

**HIT Standards Committee
Clinical Quality Workgroup
Transcript
April 7, 2014**

Presentation

Operator

All lines are bridged with the public.

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

Thank you, good morning everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Clinical Quality Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Marjorie Rallins?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Present.

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

Hi Marjorie. Danny Rosenthal?

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

Present.

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

Hi Danny. Brian Levy? Bob Dolin? Chris Chute? David Baker? David Lansky? Eric Rose?

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

Here.

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

Hi Eric. Floyd Eisenberg?

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

Present.

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

Hi Floyd. Galen Murdock? Gene Nelson? Jason Colquitt? Joachim Roski? John Derr? Kate Goodrich? Keith Boone? Kim Schwartz? Michael Lincoln? Philip Renner? Randy Woodward? Rob McClure? Rosemary Kennedy?

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

Present.

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

Good morning Rosemary. And with that, I'm sorry; do we have Alicia Morton from ONC?

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

Yes, here.

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

Hi Alicia. And Lauren Wu?

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

I'm here.

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

And Kim Wilson?

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Kim's here.

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

Hi Kim.

Kim Wilson – Health Communications Specialist – Center for Disease Control and Prevention

Hi.

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

And with that I'll turn it back to you Marjorie and Danny.

Keith Boone – System Architect – GE Healthcare

Keith Boone just arrived.

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

Hi Keith.

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

Hi Keith. Great, well, thank you, we are continuing the second of three meetings and let me just summarize some of the conversation from last week before we jump in with continuing that conversation.

So, a brief overview, our group was asked to review the ONC voluntary 2015 proposed rule, this is an incremental rulemaking approach and it's not tied to Meaningful Use rulemaking. We've scheduled three meetings the first of which was last week.

We've been asked to provide input on two major areas, one is CDS and the other is clinical quality measures. Last week we spent most of our time talking about CDS via the Health eDecisions proposal.

So, some of the feedback that we heard and I'll just list these off for you. The proposal may be more ambitious than is warranted given the current state of technological development and implementation of HIT in the US. And our thought was that it would be prudent to select one of the three CDS knowledge artifact types and require support of just that one.

So, this is sort of arguing for a more constrained approach folks felt pretty strongly that the ECA rules were probably the best area to focus, they've been around longer than the order sets and documentation and are less susceptible to challenge, so, if we had to choose one of the three ECA rules that folks felt was prudent to focus on.

And another sort of thought from the group, and this is sort of in terms of the – what ONC should focus on in terms of testing and certification, the group felt that if the primary goal is to foster adoption then it would be helpful to align ECA rules with a specific set of rules that were part of the criteria similar to what has happened with CQMs in the past. So, a handful of ECA rules to implement. Likewise, it would be helpful if there was a clearinghouse just like we have for existing eCQMs for said CDS artifacts.

A thought in reference to which the ease with which EHR technology can be developed to consume CDS artifacts, there were a few thoughts on the ease of this, one was that it could be challenging for legacy systems, the other is that it could be more acceptable if there were some – simple knowledge artifacts were chosen.

It could be more feasible if we chose a sort of focused area approach in this case focusing on ECA and then there was some – people were plus/minus on the ease to which auto-configuration of CDS wasn't possible and the group would like some confirmation on what exactly does auto-configuration mean.

So, those were the thoughts and before we sort of jump into the remaining conversation and Health eDecisions proposal I want to open it up to the group for additional thoughts and/or modification to the summary that I just provided.

Keith Boone – System Architect – GE Healthcare

So, this is Keith and I'm sorry I didn't make the last call I was in India last time, this time I'm in Riyadh, but I'm able to make this call.

So, HL7 has been involved in reviewing the rule as well and recently there was discussion between the clinical quality improvement and the CDS, the Clinical Decision Support Workgroups in HL7, discussing specifically both HeD and HQMF, and the group raised some concerns about the fact that in this particular case both of the standards that were mentioned in the rule either for 2015 adoption or for 2017 adoption are actually currently in the process of going through harmonization in HL7 so that there is a single way to deal with evaluation logic that's pertinent to both. So, you have to evaluate whether a patient has a particular condition or received a particular intervention and that's important both on the CDS side and on the HQMF side.

And so HL7 has been spending, you know, almost a year working on harmonization of those specifications based on feedback from industry as well as feedback from ONC. So, looking at our – you know, our essential principles you might look at each of the individual standards together with respect to the principles to see, you know, does it get the job done, is it tried-and-true, is it forward looking, plays well and not too difficult.

And you might think that together all of that works out, but when you start looking at the two of them together and understand that they have two different ways to represent logical criteria and so you wind up with decision support that might have one evaluation mechanism and CQMs which have another evaluation mechanism and they might not exactly come up with the same results. Then you wind up with a situation where the standards when taken together don't necessarily meet the program goals or requirements or fit into the existing architecture.

So, the Workgroup sort of understands that one of the purposes of trying to do this in the 2015 rule is to promote adoption and we're in the process of discussing our comments, but came up with a way forward which might address promoting adoption without committing ONC to putting something into Meaningful Use Certification Criteria that might not be ready, because, you know, as I said, these standards are in the process of being revised.

So, now we have something that could be adopted and then revised very shortly thereafter which is going to create more churn and a chance of delay again in vendors and implementers, and providers who are trying to implement being able to adopt.

So, thinking is that there should be a way for ONC and CMS to promote adoption maybe by saying, okay, if we have some recognized pilot programs maybe there is a way to make it easier for EHR developers who are participants in the pilot programs to certify recognizing that participation in a pilot is actually a higher bar than what happens when you go through certification testing, because you're actually working with trading partners and actually running real code.

And that for providers who are participating in some sort of pilot program maybe that's one of the Meaningful Use criteria that counts towards maybe one of the menu set options so that we address some of the challenges with providing incentives to adopt the standards and we also give providers an incentive to actually participate in the effort to adopt standards.

And in another way remove disincentives to move the bar forward. If you're trying to look at a standard that maybe wants to look at a RESTful way to view, download and transmit but it's not one of the recognized standards, but it is a recognized pilot then maybe that could be something that would be acceptable by CMS to meet your incentive criteria because you're actually trying to move the bar forward.

So, in looking at I think both sets of standards there is a recognition that both are relatively new, they've been through some testing, they both have had some implementation, but it's been limited and, you know, at least looking at some viewpoints of members from the HL7 perspective there is a desire to say, you know, hey, let us get the harmonization finished before you make people commit to implementations, because then you're committing them already to rework. So, some thoughts on that perspective from two Workgroups who have been looking at this.

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

Keith, so, this is Danny, so the – we're being asked to specifically comment on that the Clinical Decision Support Knowledge Artifact Implementation Guide Release 1, January 2013, the HeD standard, as a standard. So, Keith are you – is your feedback that this is not the right version that should be used and for the rulemaking a subsequent yet to be finalized harmonized release be used?

Keith Boone – System Architect – GE Healthcare

So, yeah, that's I think the essential feedback specifically on the standard is to look at the work that's currently going on and active in both HQMF and in HeD, Health eDecisions to deal with the harmonization.

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

Gotcha and Keith do you know when that – what the name of that version is and when it's going to be finalized?

Keith Boone – System Architect – GE Healthcare

So, you know, one can never predict a standard in flight, but there are multiple projects going on in HL7 and if I were to, you know, if I were to give you the names right now I'd probably be wrong, but I can look that up and –

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

Got it.

Keith Boone – System Architect – GE Healthcare

On the HL7 website and tell you what those are. I mean, and, you know, this is all being done with ONC participation in these activities.

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

Yeah.

Keith Boone – System Architect – GE Healthcare

So, they understand what they are, so if we just speak to the future harmonize work –

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

Got it.

Keith Boone – System Architect – GE Healthcare

I think they'll all understand.

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

Okay.

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

This is Alicia that came up on the last call a little bit just questions about – because there is knowledge of the new clinical quality framework S&I Initiative in which a lot of the work that Keith is referencing is happening in collaboration with HL7 to harmonize the data models and the logical models for CDS standards and clinical quality measure standards, which will, and we don't how much yet, change HQMF and HeD, and most likely QRDA at some point in the future. And the timelines are pretty fluid and dependent on a lot of interdependencies but late this year best case scenario, calendar year.

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

This is Floyd with a comment. I'd have to say I agree with everything Keith said and I would support that I just want to clarify the comments from HL7 haven't gone through voting in the Workgroups yet.

Keith Boone – System Architect – GE Healthcare

Absolutely, absolutely.

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

I just wanted to clarify.

Keith Boone – System Architect – GE Healthcare

Yes.

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

Other comments from the group about the summary? Okay.

Keith Boone – System Architect – GE Healthcare

So, you were asking about the name of the specification.

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

Yes.

Keith Boone – System Architect – GE Healthcare

And the CDS Knowledge Sharing Implementation Guide –

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

Okay.

Keith Boone – System Architect – GE Healthcare

Is the project in HL7. The standard is the not yet, you know, I can't tell you what the standard name is going to be, because that could still change.

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

Sure.

Keith Boone – System Architect – GE Healthcare

But it's under the same name so it would be a new revision of that same guide and looking at – you know, they say they're targeting a 2014 March right now ballot and so that means –

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

Hey, Keith –

Keith Boone – System Architect – GE Healthcare

Ballot site –

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

Keith that's the modularized version, so there modularizing HQMF and HeD first, there are a lot of things that are in flight.

Keith Boone – System Architect – GE Healthcare

Yeah, so that's like, that's like one of the things that needs to happen and there is like three or four others that are concurrent projects. So, there is a modularization of HQMF. There is a modularization of HeD and then there are three projects, there are two projects in clinical quality information and then there is the QRDA, QDM work that's also going on, but all of this has been sort of to drive some consistency into the standards and my concern is that, you know, if you commit vendors to implementation they sure want to get a lot more than a year out of standards implementation, it's a pretty serious investment to do a lot of that development and they'd like to see something that's just a little bit more stable.

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

Got it, okay, thank you Keith.

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

Danny, this is Rosemary, are there certain criteria or a minimum set of requirements for something that goes into certification or could it be flexible enough to support what Keith just described?

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

That's a great question Rosemary, you know, and I think that that's a wonderful segue. If we could jump to slide number, I think it's, eight in the slide deck, maybe it's the – the slide is titled Health eDecision Proposal maybe it's then before this, let me see if I find the slide. Does anyone know what the slide number is?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Danny, this is Marjorie, its slide 8.

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

It's slide 8 from our first presentation, slide 7 for today.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yes.

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

– here.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yeah, it's being displayed now.

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

Perfect, great, so, Rosemary one question that we're being asked for feedback on is, what specifically ONC should focus on when it comes to testing and certification for acceptance and incorporation of CDS knowledge artifacts. Is that what you're talking about Rosemary?

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

Yeah, yeah, that is exactly what I was talking about and it seems as if Keith was kind of describing the framework I guess, if you will, or maybe I'm reading into it more, to approach the pilot and the testing and the certification and potential alignment with all the standards that apply.

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

So, you know, from our last conversation it sounded like the group for testing certification was – would really like to see a core set of CDS knowledge artifacts that were focusing on just the ECA rules, hopefully in a repository somewhere, that could be used for testing and certification. Do other people have additional thoughts?

You know ONC is looking for our feedback, what should they be focusing on. Other thoughts about focus for testing certification?

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

So, this is Floyd just with a comment based on some work that I've been involved in and I think the event condition action rules may have had more evaluation.

I do think, I agree with the comments from the last call that there needs to be some kind of repository of these for use, but I also think that some of the documentation templates maybe something worth using and may have value they just – I just don't think are enough out there or it's been tested to use them yet.

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

Thank you, Floyd.

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

Floyd, do you think related to that, and I'll just throw this question out, is it possible to pick something that may give providers the ability to work with the same set of kind of terminology, value sets, constraints, etcetera that could apply to ECA and potentially a documentation template or two so if there were pilots they could look at the underlying standard and learn about how it may apply to orders, templates and ECA rules or is that too complicated to try to achieve that?

I think from a provider site if you're going to spend the time identifying, you know, the terminologies, do the vocabulary mapping and binding, and constraints and value sets we try to leverage as much as we can of that infrastructure and reuse it for multiple purposes.

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

This is Floyd, I'm just going to respond because I know you directed it to me, but I think it's for the whole group, what this kind of makes me think is that the clinical quality framework S&I Initiative is the perfect place to have this discussion and the fact that this discussion is important is perhaps a good reason why, even in a voluntary certification program that it would be premature to address use of any of this until it's really clear what that use is and really get some good examples out there to support providers.

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

So, the group last time was saying maybe it would be helpful if we had a couple of ECA rules that could be implemented. So, similar to what we did with eCQMs do folks feel particularly strongly one way or the other about that?

Keith Boone – System Architect – GE Healthcare

I'm sorry, can you restate that?

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

Danny, this is Rosemary, could you restate the question?

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

Yeah, yeah, so they're asking us what we should be focused on for testing and certification on the last call people said, you know, we should really have a – let's pick a handful of CDS ECA rules and those should be used for testing and certification, that sort of seems like a no-brainer, did anyone want to sort of elaborate on that in one way or the other? So, does anyone think that that's not a good idea?

Keith Boone – System Architect – GE Healthcare

So, this is Keith again, you know, they sort of presuppose that there is general agreement that the standard is ready and I have some concerns there. I mean, I'm questioning the question.

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

So, Keith, just looking at the question, I think that this – if we are saying that the standard is ready, right, which the question is not really asking, but if it were to be ready what should ONC focus on for testing and certification?

Keith Boone – System Architect – GE Healthcare

So, I'm looking at Part A the ease with which EHR technology could be developed to consume CDS knowledge artifacts.

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

Got it. And what we're talking about is Letter F on the bottom, so on our last call people said that, the proposal may be more ambitious than is warranted given the current standards technology –

Keith Boone – System Architect – GE Healthcare

Yes, yeah.

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

So, I think that we've acknowledged that it's not going to be necessarily a cakewalk and that's sort of captured in the notes from the last meeting.

So, for Letter F over here anything specific that ONC should focus on for testing and certification. Does, it make sense to the group identifying a core set of CDS knowledge artifacts for testing and certification?

Keith Boone – System Architect – GE Healthcare

What are our choices? I mean, that I think is a fundamental question, if you say, focus on, you know, what ECA artifacts have been available.

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

It's open ended Keith, so it's –

Keith Boone – System Architect – GE Healthcare

Yeah, yeah, so, going back to my fundamental question, so are there ones available that we could be looking at?

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

So, to the group, are there?

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

So, this is Floyd, just to follow on that, if there were a list of – with eQMs there are some that are out there. I have to say they're all in HQMF R1 so implement ability is an issue, but I don't know that there is a large or a significant list of HeD ECA rules from which we could look and say, well these are good and basic and generic enough, mom and apple pie, that everyone should be able to do them. I'm not sure that exists. If it does I'd look for someone to recommend that.

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

Floyd, do you think that testing and certification would be difficult if there weren't a set that could be used.

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

Well, I think that for testing and certification some rules could be developed, but the question is, are we looking for a rule to some ECA rules to be developed that are specific to finding a cohort for a population, are they related to drug adverse events or, I mean, what is it that we would think that they should be dealing with. There are many – the field is wide open for the kinds of things we're looking at so I'm not sure I quite understand what basic rules we would be thinking about.

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

Got it.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Well, so Danny, this is Marjorie, I think in last week's call I think what we recommended was that there was some kind of focus. Can everybody hear me okay?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System Yes.
Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Is that better?

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

Yes, thanks, Marjorie.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yeah, that there would be, you know, a type of focus but what those specific rules would be it wasn't clear or what content that we would focus on we didn't get to that level of detail.

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

This is Eric.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Go ahead?

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

Sorry, I didn't mean to cut you off, Marjorie.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

No, go ahead, Eric.

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

So, I think that certainly from the perspective of the EHR developers what is much less important than the sort of clinical somatic content of whatever is going to be used for certification is the nuts and bolts of what data is required and what are the logical operations that need to be – that need to be – that the EHR needs to execute, the rules, if you will and so if those can be constrained to some reasonable set I think you'll have a lot greater chance of success.

So, for instance if, you know, if there is no warning before certification that a particular ECA rule needs to calculate mean arterial pressure, you know, which is systolic times 2 plus diastolic times 1 over 3, you know, and they just haven't built that logical capability into their ECA engine then they're going to fail and it's probably not the outcome we want.

So, I think that we just – the testing needs to be able to provide a reasonable flow of requirements to the EHR developer saying this is what you need to build to have a certifiable system and they can execute on it. And then, you know, within that scope I don't think it matters much for the purpose of certification whether the rule that you use to test is used for population management or it's used to, you know, prevent an adverse event in an ICU or what have you, that's probably less material.

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

Got it, so Eric, said a different way, this is Danny, it's not necessarily the end that should be tested and certified, but it's the means by which you got to those ends.

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

Yes.

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

Eric, I just want to follow, this is Floyd, on your question, so one thing concerns me and I think this is kind of where you were headed, what I would be cautious about is in developing tests on eQMs vendors were asked to look for certain data and if it wasn't there they created a field to make that data available, which many refer to as hardwiring.

So, what I would want to caution against is developing rules that just encourage additional hardwiring, but don't use existing data and that is a challenge.

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

Yes.

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

I agree, there is a tension there.

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

This is Rosemary –

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

Yeah.

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

I would agree with that and the more it can align with the data that they need to capture for the MU objectives I think that will help as well, yeah, because other than that they'll hardwire it and I don't know that crosswalk what it would look like, but certainly there is a wealth of data that could probably lend itself to CDS rules, that way they can use the underlying terminology value sets and infrastructure they have in place already and add to it for the testing.

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

Great, so I'm hearing discourage hardwiring and align data with other Meaningful Use purposes to – yeah, Rosemary can you say that one more time? Align data with other Meaningful Use –

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

That's required – yeah, that's required for the Meaningful Use objectives.

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

Got it. Great. So, just keeping an eye on the clock I know that Rosemary is going to be taking over with the next conversation of CQMs. The only thing I wanted to flush out a little bit more was Letter E and then we can wrap up this conversation.

So, Letter E was focusing on the second half of the Health eDecision's proposal which was, I'll read it to you, we also propose to adopt HL7 Decision Support Service Implementation Guide Release 1 Version 1, December 2013, as a standard and to require that EHR technology demonstrate the ability to make an information request, send patient data and receive CDS guidance according to the interface requirements defined in the Decision Support Service Implementation Guide.

So, this is sort of the second half of the Health eDecision's proposal and we're being asked to comment on the feasibility of implementing the interface requirements defined in this Decision Support Implementation Guide to make information requests, send patient data and receive CDS guidance in near real-time, so it's what do we think the feasibility of implementing this is? Thoughts? Feasible, infeasible?

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

This is Floyd, I'll –

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

This is Eric, my initial impression was that this is fairly feasible as long as all that is required of the EHR system is to provide a static display of information received from the, what are they calling the entity that you ping with, the knowledge – the decision support service.

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

Yes. Okay and, you know, I think that is what they're asking. To make an information request send patient data and receive CDS guidance so it doesn't talk anything about how the guidance is used or displayed, correct me group if I'm wrong on that, but this is purely the sending and receiving of information.

So, Eric says that it's fairly feasible and if it's just the sending and receiving of information and I heard another voice on there chiming in?

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

It was Floyd and I guess I haven't seen enough use to be able to know that one it's feasible and two I'm a little concerned that it's a very prescriptive requirement that could – I think needs to be broader and be more outcome-based.

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

Can you elaborate on that second thought Floyd?

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

Well, if you're going to use these rules to accomplish something it's one thing to say, I can show something on a screen, it's another thing to say, because of coming back with some information some new change in care occurred. So, just creating new popup alerts isn't necessarily going to improve care and if that's all we're testing for that's all we're going to get. So, that's really very prescriptive and that would concern me.

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

So, Floyd, this is Danny –

Keith Boone – System Architect – GE Healthcare

So – go ahead?

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

Oh, no, I was just going to say, Floyd, does the decision support implementation guide dictate how the received CDS guidance is utilized or does it sort of stop at the this is a communication from Point A to Point B and once the guidance comes back that's where the implementation guide sort of stops or does –

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

I wasn't really addressing the guide, I was addressing the potential tests that I saw coming from this.

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

Got it.

Keith Boone – System Architect – GE Healthcare

So, I'm going to ask you to look at something on that slide. If you look at the release version and the date, okay, and then go back to our readiness principles, that standard was released in December of 2013, okay. So, we've had about a year maybe to, I'm sorry, we've had about 3 months maybe to play with it, you know, with the Clinical Decision Support Artifact Implementation Guide we've had about a year.

I'm concerned about this one as well in terms of the capabilities that are being asked for and the timeframes in which they're being asked to be implemented. So, I don't have as much insight into that particular standard with respect to what's been going on with it, because the attention has been focused around Health eDecisions in the CDS space and HQMF in the CQM space.

But, I would be very concerned about adopting a Release 1 standard three months after it had been released and I'd be interested in getting some input and feedback on that, because there are, you know, potentially mitigating circumstances.

FHIR, at the time that it went DSTU there were three open source implementations already available that had been through five testing events. I don't know if that's the case with this standard or not.

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

Got, it so, Keith, I'm hearing from you that you're concerned that the timeline is too aggressive given that it was just released in December of 2013. What would make you feel better about this that was appropriate would it be some additional pilot testing if we had to test it?

Keith Boone – System Architect – GE Healthcare

Well, I'd like, yes, I'd like to understand that there had been additional testing performed and what sort of level of that testing was. Unfortunately, there is so much going on in HL7 that it's very hard to keep track of everything and this is one that I'm just not tracking. So, I wish I knew more.

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

Got it, so I'm hearing from, this is Danny, I'm hearing from Floyd that a decision support service, in and of itself, needs to be taken into consideration with the outcomes that it's trying to achieve and then I'm hearing from Keith that you would like to see some additional pilot testing since this was just released in December of 2013.

Keith Boone – System Architect – GE Healthcare

Yeah. So, that looks like it's going through a normative ballot instead of a DSTU ballot, so that actually – that also has some significance in terms of the kind of response because a normative ballot – DSTU ballot requires I think 60% response whereas normative is either 75 or 80% positive response.

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

Got it. Other comments?

Keith Boone – System Architect – GE Healthcare

And it's a much higher bar that the HL7 membership usually puts those too and as I recall that also went through the combined HL7 OMG process. So, I might feel a little bit better about it but I still don't know – I still don't feel comfortable enough in my understanding of its status.

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

Got it.

Keith Boone – System Architect – GE Healthcare

And that, in and of itself, says a lot.

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

Other thoughts from the group on the feasibility? Great, so for next steps on this we'll summarize and bring back these complete comments on Health eDecisions for our next conversation and then I want to hand it over now to Marjorie who is going to be guiding us on the conversation for clinical quality measures. Marjorie?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yes, I'm here Danny. Can everybody hear me okay, I'm having phone challenges today?

Keith Boone – System Architect – GE Healthcare

Yes.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay. So, if we can move onto slide 10 please? Okay, that's not the same slide that I have, so, is the patient –

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

Yeah, those are the slides from the old time, we just took out – we have new slides this week and the only difference is we took out the intro to the rule.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Oh, okay. So, the numbers are off, so the patient filtering populations, I don't know what number that is, because – yeah, okay.

So, the next item that we need to comment on focuses on the CQMs and this particular item is patient population filtering and we thought we'd spend some time talking about this. And if you don't mind I'd like to read the content and then we can go on for the discussion.

So, essentially, ONC proposes to adopt a new certification criteria to require filtering of CQMs by patient population characteristics and to propose to require that EHR technology be able to record structured data for the purpose of being able to filter CQM results to create different patient population groupings by one or a combination of the following patient characteristics and that would be practice site and address, the TIN number, the NPI number or the TIN/NPI combination, diagnosis using terminologies like SNOMED, primary and secondary health insurance, Medicaid dual eligibles and demographic information.

What we've been specifically asked to comment on is whether the current CQM standards such as QRDA Category I and Category III can collect metadata for the characteristics listed above to filter and create a CQM report by characteristics or a combination thereof.

And then whether there are vocabulary standards that can be used to record the characteristics proposed. So, I don't know if we received comments from anyone from our group on this and I'll open it up to see if we have.

Keith Boone – System Architect – GE Healthcare

So, this is Keith, so on this particular case there is a distinction between the electronic medical record systems and the administrative system that's still fairly common, especially in the ambulatory space, but also occurs in some hospital environments where they have one system for dealing with their revenue cycle management, another system for dealing with their clinical data.

In those administrative systems is where you're going to find the health insurance information including identification, Medicare and Medicaid dual eligibles, it's where you might find some information about education and/or socioeconomic status.

And so it would be very difficult for those EHRs to do any sort of filtering, by themselves, because they frankly don't have that information captured, that's captured in a separate registration system at the time the patient registers to the hospital and it's tied together through interfaces, yes, but it's not possible for the EHR to readily get access to that level of detailed administrative information. So, that's one of the challenges there.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

So, that's helpful to know and is that primarily the case Keith for most systems that this information is segregated in that manner?

Keith Boone – System Architect – GE Healthcare

So, I couldn't possibly speak to the systems that are out there because I'm not a marketer so I don't know what market penetration is, but what I can tell you is that among the largest EHR vendors they're all building revenue cycle management and practice management solutions as well as EMRs that's still fairly common in the product base and there are many situations where somebody will have a GE revenue cycle management system and then an Allscripts clinical management system or vice versa, or you know pick any other two vendors out there.

So, I'd say that there is enough penetration out there of those systems that that's going to be a fairly large lift for not just the vendors who are trying to do this but also for the providers, because the providers are now going to have to look at, well now I need to look at changing not just my EHR, but now I have to rip out and replace my revenue cycle management and my practice management solutions to get whatever version has the capabilities that the EHR needs to get at that data and this is true for, you know, I would say at least 3 of the fairly large academic medical centers in the Washington, DC area based on the slide that I saw about a month and a half ago talking about the two different systems that those organizations are using.

And I know that to be true of several other academic medical centers. I can't speak to all of the ambulatory space or anything like that. But I can see that's going to be a real challenge for everybody, because you can't just change the EHR.

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

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

This is Rosemary, I just wanted to support what Keith just said, sometimes that is captured at the point of care, but its validity and reliability are assessed using those other systems that he mentioned on the provider's side. Also there are typically case management systems where a case management or utilization review will be verifying that gathering additional information, entering it into a system that's different than the electronic health record that drives care delivery and frequently they also enter into those systems education level and socioeconomic status.

And I would also question, which is probably outside this scope, the ability to collect that information in a valid and reliable way during care delivery can be challenging.

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

And this is Floyd, to add to everything just said, the two points, I think some organizations do have data warehouses that capture information from different systems that might be able to do this kind of analysis. There are – it's not part of the EHR preference in many cases.

But there are two issues on the slide that concern me especially, I can say that some things the Standards Committee have already looked at, preferred language, health insurance type as far as terminologies, but education level and socioeconomic status I don't recall that there was an agreed upon terminology or classification system for use and especially socioeconomic status which has many variables is very difficult to assess and would need some standardization to know what they were looking at.

Keith Boone – System Architect – GE Healthcare

And I'll add one more statement QRDA is based on CDA, CDA's content is clinical. So, things such as primary and secondary health insurance including identification, Medicare/Medicaid dual eligibles that's administrative content and there's some ability to represent that in things like the C-CDA and the CCD, but in general the implementations of that have not been thoroughly tested and I would be concerned about going to the level of trying to do population filtering before we've even tested the ability to exchange that sort of information just using C-CDA, because essentially what you're saying is, let's go to an even higher level of capability to test the ability to exchange that sort of information using QRDA Category I and Category III to do CQM filtering before you've even tested the ability of whether you could support that in something like C-CDA at a level of certification criteria, because that's not even in like the minimum data set, the not known data set, the Meaningful Use data set of things that are even exchanged.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

So, this is Marjorie, so what I'm hearing is what sounds like resounding agreement that it's difficult – because, the data – this kind of information is captured in different systems it would be difficult to meet what is being proposed here.

And so I'm going to ask a naive question and ask that if it's difficult that way, and I certainly am not questioning that, why is that being proposed as if it can be achieved? I'm just curious. What are your thoughts? Because there must be some –

Keith Boone – System Architect – GE Healthcare

There's a program –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Is some work being done –

Keith Boone – System Architect – GE Healthcare

There's a program demand at the CMS level.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

I see.

Keith Boone – System Architect – GE Healthcare

To be able to do this kind of analysis and they'd like the healthcare providers to help them out and do a lot of the work for them in terms of dividing this information up, because they don't have –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Right, I'm –

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

This is Floyd –

Keith Boone – System Architect – GE Healthcare

They don't have a very good way at QRDA Category I or III to get at it.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay.

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

Yeah, for some time CMS has asked that all the eQMs include supplemental data to address ethnicity, race and sorry I forgot the third one, I should know –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Preferred language wasn't it?

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

Yes, so, but they've never really explained what to do with that. So even if you could have it in a QRDA Level III you wouldn't know how to aggregate it, it's just additional data. So, I think there has always been an intent to do some population assessment but I don't know that – and I think that's where it's coming from, but you're asking –

Keith Boone – System Architect – GE Healthcare

Oh, absolutely.

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

The wrong people, I think you need to ask the people who created the content.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

I'm just – you know, maybe there was some initiative.

Keith Boone – System Architect – GE Healthcare

Yeah, so if you look at the – if you look at the data that they're asking for they're saying who is your insurer or payer, or program and what's your education level and socioeconomic status, sex and preferred language. So, these are all sources of disparities in healthcare. If you're going to filter your quality measures by these what you're going to see in the quality measures potentially is the influence of these factors on the quality of care received. There is a lot of value in being able to do that in terms of being able to evaluate.

If you've got disparities in care you can figure out what you need to do to address and make sure that those disparities aren't something that is continuing.

So, it's very clear that there is some good thinking behind why they want to do this is to be able to look at how do quality measures impact or how are quality measures impacted by things which could have adverse effects on patient care such as race or education, or socioeconomic status, or language, or anything along those lines, or your insurer.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yeah, so thank you, for that Keith. My question really meant when I asked why I just wanted to make sure we did our due diligence to make sure there was no maybe some, you know, early work happening in the S&I Framework or, you know, there is some effort to impart harmonization across all of these sort of elements that you're right describe disparities in care.

So, and what I'm hearing is that doesn't appear to be the case and so, you know, given that what would be our recommendation then?

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

So, Marjorie, I'd like to make another comment, this is Floyd?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Sure.

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

All of what was said is true about looking for disparities and seeing if there is a difference in care. I think, there is another kind of hidden issue in here and that is small cell analysis. So, if a provider actually was able to do that kind of analysis are we sure that the results would be valid because of the number of patients that might fit into any one cell and could there potentially be unintended consequences of making the wrong conclusions. So, it would concern me for that reason.

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

This is Eric, I just wanted to point out that the preamble in the NPRM does explain the rationale for a number of these and I'm looking for their explanation of why they want tax identification numbers and things like that, but it's along the lines of what Keith was pointing out plus I think they pointed out with TINs that in some cases you have multiple TINs and a given – using a given system and that it was felt by the organizations themselves that they wanted to be able to see how they're doing by, you know, split by TIN on clinical quality measures.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yeah, I guess my question again though relates more to understanding if we know that they're captured in disparate ways and the EHR is not going to be able to capture all of this information and they're asking for that type of, you know, effort, at this point if there is no way to really do it, you know, you see where I'm going with that, why would –

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

Well, yeah, I think that's why we're reviewing these – that's why they have us. And I agree that actually in many systems these will be a no-brainer if your practice management and your EHR use the same database and if they don't it can be extremely challenging. So, I think that does need to be pointed out and at the same time I think we ought to call out that at least some of these are doable, I mean, diagnosis is doable, age, sex, preferred language which is already required for capture I believe under the 2014 certification rule.

And with socioeconomic status Floyd made the point I think that standards may be lacking and I think it's worth noting that actually – I don't know if anybody saw the updates to the SNOMED CT US extension that were just released in March, but there were a bunch of them that seemed like they were specifically related to this, you know, referring to the patient's income in terms of percent of poverty level, you know, income is between 150-250% of poverty level.

So, the other thing I would actually suggest we add to our feedback is that depending on how socioeconomic status is conceptualized it may actually be challenging or impossible for the end-users, for the clinicians or their staff to capture this data.

I mean, you know, do we really want to add to a provider's daily workflow looking up what the federal poverty level is and figuring out, calculating the patient's income as percent of poverty level, I would hope not.

So, I'd like to see that as a feedback that we want to make sure, not just so we don't put in technically onerous requirements, but that we don't add workflow problems.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay, so again, what I'm hearing is that some EHRs may be able to capture this data and many may not. Is that a fair statement?

Keith Boone – System Architect – GE Healthcare

I would say that's a fair statement.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

And many may not.

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

Yeah.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay, I think that's a good rolled up summary there. And then with respect to the CQM standards what I'm hearing is QRDA is based on CDA which is clinical, some of this information is administrative so that's a challenge there and that – and what about Category III, because some of those –

Keith Boone – System Architect – GE Healthcare

Well, it is also based on CDA.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay. And not all of these elements would be pertinent to Category III because that's the population level, correct?

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

Well, this is Floyd, I think they might be relevant.

Keith Boone – System Architect – GE Healthcare

Well –

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

But they have to be defined how to aggregate it up at the population level.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Right.

Keith Boone – System Architect – GE Healthcare

Yes.

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

And if that's not defined in the measure, which it isn't today even if you could get it into QRDA you wouldn't know how to aggregate.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay, so there might be some –

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

It –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Go ahead, Rosemary were you going to make a comment?

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

Yeah, yeah, this is Rosemary, just another slant to the socioeconomic status, I agree with everything that was said, and one is looking maybe at disparities of care but another aspect is when patients are transitioned particularly from acute care to the community setting or home care sometimes that is looked at by case management and social workers to see if they can actually afford the care that is necessary. So, it's captured in some systems, a lot of systems capture that but going back to the prior point it's probably not captured in a standardized format, but it could potentially be another driver that if you're looking at outcomes you want to look at that particularly as people are improving and transitioning from one level of care to the other.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay. Okay, any other comments in QRDA Category I and Category III? Okay, so going back to the vocabulary standards that can be used to record the characteristics proposed above. As Floyd mentioned the Vocabulary Task Force of the HIT Standards Committee made some recommendations with respect to demographics and Floyd please chime in. So, preferred language was one, correct?

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

Correct. So, they had preferred language, sex, health insurance, I'm looking at all this, I don't recall anything on education level and there was actually a request about socioeconomic status and the response was you have to define what – how you define status and then they can deal with different terminologies.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay.

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

One of the issues was education level, which was not defined by the Task Force.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Right and so the question is I think when you get to certain data elements like these if there isn't maybe one standard that exists to capture these, there may or may not be, but there are current standards that could, if there are content gaps, that could represent these data elements.

Keith Boone – System Architect – GE Healthcare

So, if you give me, if you give me a few more minutes I'm looking up in my SNOMED viewer whether SNOMED actually has this covered. I suspect, in terms of education level that –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

It does.

Keith Boone – System Architect – GE Healthcare

That of course gradation is going to be there in SNOMED that, you know, you're going to have high school and you're going to have college and you could have post graduate, and –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yes.

Keith Boone – System Architect – GE Healthcare

Some various levels. So, I would say in terms of education level that's probably covered to a degree that's essential.

Economic status, no that's not going to be covered in any vocabularies that I'm familiar with. I know there is economic status criteria that's pretty well established in a variety of places say in the Medicaid programs, etcetera where there is particular criteria that might be established, but are there standard terms for it, no not to my knowledge.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

There aren't standard terms but what I'm saying is I do think SNOMED might have some socioeconomic status content albeit it might not be complete. And so my question would be, would we want to recommend, and there might be another vocabulary as well –

Keith Boone – System Architect – GE Healthcare

Right, there is –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

But would we want to recommend –

Keith Boone – System Architect – GE Healthcare

I mean, I'm just taking the –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

You but, those terminologies have a way to submit for new content should we need them. I guess that's where I'm getting at. So, whether the content may not exist at the moment.

Keith Boone – System Architect – GE Healthcare

Well any content that you submit is going to either have to be internationalized or in US extensions in some way.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Correct.

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

Marjorie, I would just want to caution that we don't want to end up with two different standards for regulatory requirement and one example was smoking status where Meaningful Use specifically asked for one of six different SNOMED terms and then in the measures there was a different set used. So, I think it would be very helpful to understand what other kinds of sets of use is already out there on socioeconomic status –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay.

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

Before we just want to say we think SNOMED covers it.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Or, yeah, and then I don't – I mean, is the time to really have that discussion you know?

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

I'm not sure this is the right group.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yeah, I think it's –

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

– Task Force.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yeah, I would agree with that. Okay, any other comments on this? Okay. So, I think ONC team you're capturing our bullet points for this issue, correct? Alicia?

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

This is Michelle, yes we are.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay, good. So, with this –

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

–

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

I didn't hear the last comment?

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

Oh, I'm sorry, it's Alicia I was on mute.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Oh, okay, so I think we've got – we've covered this particular item here. I'm wondering if we should move on or if this a good time to stop and then we can pick up with – because I think the other things are things that are unchanged in the 2015 Reg. What are your thoughts, ONC staff? Alicia?

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

Yeah, I think we should – sorry, I think we should, you know, we can't make assumptions about what the intent of the question are, so I think we do the best to our ability and then we – you know, we don't have a lot of the Workgroup members on, so I think we summarize and give people an opportunity to give us feedback via e-mail and then we move onto the next questions before us.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay. I meant for this call, so, we've got about 20 minutes left, we could move onto the other issues very quickly if there were comments.

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

This is Lauren from ONC there are a few issues that are being solicited comment on for the 2017 edition that if you feel that this group can begin the discussion today we could maybe launch into one.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yeah and I want to be conscious of the time. So, the next one, thank you Lauren, I think Eric you might have submitted some comments on electronic processing for CQMs is that correct?

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

I'd have to go back and look.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

You might have.

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

That was at least a week ago –

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

But I don't know if we've receive a lot, maybe what we do is if we don't – if the team isn't prepared to comment on the 2017 edition issues why don't we stop here and then pick that up in the call for April 10th. Does that make sense?

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

Yeah, we can do that, we only have received comments in writing from Eric and Rob. So, I can send out another reminder about what we've...

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Yeah, that would be helpful Alicia if we could do that.

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

Yeah, what we've discussed thus far and, you know, it would probably good that, you know, we let them know that we've spent two Workgroup meetings on it, so if they have comments at this point to send them in advance in writing so that we can make the best use of that last call we have.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Sure.

Keith Boone – System Architect – GE Healthcare

So, this is Keith, I have to drop off because I have to prep for my next call.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Thank you, Keith, very much for your input.

Keith Boone – System Architect – GE Healthcare

Thank you.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay.

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

So, Marjorie, it sounds like we're ready to open the lines?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

That's right we are.

Public Comment

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

Okay. Operator can you please open the lines?

Rebecca Armendariz – Project Coordinator – Altarum Institute

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

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Okay, so I think our call is adjourned, I want to thank everyone for your input and I hope you can join us on the 10th which is – is that Thursday or Friday, I believe?

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

Thursday.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Thursday, okay. So, I'll look forward to talking to everyone then.

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

Thank you.

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

Thank you.

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

Thank you.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

All right, thank you.

Lauren Wu – Policy Analyst – US Department of Health & Human Services

Bye.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association

Bye-bye.

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

Thank you.