

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

Presentation

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

Thank you. Good morning everyone, 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, 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, Measures Specifications, Standards and Informatics – American Medical Association

Present.

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

Danny Rosenthal?

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

Present.

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

Anne Castro? Bob Dolin? Brian Levy?

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

Yes, present.

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

Chris Chute? David Baker? David Lansky? Eric Rose? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Present.

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

Galen Murdock? Gene Nelson? Jason Colquitt? Joachim Roski? John Derr? Keith Boone? Philip Renner?

Philip Renner, MBA – Kaiser Permanente

I'm here.

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

Randy Woodward? Rob McClure?

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

Present.

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

Rosemary Kennedy?

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

Present.

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

Kate Goodrich? Kim Schwartz? And are there any ONC staff members on the line?

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

Julia Skapik?

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

Thanks Julia, and thank you everyone for joining. This is a meeting of the Clinical Quality Workgroup. As I'm sure you've all noticed, they've been on a bit of a hiatus. We now are excited to announce that we have two co-chairs, we have Marjorie Rallins and Danny Rosenthal, so we're glad that they are able to chair this committee and help us move forward. We have received a charge from the Standards Committee that this group will work on clinical decision support and some things related to quality measures. So with that, I'm going to now turn it over to Marjorie Rallins and Danny Rosenthal to kick things off. And as a reminder, if you are not speaking, if you could please mute your lines that would be greatly appreciated.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Mayo Clinic College of Medicine

This is Chris Chute, I just wanted to say that I have joined.

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

Thanks Chris.

Galen Murdock – Veracity Solutions

And this is Galen Murdock, I had my phone on mute. Thank you.

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

Okay, thanks.

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

So again, good morning everyone, this is Marjorie Rallins and I am glad that we have ended our hiatus. And we'd like to talk with you today about the things that we've been charged to discuss. And these things have been taken from the work plan that was developed in April, and we've synthesized that a bit to cover four domains for discussion, and we should be, if you're on the WebEx, you should be able to see the grid that we'll be discussing very shortly. If you can go back to the –

Caitlin Collins – Project Coordinator – Altarum Institute

We're working on uploading it now.

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

You're working on uploading that now. That's okay, you can go back to the spreadsheet. Okay. And so the four areas for discussion of quality measurement, clinical decision support, defects and registries but I'm going to actually, I give credit to Danny Rosenthal for putting the grids together and I'm going to turn it over to him to walk through the grids, but we want to get – we have some very specific asks for you. We'll stop you after we explain the item and then go through the ask and then get your thoughts. So with that, I'll turn it over to Danny.

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

Great and I just want to make sure I know who is on the phone. So I heard Floyd, I heard Phil Renner, is that correct? Rob McClure, Rosemary, Chris Chute and Galen Murdock.

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

And Brian Levy.

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

And Brian Levy, got it, okay. So a fairly small group, so this is good. So, folks from Altarum, when this is posted and folks can actually see it, please let me know, so I can stop the describing. So, as Marjorie was mentioning, we have quality measures, decision support, defects and registries. And I was looking at the work plan and getting a little bit caught up to speed, I was a little bit – we're being asked a lot of things, I was trying to give it a little bit of structure than can help facilitate some of the conversations. So for each one of those, it seems that the themes that we're being asked to comment on fit into sort of four buckets. For some of those domains we were being asked to comment on standards for specifications. On some, we were being asked to comment on standards for structured data capture. For some we're being asked to comment on standards for calculation and then for others, it was standards for structuring the output and then transmitting the output. So those were specifications, data capture, calculation and output.

So for the purposes of this call, there are sort of two main questions that – or two topics that we wanted the group to discuss. The first falls into the realm of specifications as they pertain to quality measurement and clinical decision supports, and specifically that topic is around a – is a discussion around aligning the semantic foundations between specifications of logic for both quality measures and clinical decision supports. That's sort of one topic. The other topic that if we have time we'll get to will be around structured data capture for the domains of defects and registries, and particularly hearing some conversation around the S&I Framework. So those are the two topics for our conversation today. Let me just pause and ask if there's any clarification.

Keith Boone – System Architect – GE Healthcare

This is Keith Boone. I didn't quite catch the two topics because I had to switch lines.

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

Got it, so on –

Keith Boone – System Architect – GE Healthcare

The latter one I caught, the first one was something about alignment with CDS and CQM, but I wasn't sure exactly what it was.

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

Yeah, so aligning logical expression between specifications for quality measures and for decision support. So, more specifically that is the current logic that quality measures have in them is sort of representing –

Keith Boone – System Architect – GE Healthcare

I've got that I understand it.

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

Got it. Okay.

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

So Danny, this is Rob McClure. So the – when you said logic, we're going to get to nuances here I think, but are you specifically focusing on the logic expressions that are used to describe a decision support – CDS versus a quality measure. Or are you talking about the model, so kind of like we talk about medication administration and we talk about diagnosis or active diagnoses?

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

More the former. And Keith, that's actually a question – I'm sorry, Rob. That's a great question and we were talking with the folks from ONC this morning to try to get a little bit of a clarification around this. And I think what they're really going after is, and I think back to Paul Tang's Venn diagram with the little gold pot in the middle from years ago, decision support and quality, and what was the last one? Decision support, quality and – something or other, anyway, it was a Venn diagram, in essence, how does – for quality measurement we have HQMF phase R1 and then R2 is also there, that's for the quality measure. And then on decision support, we have VMR and GELLO, and I know there's a lot of standards work going on to sort of align these two. And so the conversation that we're going to have today is around where are we with that alignment. Is –

Keith Boone – System Architect – GE Healthcare

You haven't even mentioned HED and getting to Rob McClure's question, a question about the logic of how you describe a CQM and a question of the logic of how you describe CDS intervention is dependent both on the way you express logic, in other words, "and," "or," "not –"

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

Yeah –

Keith Boone – System Architect – GE Healthcare

– sorts of statements, but also on the model by which the data elements against which you're expressing the logic are expressed, so you have within HQMF and VMR models. And so I think both are relevant, I don't think it's an either/or, I think it's a both/and.

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

Yeah, I have to agree with that. I think that the – it would be hard – I mean, it's sometimes I think easy to think that you can separate and say okay, well the models are close enough and we'll just talk about how we do our expressions and use "ands" and "not's" and things like that. But I think it's more clear that that's a dangerous proposition when you think about the sort of discussions that are occurring at CIMI with detailed clinical models and open air, where the kinds of constructs are more clumped together. And I think that we do need to talk about this in the context of the combination of how do we represent information in a consistent way so that it works both in quality measures and decision support, and actually everywhere. And then once you have those kind of things that you're going to represent and talk about, what's the right way of describing that clause, i.e. GELLO and other things like that. I think you do need to – we need to tackle both of those things.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Mayo Clinic College of Medicine

Yeah, this is Chris Chute. I want to reinforce that. In fact, in our SHARPh work with ONC on secondary data use, we were very explicit about focusing on, and it's consistent with CIMI, a way of rendering clinical information and more pertinently, normalizing clinical information so that logic would be predictable and executable. For logic we've chosen and adaptation of the QDM model, but manifest through Drools, I don't know that we have to micromanage the execution environment, but it's clear that the rendering of patient data is something that requires comparability and consistency so that any kind of execution logic is predictable and consistent. And they're both necessary.

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

Let me see if I can pose this as maybe two series of questions, okay, sort of to identify what gaps exist in the standards. So the questions I guess would be, we were talking about data representation and logical representation, both for quality measures and for decision support. The ultimate glide path that we want to get down to is where the – and obviously we all know that we want quality measures and decision support to converge, and hopefully converge around standards. So in order for things to converge, we first have to have standards for each, and the standards be sufficient to represent the knowledge that we are trying to express. So I guess my specific question is, are data representation standards sufficient for specifying quality measurement now. That's the first question. The second question is, is the logical expression in the HQMF sufficient now? And then we'll be asking those same two questions for decision support.

Keith Boone – System Architect – GE Healthcare

So this is Keith. Before you start analyzing specific standards, quite honestly I think what you need to have in front of you is what are the specific principles that you're interested in investigating.

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

Um hmm.

Keith Boone – System Architect – GE Healthcare

And look at it from that perspective. We can sit here and debate whether HQMF has what's needed or whether HED has what's needed and we'll be going back and forth for quite some time on that discussion. And the current debates in the standards development organizations over who's got the better model, who's got the better way to do logical expression, etcetera, will start to emerge in these discussions and I don't think that's a useful use of our time because we can all pound our chest and argue about which – who's got the best representation. I think we need to establish what are the right set of principles, and then we can evaluate each of the available components against that set of principles, rather than argue about one standard versus another.

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

Actually – and, can you give me an example of let's say two principles?

Keith Boone – System Architect – GE Healthcare

So, one example of a set of principles is what is the appropriate collection or set – actually, the principle is does the expression allow access to an appropriate set of data elements for computing either measure or decision support intervention. So that's – that I think is one of the principles. Another of the principles is, does the logic expression support the basic Boolean operations and set intersection operations for determining qualification of a particular set of data for a patient for use, either in a quality measure or in a CDS intervention.

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

Um hmm.

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

Okay, so I think those are – starting with asking the right questions – this is Marjorie. I think starting with asking those types of questions is a good place to start. I guess my question is then, when you look at the bigger picture, that's kind of how I think sometimes, as we're doing this – this effort relates to eventually, I believe rulemaking –

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

Sure.

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

– for meaningful use. And we looked at – if you look at some of the work that's already in place now for Meaningful Use Stage 3, whenever that begins, if we ask these questions and then we go down to another level, I guess my question is, how is that – how does that line up with where we are now in meaningful use? Or, what is needed for the – for why we're doing this, for the end goal?

Keith Boone – System Architect – GE Healthcare

So this is Keith again. I think we can quite quickly identify the applicable standards that have been developed. We can look to S&I Framework projects that have been moving forward. We can identify standards in HL7 and identify standards in the work that CIMI has been doing. So we can enumerate the work that is available, in terms of where it is and what is its status. Now it's somewhat unfortunate that we're having some of these discussions at this point, because this is really sort of developing requirements and input that could have been used in developing some of these standards and we wouldn't have reached some of the impasses that we're at that are causing some of this discussion to occur today.

Galen Murdock – Veracity Solutions

Keith, this is Galen Murdock. I'll agree with you on that point as well that the timing is interesting in that there's still – you mentioned past work, there's also future work happening to try to examine say for example, HQMF and HED that by the very people who are closer to the metal, acting upon the very principles that we still need to align on. Or at least their presumptions of those principles, and so we stand at a point in time where we're both looking ahead to intelligent conversations and seeing other intelligent conversations in the past.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

And this is Floyd. Just to add to that, as far as work that's ongoing, one of the things that HL7's looking at as a project is harmonizing the VMR and QDM to try to help move forward to enable both CDS and measurements. But that's just starting.

Keith Boone – System Architect – GE Healthcare

And not to put too fine a point on it, Keith again, one of the issues that would greatly impact our – or that should greatly impact our evaluation is timelines, because the decision about the sorts of recommendations that we would make would depend very much on what are the timelines that are needed to address that? Talking about, for example, the work that's happening to align VMR with existing QDM. I think that we would feel very strongly that that would be a good thing to do and to have in our tool chest. However, if the timeline is, this a rule that needs to come out on I don't know, let's just say January, the reality is identifying that as being something that might be available at that point in time, I don't know that it's entirely likely. So either our recommendation needs to include a recommendation for what's the appropriate timeline for addressing this, or we need to be informed of what is a timeline around which we should scope our recommendations.

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

I think that's – this is Marjorie again, and I think that's also a very good point. I'd like to maybe ask maybe a more granular question that maybe leads to sort of what Keith is getting at, which for example, if you look at HQMF R1 and HQMF R2, looking at – sort of asking questions about those two things. Is that the type of question that we should be asking ourselves at this point in time?

Keith Boone – System Architect – GE Healthcare

This is Keith again and I would say, I think yes, we need to be looking at those things, at some stage, but I think the first stage is understanding the principles, identifying the candidates and then being able to make recommendations around the candidates, based on any – candidates and timeline or candidates with respect to timeline.

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

Okay.

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

Keith, would you be comfortable drafting some core principles that we can then discuss as a group on our next phone call?

Keith Boone – System Architect – GE Healthcare

I would be happy to put together some core principles.

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

That would be great.

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

That almost makes me wonder if – I mean, believe me, I don't want to spend a lot of time doing this, but I mean I like the scope that we're talking about and I think it's actually really important and useful. Does it mean that we ought to spend a little bit of time making sure that our – in terms of reference or whatever it is that we might have, have aligned with that? Again, I don't want to spend a lot of time on that, I want to do the real work, but I just – it just popped in my head.

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

So when you – so, can you clarify a little bit more Rob, when you say that, what do you mean?

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

Well I have to admit, all along I've been a little bit unclear about what our raison d'être is for this group. And that's usually described in terms of reference or something like that. And may – I'd have to admit, I don't remember if we have it, if we don't, let's pretend I didn't say this.

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

Well, I think that might have been my comment before, but related to that, I think – I mean, this group has had different charges along the way. I think back to 2010 when we looked at all of the standards for reporting clinical quality measures, and I'm thinking of the terminology standards, so that – we had a very defined set of term of reference related to that work. I think for this work, I think the terms of reference, if you mean what's our focus, why are we doing this. Is that what you mean?

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

Well I think – I just would like to make sure, I mean I would hope the terms of reference are quite broad, and I like the phrase, we've got a scope of work that – a work project that we've been handed that aligns with that more general scope, that focuses in particular areas for particular needs. That makes sense to me, and I just wondered if that's what we're doing and I'm glad about that, because it's certainly happened in the past that there's multiple entities working on the same thing. And if it's clear, look, you guys need to, and then particularly given what we were just talking about, which is really defining the characteristics of our current state to inform policy that we do this in a way that it isn't colliding with other FACA groups. So by saying, okay, here's your terms of reference, here's your scope, that kind of sets our boundaries and makes clear to others what – if they run into that scope, they throw it to us.

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

Yes. So I would agree, I think that's an implied reference but we could make that explicit, if you'd be happy – we'd be happy to take that language from you and sort of put that in writing and so everyone has got – we can talk about that at our next call as well.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Mayo Clinic College of Medicine

Yeah, this is Chris, I have to go onto another call, so I haven't added much. But I very much look forward to reviewing the drafts and documents that were alluded to this morning. I think they will move us forward and look forward to that. Thank you.

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

All right. Thank you Chris.

Galen Murdock – Veracity Solutions

If I could – this is Galen. If I could follow Chris' lead there, I also have to go to a conflicting meeting. Keith, I look forward to reviewing what you have put together in preparation for our next meeting, where we can discuss those principles. I think it's a great start.

Keith Boone – System Architect – GE Healthcare

And this is Keith. I'd be happy to take input from anybody it's Keith.Boone@GE.com.

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

Okay.

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

So we have another I guess 30 minutes together, we don't have to use all of it if we –

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

We don't –

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

– .don't have topics. But one of the sort of themes that I was hearing as I'm getting brought up to speed a little bit more, it's been a couple of years since I was deep in this, is are questions around readiness of HQMF R1 versus R2 and then the go forward path with aligning the logical models with VMR GELLO and HED. Just for my own education, can someone on the call just talk a little bit about sort of how well we are aligned and how far away are we from being – having actual good alignment between quality measures and decision support.

Keith Boone – System Architect – GE Healthcare

So, this is Keith again.

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

Hi Keith.

Keith Boone – System Architect – GE Healthcare

I'm doing a lot of talking, but I've also spent a lot of time on HQMF and HED –

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

Yeah.

Keith Boone – System Architect – GE Healthcare

– both on HQMF R1 and R2 and a lot of review of HED. On HQMF R1, I personally voted negative on that as a DSTU because it was not capable of being used to automate the computation of quality measures, it got us closer, but it doesn't meet the stated goals of having quality measures be able to be imported by an EHR system and be used.

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

Um hmm.

Keith Boone – System Architect – GE Healthcare

It has been used to develop and publish quality measures, it has value in that space.

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

Yes.

Keith Boone – System Architect – GE Healthcare

HQMF release 2 we spent extensive amounts of time closing that gap. That document has completed its HL7 balloting, we are withholding publication until we get through an aligned QDM-based implementation guide on HQMF, to make sure that we have everything aligned. The pre-final draft of that's been available on the HL7 websites for Structured Documents Workgroup members for quite some time, and I've reviewed that. But I feel very good about the state of that, having done already some implementations that – trial implementations or prototypes that show that I can compute measures from that work. And I've also worked with others who have used the same and done the same, so it's not just me who's shown it, but it's also others, for example, for MITRE. That's going to be a DSTU when it comes out.

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

What?

Keith Boone – System Architect – GE Healthcare

It's going to be the second release of it, in terms of its readiness for use, say in a rule that comes out a couple of years from now. In terms of its implementation timeline, I would say that some pilots are still needed to prove that our, but in terms of putting together a proposed rule and saying, this is what we think would be most appropriate, it seems likely that that would be a good place to go. I think that there may need to be some interim work in terms of pilots, to establish that this is – yes, this is indeed the right direction. On HED, there have also been pilots –

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

Um, hmm.

Keith Boone – System Architect – GE Healthcare

– based on the existing specifications, there is a lot of work that’s happening around HED. It has just recently come out of HL7 for ballot. There was a great deal of discussion internally to HL7. It went to the second highest governing body in HL7, the TSC, the Technical Steering Committee, to address some of the issues around lack of coordination in the specific HED specifications, and I was involved in some of those discussions. I think that within HL7 we came to a conclusion that would allow those ballots to go out, just a little bit later than usual. And I think that that work is close and I’ve also done an evaluation of the models and the logic and find that in some areas they are aligned, in other areas, the lack of alignment comes from variations in expression of the logic. And that impacts the implementers of the two sets of standards. So while both are in pretty good shape as being able to be picked in their own context for a specific – they are not aligned together with each other, and we don’t, as yet, have a set of standards which are aligned.

The CIMI work that I’m somewhat familiar with is, I believe, a little bit further out in terms of where it’s progressing. I don’t know that they’ve published anything specifically for a ballot or review or anything along those lines. I am somewhat familiar with the detailed clinical model work that pre-dated that, as well as the open air work that predated that. I think discussion about sort of what’s the right level of detail for models is probably one, which we’ll still be talking about for quite some time. We’ve got some work in S&I Framework that already covers quite a bit of that. So that’s it.

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

Keith, let me ask you a question, and I ask this to the group as well. So as someone who implements meaningful use measures, it makes a little bit nauseated even thinking about having to adopt a new standard from R1 to R2, but this is the reality. And yet if I think about even further in the future, if R2 becomes close – more closely aligned with HED, which sounds like which is our goal, then it would be yet another standard. I mean, what are your guys thoughts on do we – for meaningful use do we stick with R1 for the time being, until there’s alignment with R2 and HED. Or does it make sense to go forward for meaningful use with R2 as is? What are your folks thoughts on that?

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

Let me jump in with a kind of orthogonal statement. In part, the – I mean, there’s I think a very real – we have a couple of very real goals, so one is harmonization of technical requirements that cover similar things, but aren’t the same thing, and therefore, because they are similar things, the implementers are struggling to do decision support and report on quality measures in different ways. And so there’s an absolute important goal of harmonizing those, which is what we had talked about as our key goal. But there’s another thing that frustrates implementers, which I’m sure many people on the phone would relate to, you in particular. And that is, even within any single one of those, so for example, within meaningful use using R1, there’s a tremendous amount of variability in how that “single” standard is applied to do kind of similar things, when you look at measure to measure to measure.

And we’ve been struggling to put together a process to begin to get rid of some of that variability, there was variability in terms of how value sets represent a kind of common idea. There’s aligned with that a tremendous amount of variability in terms of how R1 and QDM really is applied to represent something like did the patient expire. And so I think the core of your question, if we think about making implementers lives better. There’s a part of the answer to that that says, well, if we just stick with R1, does that really make their lives better. And I wonder if that’s true, given the kind of variability I see looking at the meaningful use measures that they’re still going to be struggling to try and make heads or tails out of the practical thing of trying to get a bunch of measures implemented in their system. And so I wonder if – I just, like many things, the answer to that question is slightly complex because it’s not simply that it would just be easy to do R1, because everybody’s got it nailed, I don’t think that’s true. I’ll stop at that, I mean, I think you get my point. So in essence I’m saying, look, if we really get a lot of benefits by moving to R2 and we can clean up the kind of variability that we see in people applying R1 “correctly,” then maybe that pain gets rid of two different problems.

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

Interesting, what – Floyd and other's thoughts.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

So Rob, I'd like to add to your comment – this is Floyd. I think what you've addressed is the governance issue over how standards are applied, especially in the example you used, for quality measures. And where there are some models, that doesn't necessarily mean that they're always used consistently, and you gave an example on a patient expires. My question is, will HQMF R2 actually resolve that or is that more of a more implementable artifact that we still need the governance to manage the expressions?

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

Any other thoughts?

Keith Boone – System Architect – GE Healthcare

Well this is where I got to the discussion around principles – Keith again. And working towards making sure we understand and appreciate the principles of what we're trying to achieve. We can certainly – I can certainly tell you what my preferences are around what I'd love to see for doing measures – quality measures, and I put a lot of time and effort into HQMF. But until we actually have established a set of principles, giving you an honest assessment of whether or not it meets the principles that we're looking towards is not something that I feel comfortable doing. Now if you were to say, do a – if one of the principles was do as little work in being able to edit quality measures as being one of the principles, that's an argument for HQMF release 1. I don't necessarily agree with that as a principle, but if that's what we agreed to as a principle, that's the recommendation I'd give you.

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

So it's kind of like we're talking about two sets of principles, one is the principles for is the standard – whether the standard done, right, so, when is the standard complete. And the other is sort of a set of principles that I'm hearing are also principles about alignment, what are the principles for alignment. So principles for alignment also are principles for the standard representing the truth of that domain. Are those two sets of principles there or, what are your thoughts?

Keith Boone – System Architect – GE Healthcare

So I'm thinking about trying to understand what is it that we are trying to accomplish and by when. And in terms of that, what are we trying to accomplish, it's really, I think part of that has to do with – I mean, once we understand what it is we're trying to accomplish, developing principles from that –

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

Yes.

Keith Boone – System Architect – GE Healthcare

– is really pretty easy. We've been given sort of a high-level mission statement, right, from there we need to drill down through goals and objectives and specific deliverables and plans for meeting those deliverables. And I don't – I'm afraid if we start jumping in from the bottom and working our way back up, we're going to meet a – we're going to hit a different mission statement.

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

Yup, and we agree with that. So I think we're at a point in time where I think we know what we need to do next and I think we'd like to look at those principles, right? Keith, you had offered to draft some and I think we'll – and anyone else who'd like to contribute to that work, Keith, what's that email address you gave us again?

Keith Boone – System Architect – GE Healthcare

It's really easy it's Keith.Boone@GE.com.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
@GE.com, and so in between now and the next meeting, we're going to work very closely with ONC and the Standards Committee to identify a series of specific questions that they need explicitly answered from us. And I have a feeling that we're going to have these same conversations again, but hopefully if we have a little bit more direction as to the specific questions, our next meeting we can jump into those next steps.

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

Keith Boone – System Architect – GE Healthcare
Well, and, pushing back the other direction, I think one of the questions that we have that should go back to ONC and the Standards Committee is a question of, are they asking for recommendation on timeline or do they have a timeline in mind that they can share with us.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association
Well I think – yeah, that's a good question. Prior to the call, we actually were discussing that, I think we'll get some clarification on that, but my feeling is, it's the later, that they have a timeline that they will share with us, that we need to work within.

Keith Boone – System Architect – GE Healthcare
And that's fine, either one is appropriate.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association
Right. So, okay. With that, Julia or others, when's our next call?

Julia Skapik, MD, MPH – Office of the National Coordinator
I don't believe we have a call on the books, so I would suggest now that we create a strategy for the next several meetings and schedule those now. What would be the soonest we would want to meet?

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

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
I guess it would have to do with our timeline, right? So we owe something to the Standards Committee you said in November, is that –

Julia Skapik, MD, MPH – Office of the National Coordinator
And our list of asks had October on it, so I would suggest that maybe we try to meet in two or three weeks and bring all this together so that if there are more specific asks from the Committee, that we could answer those.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator
Julia, this is Michelle. So I know that Doug is meeting with the chairs of the Standards Committee, John and John, later on today. So I can ask them what their thoughts on timeline are and share that back with you.

Julia Skapik, MD, MPH – Office of the National Coordinator
Thank you Michelle.

Marjorie Rallins, DPM – Director, Measures Specifications, Standards and Informatics – American Medical Association
That's absolutely great, and that would kind of help us. But in the meantime, I think we should regroup in two weeks. Now does that fall into the HL7 schedule?

Keith Boone – System Architect – GE Healthcare

Yes that does, you've landed right in HL7 week, and it would be somewhat challenging and then I'm teaching that week to absent myself from certain times.

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

Okay. So, we'll – maybe the week after –

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

– and then maybe have meetings every other week for a few meetings so that we can get up to speed and not fall behind just potential upcoming dates for the Policy Committee.

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

So we'll work...

Keith Boone – System Architect – GE Healthcare

Yup and Floyd, if that's going to be a topic of a CQI meeting at that workgroup, let me know when.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

I will do. Thanks.

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

Yeah, and I want to agree that if we start the next meeting the first week of October and go every other, if that's our choice, the nice thing is that misses the SDO meeting, which is the second week in October.

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

Right. And many of us will be there as well. Okay –

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

So we are having a meeting in the first week of October?

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

No, we're going to have a meeting the first week in October, which is three weeks from now.

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

Okay, great.

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

Okay. And what's – this is our standing time?

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

This doesn't have to be our standing time, we've actually had a variety of times –

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

This seems to work for most that are on the call today –

Keith Boone – System Architect – GE Healthcare

We did have two drops today.

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

Two drops – at 11 we lost two people.

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

I mean, just from those who are on the call, is there another day of the week that would work? Thursdays do not work well for me and Danny?

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

The only time that doesn't work for me is Friday afternoons.

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

Wednesdays at 10:30, 9:30 –

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

Wednesdays at 10:30, we're talking Eastern Time?

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

Yeah. But I could do Friday, too. Friday is good also.

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

Does Wednesday at 10:30 Eastern work for everyone as an alternate day? I would suggest that we –

Keith Boone – System Architect – GE Healthcare

You've got it.

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

This is Michelle, I just want to make you aware that it's going to be very difficult to do a meeting like that because we have to consider all the other meetings on the FACA calendar. And Wednesday's tend to be the day when we have Committee meetings, so I'm not sure how easy it will be to set up a consistent time, just to –

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

Michelle, can't Altarum send out a poll of some kind, they've done that in the past.

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

Yeah. So we can do a poll, if that works for everyone, maybe we could get some suggested times from the chairs and then we can use those to send out a poll to the rest of the members of the workgroup.\

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

Okay. May I suggest that we keep – while we have this time, that we make the next call for Friday and then poll for the every two weeks after that.

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

Okay.

Keith Boone – System Architect – GE Healthcare

That works.

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

Okay. We will do that. Thank you everyone and we look forward to speaking with you again –

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

That would be October 4?

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

October 4 is our next call, if that's a Friday.

Keith Boone – System Architect – GE Healthcare

Yup. And I guess we go to public questions at this point?

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

I think you actually have to open up for public comment.

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

Yes, we do need to open it for public comment. Thank you.

Public Comment

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

Operator, can 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 comments at this time.

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

All right. Thank you everyone.

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

Thank you. Have a nice weekend everybody.

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

Thanks.