

**HIT Standards Committee
Clinical Quality Workgroup
Transcript
December 9, 2013**

Presentation

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

Good morning everyone. This is a 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 this meeting is being transcribed and recorded so please state your name before speaking. I'll now take roll. Marjorie Rallins? Danny Rosenthal?

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

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

David Baker? Keith Boone? Anne Castro? Chris Chute? Jason Colquitt?

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

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

John Derr? Bob Dolin? Floyd Eisenberg? Rosemary Kennedy? David Lansky? Brian Levy?

Brian Levy, MD – Senior Vice President & Chief Medical Officer – Health Language, Inc.
Yes, here.

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

Rob McClure?

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

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

Galen Murdock?

Galen Murdock – Veracity Solutions

Present.

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

Gene Nelson? Philip Renner? Eric Rose.

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

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

Hi, Eric. Joachim Roski? Randy Woodward? Kate Goodrich? Kim Schwartz? And I believe Jon White is on the phone from AHRQ?

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

Hello.

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

And are there any ONC staff members on the line? Okay, so good morning everyone and there has been some weather, at least on the East Coast and I think in other parts of the country so there's a few members that have been unable to join. Julia isn't with us today because the federal government did have a two hour delay in starting today and I think Marjorie is also experiencing some weather difficulties. So, thank you for those of you who are able to make it. Danny, do you want to make a few remarks before I summarize what I received?

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

Yes, please, first of all thank you everyone for the quick turnaround on your responses to that document. The purpose of today's phone call is to review the responses that we've received from the group and come to consensus or develop additional comments once we are all able to look at what each other has written.

So, I'm going to ask Michelle to give us a brief overview of the volume of comments and then we're going to use the rest of the call to go through the PowerPoint that she has put together to review each one of these questions and the responses.

When we're done with this phone call we should have a pretty good working document of the Workgroup's thoughts and beliefs for these particular questions.

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

Yeah, so –

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

Any questions on the purpose of this call folks?

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

Sounds good.

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

Great, Michelle?

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

Thank you, Danny, and thank you Danny for helping to coordinate everyone and putting together the document that we used to aggregate feedback we really appreciate that.

From my perspective I have seen responses from five different members so I received something from Galen, Keith Boone, Chris, I'm sorry, Eric Rose, Rob McClure and Rosemary Kennedy. Eric's responses weren't in the format from Danny and just due to timing today his feedback is not present in the PowerPoint but hopefully Eric will be able to speak to his thoughts as we discuss.

So, we did receive feedback from five different members and that will be reflected in the ugly PowerPoint that we're going to review today.

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

Great.

Keith Boone – System Architect – GE Healthcare

Hi, I just wanted to let you know that this is Keith and I am here on the phone but now going on mute.

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

Thank you, Keith.

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

Okay, this is Jason Colquitt and I responded to Julia so I don't know if that didn't make it to Michelle or not?

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

Yeah, I didn't – I don't think I saw it Jason I'm sorry and without Julia being on the line and I haven't heard from her this morning, so, your responses won't be reflected in the PowerPoint today.

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

No worries.

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

Okay, Michelle, great, thank you do you want to open up the PowerPoint.

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

And Danny, this is Marjorie, I just joined.

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

Oh, hey, Marjorie. So, Marjorie Michelle was kind enough to consolidate the responses that we have received thus far and we've gotten 1, 2, 3, 4, 5, 6 including yours and my comments, Jason also has comments that he sent to Julia so we may have a couple of other comments from Julia's side.

So, the three questions that we were sort of addressing were how usable are current CDS standards to identify what required data elements and where in the systems they should be found? That's the first question. So, how usable are the current CDS standards?

The second question was, can external data, for example from a registry, be used to trigger decision support?

And the third question is, how feasible are current certification criteria?

So, what I'm going to suggest and let me know if this makes sense to everybody, that question number one we have 1, 2, 3, 4 pages of thick dense text and so whereas the information that we got from question number three, how feasible are the current certification criteria is a little bit more concise and unstructured.

So, to sort of start off the conversation I was thinking maybe we could even start with the certification criteria. How does everyone feel about that?

Keith Boone – System Architect – GE Healthcare

That's fine.

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

Great, so could you just skip to slide number eight?

Keith Boone – System Architect – GE Healthcare

Dan, I can't see the slides.

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

Who is saying that?

Keith Boone – System Architect – GE Healthcare

Sorry, this is Keith; I'm not on line yet.

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

Danny?

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

Hi, this is Eric Rose, I just wanted to mention I can't see the slides either I'm still on my way into work.

Galen Murdock – Veracity Solutions

This is Galen Murdock I'm in the same position.

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

Got it. So –

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

This is Rosemary I'm in the same position Danny if you wouldn't mind just reading it.

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

Sure, sure. So, Michelle or someone on the call, are you able to send the group this slide deck?

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

I believe Altarum already did. It sounds like most people are kind of driving and so forth.

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

Right.

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

So, we should probably just read the slides.

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

Got it, okay. So, I will start off with – and so the way that the questions were structured is how feasible are the current certification criteria and for each of the certification criteria the question is for example, ability to track CDS triggers. The first question is, is this even feasible for a vendor to meet yes/no?

The second question is, well is there a standard to support? If so list that standard.

And then third is if there is not a standard should a standard be required or can certification reasonably occur effectively without a standard?

So, let me go ahead and read you these answers. Can you actually go back to the prior slide? Okay, the first one is the ability to track CDS triggers okay and I'll try to summarize as I'm reading here. I see on the screen here four responses to this particular question. Is the criterion feasible for a vendor to meet? All four answers were "yes."

The next question was, is there a current standard to meet this functionality? If so list the standard. Of these four answers two were no there is no standard. Another person said, unsure what this might be likely, no. And a third person said, yes HeD with a vMR logical model and vMR templates can be done fairly easily in terms of generic notification handling at the data layer with of course refined processing to support template specifics if necessary.

So, that's, is there a standard, so three said no, one said yes. And then on the question of if there is not a standard should one be required. Three said no one should not be required and the fourth voice said, I personally don't see how any meaningful certification can be accomplished without some type of specification indicating how the trigger should be done, but this runs the risk of prescribing something that may end up stifling innovation rather than an integration with a demonstrated specification such as HeD that could be implemented as a layered approach.

So, let me open it up to the group for conversation. Is this feasible for – is this certification criteria feasible, yes that a standard exists, three no's, one yes and if not should there be a standard three no's, one yes. Thoughts?

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

So, Danny, this is Rob McClure, I think for some of us and I'm the one that said "I'm unsure what this might be" so that kind of states my position. I don't know what the phrase CDS trigger is supposed to mean and so, you know, we have to guess. I mean, that can be anything from the – and in particular actually its track CDS triggers that's the phrase.

So, if you, you know, are saying that a CDS trigger is the thing that is on the left-hand side of the equation, right, so the thing that's being looked for then in order to initiate or – so that's one, initiate a CDS action. Another would be to identify a population that the CDS actually acts on and then if that's what a trigger is what's tracking that trigger. I don't know what tracking it means.

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

This is Eric, I had exactly the same thought as Rob, exactly, it's an ambiguous requirement.

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

So, we have to decide what this is asking I think before we can make any kind of statement as to what, whether we think it's, you know, something that we are currently doing. Because, obviously identifying patient populations and identifying whether a CDS should trigger are things we do, but tracking I don't know what that means.

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

And so this is Michelle, the intention for the Meaningful Use Workgroup was to track from a provider perspective if they're prompted with a CDS intervention how many times are they ignoring it or are they reacting to it.

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

Okay.

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

So, it sounds like we need to make a language change and so I obviously defer to you all with what's the better way to say what they're trying to ask and then knowing that what is a response from the group.

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

So, the –

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

Sorry, it sounds like the requirement then is to record each instance of presentation of CDS feedback to the user with presumably some metadata like who the user is, what the date and time is. Is that it? And the user response.

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

Yes.

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

Yes, it is also, this is Rosemary; there are different options allowable options that can be variable as well and probably few standards around that. I mean, we could just track but if the trigger presents itself then there are different options –

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

Well, first let's stop using the word trigger, because that's not a trigger in any sense of the word so far as I can tell. I mean, we're tracking user responses. There are all kinds of places where that happens. I mean, this is a CDS intervention and we're apparently tracking user responses to CDS intervention.

So, let's first, let's change the word because that word is totally wrong it's not a trigger at all, it's a trigger perhaps to the user to do something but it's not a decision support trigger. A decision support trigger is a thing that triggers the decision support. This is a – this is, it sounds like that issue is how do we track user responses to CDS interventions. Is that the right thing? Is that what we're talking about?

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

I think that it's both the – it's both that an intervention fired and then so it's both intervention as well as the response to intervention, correct?

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

Correct.

Keith Boone – System Architect – GE Healthcare

So, this is Keith, on the idea of keeping track or keeping a trace that any intervention fired what you're really talking about there is a functional requirement which might be met by a functional standard but there is no interoperability standards necessary to keep track of that sort of information.

So, it's just as if you were dealing with the same kind of thing as is dealt with in audit in the Meaningful Use specification, which is describing the requirement functionally that this kind of information is captured and there may be some information about – in HL7 on that sort of activity in the EHR functional model. I suspect that there is not because you're asking about something that's actually rather specific.

Nor in this sense do I think you really need a standard if what they're saying is “we'd like to know when a CDS intervention is triggered and whether or not the physician responded to it.”

Now on the whether or not the physician responded to it that's an interesting question because some CDS interventions the physician has to respond to because the intervention is essentially pulling up an order set that the physician can then just customize and an order is designed to be used in that fashion.

And there are others where the physician might say, ignore that that's an alert and I know that I'm prescribing two blood thinners for this patient but in this particular case this is exactly what I want to do. And so you may not always have anything as simple as a yes/no physician responded to it sort of response it's not that easy.

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

What are we trying to achieve? What is the ultimate goal? Because Keith a physician may not respond or may just ignore it and want to go off and consult with somebody else and it may not be the physician it could be another member of the team that automatically does something. So, what's the ultimate goal we're trying to achieve with the audit?

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

That's a great question Rosemary. Michelle do you have a sense of that?

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

I believe to determine the number – because I think as we all know, especially with say drug-drug interactions for example there are a number that people are – providers tend to ignore and I think it was to get to the point where, you know, if a number of things are being ignored what can be done to improve upon that process or if something is being ignored and it shouldn't have been, you know, what are the next steps that should be taken.

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

Yeah, I – this is Rob, I think there's a couple of things and we could – I don't know how many of these we need to get through today, but I think this one is pretty straightforward. There is no standard and not to say that it's not an important thing but there isn't a standard so we can't – I mean, you know, flat out, so far as I know, I mean, I'd be interested if somebody else said there is, but there simply no standard for this.

And even if we were to – and I would suggest that whoever decides that they do this, start with a very focused thing perhaps like what was just suggested, in other words, we want to be able to identify responses to drug-drug interaction alerts. Can we identify a standard that supports that? And then implement it and test it.

It sound like something that's reasonable and that could then therefore be broadened to cover other kinds of CDS interventions and interactions as we are noting this is a very complex thing, because you're going to have a lot of different key members interacting with it, their response can be as varied as, you know, simply acknowledging that, you know, kind of turning it off because that meant you saw it to actually, you know, generating some completely complex care plan based on it.

So, anyway I think this has got a really straightforward answer and that is no it's not feasible for a vendor to meet this as a standard, certainly vendors do it right now.

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

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

Every implementation environment that's dealing with alert fatigue is dealing with this somehow but not in a standardized way.

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

So, the question for the group is that if – for those vendors on the call, can you today produce a – some type of audit that basically says here are the CDS rules that fire and here is the user response to those rules. So, Jason I know that you're on.

Keith Boone – System Architect – GE Healthcare

This is Keith.

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

This is Jason –

Keith Boone – System Architect – GE Healthcare

Go ahead Jason.

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

No, I was going to say, we definitely track an audit it's similar to what Keith was saying, you know, the audit trail is there for this, what action the provider or the user takes off of that, you know, we definitely have audits of what they're going, but I don't know necessarily that we can track back to exactly the action was taken off of that CDS if that makes sense, unless it's specifying like what Keith was saying some specific order off that CDS rule then I can tie those two together.

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

Yeah, I mean that – this is Rob McClure again, does that raise the possibility as one suggestion that we could have is that there, you know, start the process by, you know, expecting that an audit of fired interventions and, you know, the – I'm trying to say this in the most general way possible, but the response to that intervention that there was a response or was not, was it ignored or did some other action occur, you know, that simple audit probably – I mean, it's not a standard that's not a standard, right?

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

Correct.

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

But that's at least something that could be described as we would expect that you track these in some way that seems reasonable.

Galen Murdock – Veracity Solutions

This is Galen, I agree with the conversation –

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This is –

Galen Murdock – Veracity Solutions

I was going to say I agree with the conversation that's happening. I missed the importance of the word track in the question so my response is not matched nor is it appropriate.

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

Who is that now speaking was that –

Galen Murdock – Veracity Solutions

This is Galen.

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

Oh, hey, Galen.

Galen Murdock – Veracity Solutions

I was the one that sent in – suggested for the standard, but I was off in trigger, in the trigger space as opposed to tracking the triggers.

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

Got it, so the – and Rosemary did you have another thought there?

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

Yeah, I thought that tracking the trigger and the actions that people take is – there are multiple variables around that so if they ignore the trigger it doesn't necessarily mean that they ignore the semantic content within the trigger additional data would be needed to know whether they truly ignored it or followed up with a course of action.

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

So –

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

You know, was the order placed, was it not placed, it seemed to be as if the action they take ignore in and of itself doesn't really paint a complete picture, it may Rob around drug-drug alerts but it seems as if additional data would be needed from the record in order to interpret the ignore or else we'll really be thinking that everybody is ignoring everything when in fact they may not be.

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

Got it, so for the group asking the two questions again, is the – is this a feasible criteria? Now again, we're not commenting on whether it necessarily makes sense to be tracking an audit trail but if it's intent was what is being ignored and the example that you gave, Rob, for the drug-drug interactions are they firing and what's being ignored. Is the criterion feasible for the vendor to meet?

It sounds like, and tell me if I'm wrong on this, that the group is saying that its feasible meaning most vendors can do something like this, is there a standard for this? No there is not a standard and that we're sort of iffy on whether or not you necessarily need a standard if you wanted to do this based off an audit trail.

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

Well, this is Eric, I guess that I would have a little bit of a problem with that response given the point that Rosemary just made which is that you can collect data on user response within the context of whatever the user response options are in the particular, you know, the particular design of the CDS user interface, but it's not – but it may not be meaningful information as to the clinician's response to the information provided and –

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

Got it.

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

So, it makes me a little nervous that there might be expectations created that would result in EHRs that were designed in good faith not getting certified because they're perceived not to provide the data, you know, expected.

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

Got it, so who is that speaking again?

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

That was Eric.

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

Eric, so it sounds like that this is more feasible for the interventions. We all know what things are fired.

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

Yes, yes.

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

But no it's not feasible to be able to track the user's response.

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

Right, it would be very easy by the way to create a requirement saying allow the user to indicate that a particular piece of CDS advice is not clinically applicable to the patient, you know, that's something that would be certainly functionally feasible and be collected as data and might be useful.

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

Now, I think Eric's suggestion is actually a good one, I mean, I think and this – if we can craft this well this is probably going to serve as a template in a lot of situations, but – because what we're saying is we expect that – you know, every system should in some way be able to collect information around this and this is common in situations but we don't have a standard that would create some process that would allow uniform collection of this data across, you know, all different vendors and all different situations but we think it's really important to collect.

And so somehow we have to say, yes you should be collecting this because this is important and here's the minimum, one you obviously want to track when these things were fired, interventions are fired and the second one and I like what Eric said, and the only thing that we know would be an important thing to capture is at least indicate whether it was, you know, inappropriate for the patient's clinical state or some phrase like that.

I guess the other would be to also track when it was, you know, clearly followed but even that's soft and I wonder how hard that would be. So, but the one thing that we know is happening that is a concern that we're trying to figure out is, this makes no sense for this patient and I'm going to tell you that.

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

Got it and for both of those things here, we don't have standards, should there be a standard for certification? Should there be a standard or if the certification criteria was specific enough, as you were saying Rob, capture, you know, at a minimum A, B, C, D is that sufficient for this or does there really need to be a tested standard for capturing the interventions and processes?

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

Yeah, so let me jump in and I'll say, no, I mean, I'm assuming this is an attestation –

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

Yeah.

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

That can be audited. That's not to say that someday there will be a standard, right? We all get that, it's just that this is the whole point sometimes we say this sort of stuff now.

Galen Murdock – Veracity Solutions

This is Galen, I agree.

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

Who was that Galen?

Galen Murdock – Veracity Solutions

Yes.

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

Okay.

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

This is Rosemary, I agree.

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

Great, okay, so let us move onto the next one I'm going to read it off to folks. The next question is around – and then can you advance to the next slide please? This is the ability to flag preference sensitive conditions. The ability to flag preference sensitive conditions. So, someone thought that for example chronic stable angina, early stage prostate cancer –

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

I'm sorry Danny we're getting a lot of feedback if somebody could please mute their line we'd appreciate it.

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

Thank you, so the preference sensitive condition examples are chronic stable angina as an example. So, is it feasible for a vendor to meet the criterion of having the ability to flag preference sensitive conditions? Everyone said "yes." We had four answers for this one, four people said "yes."

Is there a current standard for this? We had three answers for this; the first one was yes HeD with vMR logical model and vMR templates. The vMR model can capture these according to the people on the HeD team that are more clinical than I.

The second answer was "I'm not sure what unique standard is needed for this?"

And the last one is "I'm not aware of a standard but this could be supported at the application layer not the standard layer."

And then questions were around if there is not a standard does there need to be one and two people said no. So, opening up for conversation around flag for preference sensitive conditions, is it feasible; is there a standard, if not do we need to have a standard?

Keith Boone – System Architect – GE Healthcare

So, this is Keith, one point I would make on HeD is that I don't believe that HeD has reached publication status at HL7 although possibly it will by the time our feedback gets to the Standards Committee. I'm just not aware that it's actually reached that status yet, it's in process. That may have some impact on our discussion.

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

Got it. So, this is Danny, my opinion on this is that the ability to flag preference sensitive conditions for example angina that's like the 101 of decision support that you're able to flag conditions whether they are preference sensitive or not I don't really care just tell me what the disease process is and CDS should be able to flag it. So, I think that this is – if you can do CDS than at a minimum you can flag preference sensitive conditions that was the way I was sort of interpreting this. So, yes.

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

Yeah, this is Rob McClure; I'm kind of the same way. I think – maybe I'm missing something here, but this is just a subset of conditions that by some criteria has some unique characteristic right and so it's just a list. It's not – I'm really – I'm totally missing what's different about this other than it's just a list of particular diagnoses as opposed to – it's like as much a list of those diagnoses that represent diabetes as it is a list of anything else. So, I'm worried I'm missing something.

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

Michelle, can you add a little bit more context for this?

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

This is Eric, I wasn't really clear on what preference sensitive meant?

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

Preference sensitive in the examples that I saw in the other document was they gave examples of chronic stable angina, early stage prostate cancer. So, for –

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

So, Eric we all had the same question and what it was supposed to mean was that the patient's preference had an impact on appropriate choice for care like –

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

Oh, I see.

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

Do you want to have surgery or do you want to have medications.

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

I see, I see, okay, yeah.

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

Thank you Rob.

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

Because I was completely lost on that too.

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

Okay, sure, sure.

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

Michelle, can you add a little bit of context to this?

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

Well, I think Rob just said it best that's the best context I can give.

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

So, I guess part of this is that, again for me, you know, is there something else about these that is in this question that we're being asked to assess a standard for other than the really basic thing that I'm seeing which is it's just a list.

I mean, is there like an expectation for "oh, we need a standard to capture something that's unique about the patient's desired preference" or that – I don't know – I'm just – you know, anyway that's what I'm trying to get a sense of because I don't really see what's different about this.

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

This is Eric that would be my concern as well, but I agree that on the surface of it there doesn't seem to be anything troublesome.

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

Okay, any other comments on this one? I mean, the other two questions they're asking is, is there a standard and so I would reduce this question to is there a standard for decision support? And the answer we have on that I believe is "no" is that correct guys and gals that there is no standard for CDS at least that has been vetted and tested and gone through the standard making process?

Galen Murdock – Veracity Solutions

This is Galen I think if we're referring to the full process for which I'm – of which I'm admittedly not fully familiar, then I think that I really don't know how to answer to that question. My guess is no standard that I'm aware of is far enough along.

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

Okay. And then for, if this certification is as simple as can you identify patients that have angina should there be a standard required for certification? And Rob to quote you I think that you said for the last question that yes it would be great to have a standard and we're certainly getting there but this could be potentially done in an audit with attestation.

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

Yeah, we're still talking about preference right?

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

Yeah, yeah.

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

Yeah. I have to say, I mean more than any of the things that we were asked about this one seems like we're talking past each other in terms of what we were asked and what we're responding to because there is just simply nothing unique about this that demands anything and so I don't – I think I'm being asked a different question.

I wonder if the question really was trying to get a sense of is there a way that we can capture some kind of record about the patient's preferences and the thinking that went behind that or something, I don't know, which is much more complex.

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

Yeah.

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

So, I wouldn't even, to be honest I wouldn't even say that this is an audit thing I think it's – there is no standard and it's just simply list management and that is a – I think it's part of even Meaningful Use 1 in the sense that there is an expectation to be able to manage problem lists which is list management and I think it's not even a new criteria.

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

Got it. Any other thoughts on this one before we go onto the next criterion? Okay. Next slide, please. So, this is one on provide decision support materials for patients. So, the questions are, is that feasible for a vendor to meet? The criterion said "ye shall provide decision support materials for patients or have the capability to do that." Five people said "yes."

The next question is, is there a current standard to support this? We have three "yes" actually sorry, we have – everyone said "yes" one respondent said HeD supports description of the intended recipient of an action and another respondent said InfoButton.

And then the last question is, if there is not a standard should one be required and we have two responses on this. The first response is this is already part of Meaningful Use Stage 2 in 2014 certification criteria. And the other response was "no, I think the objective should be required but not a standard to meet the objective." So, before I –

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

Can we move the slide forward so that we can see? Because we're on preference sensitive conditions, so there we go.

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

Before we open up for conversation Michelle do you want to provide any additional background on provide decision support materials for patients?

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

I think what – the question was to make sure that they would be able to do this based upon patient preferences.

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

So, this is Rosemary –

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

So, it applies to the other one is that –

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

Oh, sorry –

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

Yes, these go together.

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

Oh, that changes it.

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

So, how – so though do you – Michelle do you sense something unique about the ability to support, provide, you know, directed information to the patient based on, you know, a CDS action? Is that kind of what this is? Because isn't – I mean, that's what I'm reading, you know, the idea that there is some kind of a CDS process that could lead to determining a particular set of patient material, patient support materials, right?

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

Yeah, I think what would be needed is the ability to capture patient preferences first and then, you know, once you have that information you have the clinical decision support that can be – you can use that information to provide the –

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

So, we're saying – so wouldn't we – so we're saying based on your preference we'd only want to give them education material based on that preference?

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

Yes.

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

What if, as a provider, somebody, I don't know, would want to give them the full range of options and kind of target them towards one, but I wouldn't, as a provider, want to just give limited information out, you want to give a broader range of information. But I –

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

You know, I wonder if – sorry, Rosemary, I didn't mean – but I just wonder if this is actually driven by an interest in supporting CDS and patient portals without physician intervention. Is that Michelle – is that partly what's driving this?

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

Yeah, partly, I mean, so they want to be able to – if a patient has asked – the patient preference is to receive educational material through the patient portal for example and you're not sending them or handing them something in the office, you know, you're giving them whatever their needs – they are asking for and the way that they've asked for it.

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

Okay.

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

Does that make sense?

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

Well, that's different, that's totally –

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

So, the preference in question is the modality of delivery of patient educational materials?

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

Yeah, maybe.

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

I didn't –

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

I mean, this is again, we need to be really careful about guessing, because –

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

Yeah, so I think – I think it probably – my guess is, this is Eric by the way, my guess is that the intent was not to say that a system should capture patient preferences about treatment or screening, or what have you electronically.

So, I think that probably wouldn't make sense, you know, if you want an annual mammogram or not, you know, on a website versus a face-to-face conversation with your physician, but if – but it's – I can't imagine that it would be that important to record that preference of somebody, you know, I want to receive educational materials through a patient portal versus send me something in the mail versus hand me something at the office visit, but it seems such minutia to be asked.

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

Eric, can you repeat the first part of what you said because it's not just about educational material?

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

Oh, okay, yeah, so I was saying that I don't – one possible interpretation of this I think is that is an intent to have – to electronically capture patient preferences about their care.

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

Right.

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

Which I think might make a lot of people a little nervous because the possibility for misunderstanding the consequences of misunderstanding are so great, you know, like do you want – do you want a colonoscopy or a fecal occult blood testing as your form of colorectal cancer screening, you know, that's not something you want somebody answering on a website and then basing care decisions based on something other than a face-to-face human interaction. So, it's just – I'm trying to think through what might be the plausible interpretations of this.

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

Yeah and that again, you know, I think Eric's hitting the nail on the head, we've got to be – these questions I think are making us guess at what we're being asked because the simple fact of the expectation that systems support clinicians and identifying and then providing, you know, clinical support information to patients is an already existing criteria for certification and I think it was in Meaningful Use 1, that's certainly an important thing.

Then moving to this more complicated stuff around patient portals which again, now we guessed, there was not a single word anywhere here about patient portals, but and/or, you know, some kind of complicated patient preference system that would record and provide feedback to the patient based on their preferences again is a guess. So, I'm really worried that –

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

Yeah, so this is Michelle, so it's not a guess, because –

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

Okay.

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

I mean, I've been working with the Meaningful Use Workgroup so – but it's not just about educational material it's about all, you know, any patient preferences in regards to their care. So, that's why it was –

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

But in the context of non-clinical interaction but a patient portal interaction –

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

No, no, so, Michelle tell me if this makes sense that the patient preference refers to the preference sensitive condition and not to the mechanism about receiving materials?

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

Correct.

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

Correct, so, I guess what this is saying is the content group is saying, you know, what patient preference is important can decision support – can we include in the certification the full breadth of decision support for preference sensitive conditions including can we identify the patients, can we give them educational materials, correct?

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

Yes, thank you.

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

So, it's sort of can decision support meet the needs of preference sensitive conditions.

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

Right, so maybe, can decision support capture patient input as opposed to just embedded knowledge, maybe that's – in other words are there standards for gathering patient input as opposed to just, you know, because right now what we're doing is there may be clinician input but a lot of it is based on existing system data, right?

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

Yeah.

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

You know you've got a lab value, you got weights, you've got recorded information and then the CDS acts on that and so I guess the question here is are there CDS standards that also then interact with patients, because once a patient provides a preference, and granted I don't know systems that necessarily do this even, but then it's just another piece of data just like a lab value.

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

Right.

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

But, so maybe that's part of it and then my answer to that is then we're back to where we were before which is probably yes we have standards that could support that although I don't know of any pilot that proves it and I don't know of any use case that demonstrated it so therefore it's an unknown. But, I could be wrong about that actually, I don't know if some of the SHARP Grants tested this out or not.

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

So, the question to the group then is if there is not a standard that has been piloted and tested and used in a use case to demonstrate this is that, is that needed for the next stage of Meaningful Use?

So, if the certification says something like you need to be able to identify patients, you need to be able to capture patient preference and then you need to be able to track what is – what decision support materials are being provided to the patient. Do we need a standard for that or is an attestation with an audit trail sufficient?

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

Danny and colleagues this is Jon White from AHRQ, I just want to briefly pitch in and say I'm not aware that SHARP or any other place within ONC, AHRQ or elsewhere has kind of demonstrated this or piloted it to any degree.

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

Thanks, Jon.

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

Yeah, thanks, because I wondered if that was true, it's kind of surprising. So, my answer to your question, Danny, is yes, although I don't know yet how we tie the desire for someone to move forward in that area to Meaningful Use. I think of it these days more as an S&I Framework kind of thing, but anyway, yeah, I mean, this is clearly an important area.

I think we do eventually have standards that could be kind of just utilized in that way but it does present unique problems that I wish that it would be – we need to test before we make any kind of certification criteria around that.

And I'd be really cautious about saying you can attest that you're doing it until we've at least gone through the process of getting participants to discuss what that might need.

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

And hey, it's Jon; let me qualify what I said in one way. Folks have looked at this, right, folks have tried to do this in pockets around places and I think there may even be some funded research about it, but they haven't tried to do it in a scalable, standardized way if that makes sense.

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

Right.

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

Yes.

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

Yeah and let – I'll make one more thing, so is there a way that we in this process could encourage let's say leading edge implementers and vendors to begin testing this out but not make it – not put them in a situation where they believe they're actually creating something that then becomes kind of ingrained and they're done, in other words the fact that they've certified that they've done it means that they won't have to change it, you know, this is back to why I say S&I.

I mean, the S&I Framework, one of the great values of that is that it focuses attention in a way that Jon was just kind of talking about and let's people who want to begin to test things to do that and discuss it knowing that the results of that may be a standard that everybody would need to change to support as opposed to saying, well there's no real standard around that but we want you to actually do it and therefore you have to attest to it then everybody is off running doing it and then when you come back and say, hey now there's a standard everybody has to change and that's problematic sometimes.

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

Other thoughts from the group?

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

This is Rosemary and I don't want to repeat everything that Rob just said but I agree with him 100% this concept of patient preferences also can sit at multiple levels within decision support.

So, maybe I agree to the treatment but I have certain preferences at levels in terms of how the treatment gets conducted and I think to vet it out and have some testing before we put it into a standard and have vendors check the box would be a good thing to do.

And I think S&I or HL7 patient care is discussing some of this a little bit as it relates to the care plan and the plan of care.

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

Okay, thank you Rosemary. So, our next question, if you can advance to the next slide please, is around capturing appropriate care goals to encourage shared decision making. Capture appropriate care goals to encourage shared decision making. So, the feedback that we got, we got five answers everyone said that this was a – this criterion was feasible for a vendor to meet.

Do we have current standards for functionality, one "yes" HQMF with appropriate harmonization and depending on the interpretation of "shared decision making." Another person said "yes, Consolidated CDA." One person didn't know. One person said "no, HL7 work on care plans, goals, etcetera, needs to be completed first." Another similar answer "this may be a part of the work done in patient care but is likely not well established so questionable."

And then the comments on if there is not a standard should there be one? One "yes" one "no" and one "this is already part of Meaningful Use Stage 2 in 2014 certification criteria."

So, the question is capture appropriate care goals to encourage shared decision making. Thoughts?

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

Well, this is Rob McClure, so that really is – I think that second answer kind of highlights this, because the Consolidated CDA I think is tied to the care goal part. The idea of shared decision making is a complex new wave idea I guess and how that is reflected in care goals I think is a real – that's a real good question, but just focusing on care goals – I mean, there are, you know, some HL7-based constructs that are so called "care goals" you know what that is, you know, ranges from some technical thing that's very specific or that you in an HL7 version 3 kind of parlance you can put a mood on it and say it's a goal and therefore it's a care goal.

How that translates into real systems I think we have some folks who can probably give us a sense of that that's on the call, but I'm guessing that it's pretty hard and even so a little difficult to line up with traditional delivery of care and so, you know, for me absolutely understanding the importance of this as a leading edge issue with regards to, you know, patient centered medical home and, you know, participatory care these are all – we're in the midst of a transition in the delivery of healthcare.

These ideas are very topical and important, but defining standards around that right now for me I think way too early. Let's let the care system work itself out and, you know, I understand that this makes some folks, particularly policy folks uncomfortable because we want to encourage it, but I have no idea how we'll actually capture it, align to it and record it.

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

This is Rosemary; in a prior life for a major vendor we were able to structure care goals within the terminology engine and capture it with the appropriate data and metadata around it at least for some members of the clinical team. I think that HL7 is discussing standards, because it's not just the goal – of a plan of care for conditions, diagnoses and orders which has not been solidified yet.

And I think the real challenge is we say appropriate care goals, are they my goals or the goals of the provider and the real challenges come around reconciling them or agreeing to them as they move towards decision making, because I could have a goal that I want that goes against, you know, what the providers will be saying. So, I think that's when it can get very complicated because shared decision making implies that there is some commonality and agreement around the goals or at least mutual respect and in terms of workflow and tracking that can be very complicated.

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

So, is capturing care goals part of the Meaningful Use Stage 2 2014 certification criteria already?

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

I thought it was 1-2 goals upon discharge.

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

Got it, so then – but in the Stage 2 certification there is not a standard for this?

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

I agree with where you're going with this. I'd really be interested in what Eric has to say about this, but, you know, if we took off that second part this idea of shared decision making, because I find that very important and, you know, I don't see standards leading that charge.

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

Right.

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

I see many other things involved, but the idea of being able to capture care goals I think is really important and if we focus just on that there are some standards that are in place at HL7 and the problem is that having a, you know, having a mail slot to put the letter in is one thing, writing a letter is a whole different story. And I think in this case it is tough to figure out, okay, well, yeah, once we've figured out what the care goal is I get it, I'll stick it in that standard, but I'm pretty unsure about what I'm going to be recording.

You know as Rosemary is saying there are lots of – you know, there is a whole team, clinical team-based care goal process which is quite complex and let alone then adding the patient to the mix. So, it seems reasonable to me that we could encourage vendors to follow a standard for once you've figure out what care goal means to you at least record it in this way. But the whole idea of shared decision making I think we should walk away from that one.

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

Yes, I agree with that Rob. I mean, the –

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

Is there a definition for shared decision making? I'm not quite sure what it means. I mean, I don't know what does shared decision making mean? Is there a definition or a description of it?

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

Well, this is Eric; I believe that it's a generic sort of more or less colloquial phrase that just refers to a clinician and a patient or the patient's care giver collaboratively coming to a decision about how to proceed with decisions about care rather than it being unilaterally the clinician's decision.

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

Yeah, I mean, conceptually it kind of makes sense but then when you go to represent it as a data element within a record it has all kinds of nuances that can make it somewhat challenging, you know, working the other day in the CCU there wasn't too much – you try to take shared decision making into context but then you try to educate and bring the patient around and I don't know how you represent that and your documentation can be somewhat challenging.

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

Got it. Okay and any other thoughts on this one? Okay, let's move onto the next question. This one hopefully will be a little bit easier. The criterion is check for a maximum dose weight-based calculation. So, the responses here five "yes." Is there a standard, four "yes" if not should there be a standard and some said "not necessary, existing systems support this capability, this is a functional requirement." So, any other discussion on this?

Great, let's move to the next one. Use of structured SIG standards. We have two "I don't know" or is this feasible and then three "yes." For the, does a current standard exist one person said "no question mark" and another person said "NCPDP script and Consolidated CDA" the last person said "yes, but outside of perhaps some pharmacy systems I don't know if this is even true, this is not likely implemented therefore not tested anywhere."

The lastly is, if there is not a standard should there be one? One person said "yes" one person said "I don't know" two left blank and the last person said "Consolidated CDA is already part of Meaningful Use Stage 2 in 2014 certification criteria. Use of the NCPDP structured SIG in ePrescribing should be an optional criteria as I don't believe it is used today."

So, thoughts on the use of structured SIG standards? Is it a feasible criterion? Do standards exist and if not should there be one?

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

Hey, so this is Jon White again, amazingly, this is something that I know a little something about, in, oh, gosh, six years ago, seven years ago maybe even eight years ago we supported, with CMS funds, evaluation of a bunch of ePrescribing standards structured SIG was one of them, it was deemed to be useful but not quite ready at the time. I know that NCPDP has been working on it fairly extensively since then.

You know, I don't know if, you know, getting in touch with the folks at NCPDP and some relevant folks might be the best input you have if nobody has good input about it now, about, you know, where is this, is anybody using it, is it ready for primetime and that sort of thing.

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

Okay.

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

And this is Rob McClure I also participated, it now must be, God it could be a decade, so if you were testing it eight years ago, in the development of some of that work and I agree with Jon you should contact the NCPDP folks to find out if they know if it's being implemented that's – I was the one that said outside of some pharmacy systems.

This was one of those things where I'm not sure if we, in building the ball field and the cornfield if anybody actually came. It seems valuable, but I'm biased, and it would be really – you know, this has been a standard that in some way has been around for a while now and so it would be, you know, useful to know having a standards that was available if no one has implemented it – that doesn't mean that someday in the future it won't be important.

But it may not be kind of lined up with the sort of things that people really need to have encoded, because that's the thing, I mean the structured SIG was a very detailed encoding of all of the components, almost all of the components of a prescription and you do that because you want to computerize and interoperate on those things.

And so if NCPDP says "yeah we've had this standard but it's not been implemented" then I think I'm going to guess that first response was Keith and I would agree with that where we would say, hey, it's an optional thing therefore encouraging people to think about using it because it exists and find out where it's useful.

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

Yes, this is Jon again, the only thing I'd add is that, you know, what Rob said was exactly right, you know, if you think about all the crazy stuff that you can write on a prescription pad that's what you're trying to capture in structured SIG.

The world has changed, right, since we did that work, you know, a lot more uptake certainly of electronic prescribing as well as, you know, other systems, you know, the world might be readier to have those things encoded and to use that, but again, I don't know.

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

So, a follow-up for this one over here is that it seems that the NCPDP script and Consolidated CDA are potential candidates and that we need to have a conversation with those folks to learn how ready for primetime it is. Is that the consensus of the group?

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

Yes, I think so, that's mine, yes.

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

Okay, let's assume what if it is not ready for primetime; is this criterion still feasible for vendors? If it is not ready – if the standard is not ready for primetime?

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

I don't know that there is a good alternative out there that you could turn to.

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

Yeah, this looks very thoroughly constructed. I mean, I hate to be kind of black and white about this, but maybe if this – I don't think – my guess is it's not going to be "it's not ready for primetime" what it's going to be is "we haven't gotten any adoption because nothing is driving the need" and until that adoption begins that's when you can say "whoops, we goofed" but I don't know that – you know, until it gets implemented and people start complaining we won't know whether it's broken or not but I think it's done.

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

Got it. So, it sounds like that, is this feasible, so it's only feasible – so I guess we're saying that it is feasible that the standard exists, correct?

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

Right it's just like that first response. I think we should say it should be encouraged as an optional criteria unless NCPDP tells us something totally that we don't get.

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

To be encouraged as optional criteria.

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

Right. In other words if you're going to start capturing information about a SIG beyond the information that's currently expected in Meaningful Use 2 you should be using NCPDP structured SIG, but we're not telling you that you must do it.

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

Yeah, this is Eric, I think that the 64 dollar question is whether pharmacies are able to receive and ingest, whether pharmacy systems are capable of ingesting that as opposed to a free text say.

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

Yeah, actually Eric I'll bet what we really want to find out is PBMs, I mean, you know most of the –

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

Yeah.

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

Pharmacy data that's really used is going to PBMs and so what we really want to know from NCPDP is are the PBMs demanding this because they're the ones that would use it first to make some decisions and so that's really, that's the leading edge of this storm I think is let's push to see if PBMs have found that they need to decision support or some kind of analysis based on the more detailed information on structured SIG and ask them.

I mean, that's the other thing to ask. I mean, one is to ask NCPDP and confirm what we're saying which is they're done and they're waiting and then, you know, through them maybe find out, what do the PBMs want, maybe the PBMs actually have been saying, we've been really wanting this but nobody will capture it and if that turns out to be true they can come back to us and push it.

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

This is Jason and I would be curious to know what's the gaps, because my sense is vendors are capturing a lot of structured data around the SIG, so what's the gap, I think that's what we're saying that we need some sense of what is that gap, is it something we can close or is it something we can't get to?

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

So, it sounds like that we're not making a recommendation for or against NCPDP on this phone call and that we need to do a little bit more homework as far as what is the gap that we're trying to fill talking to the NCPDP folks and talking to some PBMs to figure out if it's being used and tested. Is that –

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

I agree with that.

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

Okay, next topic, next slide please. This is around consuming external CDS interventions, consuming external CDS intervention, so is this criterion feasible? There are five answers here. One says "yes although the certification would need to specify what constitutes consume." Another person says is it feasible "few" I'm not sure what that means.

Someone said "yes" another person says "yes, however the methods may vary and may not support workflow; it depends on how the application is coded." And the last person said "yes, need to define consume, is that a manual copy/paste is consuming or is there some type of test for rapid automation required." So, what is meant by consume?

Is there a standard to support this functionality? Two votes for "yes, HeD." One vote for "InfoButton is a simplistic approach to this, but this is the entire focus on HeD and other than in pilots it is not implemented as a standard, note, every decision support vendor such as Zynx, WK, etcetera is doing this now for their clients it's just not standardized and it's in limited areas."

And two of the folks said "I don't know if there is a standard for this, for consuming external CDS interventions." And then on the, if not than should there be we have one "yes" three "abstentions" and one "make it optional as the standard is still in flight and the additional improvements are being worked on."

So, for the criterion of, is there external CDS, to consume external CDS interventions is this feasible, is there a standard and if not then should a standard be required?

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

Hey, Danny, it's Jon again, framing question, are we talking about for 2015 certification?

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

What we're talking about is Meaningful Use Stage 3, yes.

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

That's not 2015 anymore though is it?

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

Whenever Meaningful Use Stage 3 is Jon.

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

Yeah, okay, got it, okay. I will give a non-ONC federal stab at this and then you all can discuss this which is basically that I like the idea of whatever the next round in certification is making it optional, the round in certification after that is likely what's going to be applicable for Stage 3 based on the way the, you know, timelines have shifted. So, you know, that would seem to be a reasonable path to me make it optional for the next round of certification and then, you know, hope for it to be ready for Stage 3.

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

Yeah, so this is Rob McClure, you know I've been deeply involved in the Health eDecision's work, when you're deeply involved, you know, more stuff than you probably should use in making these kinds of decisions, but this is in fact the focus of Health eDecisions, this is – and in order to answer this kind of what is consuming my assumption was consume means take a standardized clinical decision support artifact and be able to bring it into your system.

I'm going to put some smaller quotes around that in that the – where we are now, this is brand new, so far as I'm aware other than there have been, you know, a series of research attempts over the past decade to do this Health eDecision I guess you could say is the latest one, it was successful but even in that context there is still, not surprisingly, some special sauce you have to put in it in order to be able to get it working in any particular system, but it was use case one and Health eDecision and it was successfully completed.

The thing that's happening though is that Health eDecision is in the midst of changing in order to, very much appropriately, align the constructs, the clinical model representations that would be used for decision support for those are also used in quality measures and – well, primarily have quality measures, that's really good news for people so that we can begin to have one uniform way of describing things for Meaningful Use quality measures but also use those same sorts of things for decision support.

So, even though there is a freshly minted standard to support the consumption of externally defined standardized artifacts to represent clinical decision support that standard is changing and, again, in a good way. So, I think that I would be, again, this is the same theme I've been saying all along, I don't want people – I don't want us to go out and tell people to adhere to something and they build out to it and then we change it underneath them.

So, I think that's a long way of saying – and I think I agree with Jon in that we encourage people to do this, we encourage them to go and look at existing standards like Health eDecision and begin to code to that as an optional thing, again, I can always say this as a caveat, it will change so don't, you know, whine and cry in your milk about the fact that you've designed your system around something that's hard coded and now we've changed it, but please participate and play because this is coming.

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

Other thoughts from the group? Okay. You know my own opinion on this is that this is the whole goal of having the standards that we can sort of share artifacts and get them in and, you know, I think we saw this with quality measures was that, you know, we had standards but we had the HQMF but what most vendors did was they didn't consume them, they looked at them and then they just encoded them in. So, until the standard is there, tested and fully flushed out.

When we talk about consumption if it's optional, I mean, I guess Rob you can hope that people will start to encode for it but the alternative is that people will just look at the artifacts and say, okay, I see what you're trying to do there and just manually do it in their own way and that's –

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

But Danny do you see that as a good thing or bad thing? How do you look at it?

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

Yeah, I see it as a bad thing if we're trying to sort of make the sharing of decision support very, very easy and when you ask your vendor to put in another – or if you ask your IT folks to put in another decision support rule the goal is to make it easy and make it very, very simple, but until the standards are in place there is no other option other than just, you know, hacking through it the way that we currently do now.

So, I think that Rob that it's a bad thing but it's just the reality until the standards are actually there.

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

Right and so this gets to this whole issue of how can we push the process forward? How can we keep the ball rolling and, you know, in light of the fact that the standard is changing and to some extent, I mean, you know, I don't want to really buy into this whole, you know, standards are never set kind of mentality even though that's partly true, you know, the only way that we get traction is that people start to do this and again this is overly simplistic, but in essence I want to demand that people play but I want to demand that they play in a way that allows them to change and how do we do that?

How do we get people to start this process by looking at Health eDecision use case one, beginning to implement around that knowing that the standard will change. How do I get my cake and eat it too?

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

Any other thoughts folks?

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

Well, this is Eric, and this is kind of maybe outside the framework of how Meaningful Use certification works now, but I think that building on the prior comment I think that the progress toward a plug-and-play CDS content is going to be incremental and I think that the unknown unknowns or maybe known unknowns are where the – what are the types of data that are going to be hard to bind from a coded CDS intervention artifact object, data object and an EMRs data model.

And maybe what needs to happen, and maybe this is what's already happening with the Health eDecision pilot, is asking the vendors to identify what are the things that you found difficult that you had to basically bind by hand because the data models were incongruent – so that really falls I guess in the pilot arena and as I'm talking I'm thinking that probably is already happening with Health eDecisions. Are you getting feedback from vendors on what –

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

Yeah, well we did, I mean, and to some degree like many pilots, you know, when you do something like this one pilot isn't enough and that's part of the problem. So, the kind of information we got back from this was there was a lot of hand tweaking and then kind of hand tweaking not only of what was done but hand tweaking of the pilot so that yeah it was consumed but it was that one artifact was consumed.

And then what you want is then you want to take that same standard and press it forward to do more complex things and answer the question that you just posed. Unfortunately, in this case that's not really going to happen or at least it's going to be kind of clouded by the fact that there is this bigger harmonization process that's taking things in a slightly different direction and so again, you know, this is really important, this has been a very difficult process, you know, I was involved in some early work on this and it's just really hard.

And so – but we’re making progress and my, you know, my plea again is that one we want to encourage participation in this. So, we want something in the criteria that says you need to be able to consume external CDS interventions and there is a current standard which is balloted and, you know, under DTSU and HL7, and that’s where you need to look, but it’s going to change and so start gearing up, start beginning the process and this is not something you get to kind of “well, when it’s final then I’ll start to look” that’s not part of – that’s not how this game is going get played. But, when you build it you’re going to need to build it in an environment where in fact it can change, that’s the criteria I’d like to see.

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

So, folks we only have 5 minutes, left, I wonder if we can just get a little clarification on the next question and then we’re going to open it up for public comment. Michelle the next question was use information systems to support maintenance of lists and people didn’t really understand what this question was asking can you clarify that.

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

Yeah, so by list they meant problem list, medication list, allergy, medication allergy list. So, this was prompting a provider for example if an antibiotic has been on a medication list for over a year and, you know, it really should have only been there for a week or so, or if diabetes isn’t on the problem list but everything about the patient seems to say that they do have diabetes is prompting the provider to say, should diabetes be on the problem list and, you know, it’s asking the question but not automatically putting it on the problem list for them.

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

Got it, so asked another way, is it – is certification criteria feasible to say, decision support shall be able to do things like suggest diagnoses off of lab values?

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

Yes.

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

Is that correct Michelle?

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

Yes.

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

So, my opinion on this is I think that’s what CDS does and that’s like 101 for CDS. Other thoughts on this function?

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

I think the question is – I know there are vendors that can currently do this but from the Meaningful Use Workgroup perspective it’s just making sure it’s feasible for all vendors and, you know, if it’s something that’s put into Meaningful Use, you know, how difficult will it be for everyone to be able to have this capability.

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

Yeah, this is Rob; I absolutely agree with you Danny, I think that this is kind of standard CDS. There is – there doesn’t have to be a standard this is a functional requirement and it’s something that should be a part of the criteria where again I think this is going to be an attestation kind of thing, but if they can implement decision support and kind of just functional capabilities around list management.

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

Okay, in the interest of time I think we have to open it up to public comment.

Public Comment

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

Okay, thank you Danny. 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.

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

We've flooded the public.

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

Listen, thank you everyone for your quick response to this and for the excellent conversation. Our next steps are we're going to be consolidating this information of putting it into a final document and we'll be sharing that document with the Meaningful Use Workgroup which I believe is tomorrow. So, we're on a tight timeline here, but thanks again to everyone for your feedback.

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

Thank you Danny.

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

Thank you.

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

Thank you.

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Take care, thanks.

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

Stay safe and warm, bye.