization effort between the clinical decision support standards and the existing quality measurement standards. Would that be helpful to the group or do – are most of the members that are on the group already pretty familiar and they feel like it wouldn't be as valuable as potentially trying to address some other agenda item? Does anyone have any thoughts or feedback on that?

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

This is Danny; I think it would be helpful.

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

And this is Floyd, I'm well aware of what all those are but I think it would be helpful to have it in this discussion and context to talk about those, so it would be great.

Keith Boone – System Architect – GE Healthcare

This is Keith; I would agree and would recommend Marc Hadley.

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

I agree also, on both those points.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Okay, great. So we will work with the Co-Chairs, Danny and Marjorie and Marc Hadley and others from HL7 to get that on the agenda for the next meeting. Are there other agenda items that folks feel like – we'll work with Marjorie and Danny to get their input as well, but from others on the group, are there things that are burning topics you feel like we could try to address?

Keith Boone – System Architect – GE Healthcare

Yes. So unfortunately, because of my travel schedule, I'm not going to actually be able to participate in the February discussions happening in Washington around quality measurement. But I would – I thi – and I don't know if everybody in the group is going to be able to participate in those, but I think it would be good for us to be able to get some sort of summary report out of that at some point in time when that's available. And I don't know if that means February or March, based on timing.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Danny and Marjorie, did you understand Keith's request? I'm not sure I did, but if you did, I think we're okay.

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

Yeah, well my question is –

Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

This is Floyd; I think he's referring to the Kaizen you're planning.

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

Oh, is that what it is, okay. So Keith, you wanted a report out from the Kaizen event.

Keith Boone – System Architect – GE Healthcare

Yes.

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

Okay.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Oh great, that makes sense. Thank you for clarifying. And we will –

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

Yeah –

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

– yeah, and I'll talk to Michelle and the Co-Chairs about whether or not we want to keep the meeting on February 13 or potentially reschedule it and we'll get that updated on the FACA calendar as soon as possible.

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

Yeah, so the February 13 is during that Kaizen, so that could be an issue.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Yeah.

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

I will actually be attending the Kaizen so, that might affect it.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Okay, so we'll go ahead and assume that we'll probably reschedule that meeting and we'll get that updated on the calendar as soon as possible.

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

If I can make a request, if it can be not the following week but the week after that, it would be great.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Okay, great, we'll take that into consideration, thank you Rob.

Keith Boone – System Architect – GE Healthcare

Me, too.

Julie Crouse, PMP, MS – Program Analyst – Office of the National Coordinator for Health Information Technology

Great, so if there –

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

I'm sorry, which week was Rob referring to, the week of the 24th, because that's HIMSS.

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

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

Oh, oops.

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

I wouldn't suggest that week, but we'll figure it out in scheduling.

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

There's always something.

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

Are we ready to open for public comment?

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

Yes, we are. Marjorie, anything else you wanted to add.

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

Yeah, I'm fine with that.

Public Comment

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

Okay. Operator, can you please open the lines?

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. We have no public comment at this time.

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

Thank you everyone and thank you very much, Danny. We appreciate all the hard work you did today.

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

Yup.

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

Thank you everybody.

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

Yes, I agree. Thanks a lot guys.