



HIT Standards Committee Transitional Vocabulary Task Force Final Transcript October 14, 2015

Presentation

Operator

Thank you. All lines are now bridged.

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

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is the first meeting of the Transitional Vocabulary Task Force under the Health IT Standards Committee. This is a public call and there will be time for public comment at the end of today's call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Chris Chute?

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

Present.

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

Hi, Chris. Floyd Eisenberg?

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

Present.

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

Hi, Floyd.

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

Hi.

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

Gay Dolin? Joseph, can you pronounce your last name for me Joseph so I don't butcher it every time?

Joseph L. Jentzsch – Principal Consultant – Kaiser Permanente

...Joseph Jentzsch, I'm present.

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

Jentsch, okay...

Joseph L. Jentsch – Principal Consultant – Kaiser Permanente

Jentsch.

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

...thank you. Marjorie Rallins?

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

I'm here.

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

Hi, Marjorie.

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

Hi.

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

Nancy Orvis?

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

Here.

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

Hi, Nancy. Rob McClure?

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

Present.

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

Hi, Rob. And Debbie Krauss?

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Present.

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

Hi, Debbie.

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Good morning.

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

And from ONC do we have Julia Skapik?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

We do.

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

Hi, Julia. Is Doug Wilson on the line? Okay; with that I'm going to turn it over to our Co-Chairs, Chris Chute and Floyd Eisenberg to kick us off.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Good morning everybody and thank you for joining us and thank you for agreeing to participate in what I think you will agree is an important body of work. I know many of you have been involved in this process throughout its unravelling or rather its unfolding, that's a better word and I think the issue that we have today is really addressed in our agenda. So why don't we go to the next slide.

Obviously this isn't terribly surprising to you, look at an overview, review our work charge and plan and I would add that we'd have a significant amount of discussion after our work charge and work plan, although it's not clearly indicated here, before we go on to public comment. With that, why don't each of you, if there's no objection, give two lines about your background, since not all of us know each other as well as we might. I see that we're on the...I'll start. As you see, I'm Chief Information Research Officer here at Johns Hopkins and Academic Informatics participant who's been involved in standards really my whole career. Floyd?

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

Thank you, Chris. I'm a consultant and work in healthcare IT, especially related to quality measures and participating in work on measure standards with CMS as well.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Marjorie?

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

Good morning everyone, I'm Marjorie Rallins and I'm the Director of Measurement Science for the PCPI. I've worked with many of you before and on the initial Vocabulary Task Force.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Thank you. Gay?

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

We haven't gotten Gay yet.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Fair enough; Rob?

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

Hi, Rob McClure; I'm a physician. I've been involved in the informatics community for quite a bit of time and doing a lot of standards work here most recently and I'm currently focused on how we represent clinical information in value sets. And so I'm working with NLM on standing up the Value Set Authority Center, the VSAC and also I work with ONC on quality measures and value sets in support of that.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Thank you. Joseph?

Joseph L. Jentzsch – Principal Consultant – Kaiser Permanente

Yes, I work for Kaiser Permanente. I currently manage a quality report card for corporate. I also am heading up a task force trying to manage the eCQM Initiative that we have internally. In my prior life I have worked with...created a lot of HEDIS packages that are commercially available today.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Thank you. Nancy?

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

Hi, I'm with the Military Health System in DoD and have been involved in standards and vocabulary for a number of years, representing DoD at HL7. And I'm the Chief of our Business Architecture & Data Standards Governance groups. So...

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

And Julia, you can't escape.

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

Well, sorry; Debbie Krauss is missing from our slides; she is on.

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Hello?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Oh please then, Debbie.

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Oh hi, this is Debbie Krauss; thanks for inviting me to attend these meetings. I'm an informatics nurse working at CMS on Meaningful Use, clinical quality measures and operations.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Excellent, thank you and our apologies that you're not on the slide; I'm sure that will be fixed.

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Oh, no problem.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

And Julia, you tried to escape, but this time for sure.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Julia Skapik, Medical Officer in Office of Standards and Technology over at ONC. I've been working since about 2012 with the National Library of Medicine in the quality measure space and sort of...to some of the greater standards work.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Excellent; thank you.

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

And I think we've got Gay.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Oh excellent; Gay, can you give us a couple of sentences on your background?

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

Sure can. I'm a nurse by background, a healthcare informaticist and I've been involved in the standards community since about 2005. And I'm one of the primary authors on Consolidated CDA, QRDA 1 and 3 and HQMF and I'm also very involved...in terminology and currently working at Intelligent Medical Objects.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Heavens, a very appropriate background; thank you very much. With that, again, I want to thank all of you and I think people would agree that this is a well representative group and a very knowledgeable

group, so I hope that we can address our questions and issues. With that, let's move to the next slide where we talk about our Transition Vocabulary Task Force charge and work plan. Next slide.

I'm sure you've all read this. The background is, back in 2011, and many of us were on the HIT Standards Committee at that time and remember this well, we issued recommendations on the assignment of codes for concepts. And the whole question at present really surrounds the decision at that time to allow a transition period where more than one vocabulary really could be bound to a particular quality metric or use case and that that would be revisited or considered in the context of, as they say, a variety of circumstances and questions.

So, next slide. Our charge basically is whether that's a good idea, should transitional vocabularies be eliminated, since it was clearly intended to be an interim kind of solution. As we think about reporting federal quality metrics and I would add parenthetically that we all know these transcend simply the federal quality metric use case since when people see Meaningful Use specifications for vocabularies or value sets, they're really considered in all context of Meaningful Use and health information exchange. As far as scope and impact here, while at least from a technical focus is on federal quality measures, we should bear in the back of our mind really the ripple implications for specifying these vocabularies in the context of Meaningful Use per se.

There are therefore a number of associated secondary questions, as you see. What is the impact of retaining these transitional vocabularies, particularly on reliability and validity? What are the costs and implementation impacts of really the alternative? And how does that compare to the current situation?

And there are a set of assumptions. EHR vendors need to know what will happen with respect to transitional vocabularies so that they can either phase them out and incorporate a canonical form or acknowledge the requirements that come with transitional vocabularies of mapping and maintaining sort of a poly-fluency across value sets and vocabularies.

Measure developers clearly need to know, since at present they are really permitted to specify their measures with these alternate vocabularies, that's the whole point. And if they can't do that, that would impact how they go about defining their metrics and particularly their value sets and would impact development costs and testing efforts, obviously.

And then the final assumption is that most vocabulary experts and many of you on the phone are exactly that, see the clear benefits to interoperability and comparability and consistency of a single coding system. But it's not without its costs and the issue is with that mandate, additional mapping or are we de facto already confronted with a mapping issue in any event with the setting of trying to accommodate multiple terminologies and value sets. I'll stop here and entertain questions, inquiries on the charge.

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

So this is Rob; I have one. So, is our charge to figure out how to remove the transitional vocabulary issue or is it that to assess again whether we should continue to have transitional vocabularies or not?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Well...

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

In other words our end game...could our end game be, yes we decided that transitional vocabularies should stay? Is that acceptable?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Umm, I think if I read the charge literally, it's we have to consider whether they should be eliminated or not. And if so, then what do we do about that? So...

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

Right.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

...the reading of the charge is, yes we're being asked to address the question yet again of whether alternative vocabularies are appropriate and warranted four years on in the Meaningful Use journey. And if we conclude that alternative vocabularies should be eliminated, then which ones and at what time and what other...what could we recommend with respect to mitigating conditions around that particular problem? Now that's my personal reading; I'm looking at the darn slide; I welcome anybody to...I think it's our charge as a task force to come up with a responsible and responsive reading. So I welcome other comments on how they read it.

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

Chris, this is Marjorie and in reading the charge and listening to your comments and Rob's, I think maybe we would want to rephrase the charge to consider the tra...the transitional vocabulary recommendations rather than to be eliminated because if you read it as being eliminated, it looks like we've already sort of steered ourselves in one direction. That might have been what Rob was trying to communicate there.

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

Yeah, that is partly what I wanted to get a sense of and I have to say, and I'll say it right off the bat because I liked it. So Chris used, and I'm sure he did this on purpose, Chris used the phrase alternative vocabularies instead of transitional and I think that's another thing for us to, I thin...to kind of directly address because I think that's the issue. Transitional, there's...is alternative vocabularies with a time limit, I guess. And I think all of those are levers that we have to assess and the first one being, does it make sense to have in these measures, more than one vocabulary for a particular use and what does that mean in whether...if we decide that it is proper, then we have a question as to how long that should go on.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

And Marjorie, this is Julia from ONC; I'll speak to the wording. The original recommendation of the Standards Committee was to have a single terminology for each data type, as Chris described. And then they also had made a recommendation that there would be a time limited period for the transitional vocabularies. And so the reason is, should the previous decisions of the Standards Committee be enacted by the programs or should we alter those recommendations and reconsider them.

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

Right and I think that's the better way of phrasing the charge.

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

Actually, can I ask one other question about that because you said something and maybe I misinterpreted it; but just to be clear, there is no regulatory requirement to support more than one code system, right?

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

So if I remember correctly, these were all recommendations that the Policy Committee put for...I mean I'm sorry, that the Standards Committee put forward. I don't know how they landed in regulations, though.

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

That's a Jul...

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

This is Nancy Orvis. I think one of the subtleties is that for HIPAA and administrative interchange, there may be one kind of standard. There are vocabularies that are for different purposes and for strictly clinical exchange, it may be a different vocabulary or...than what is required for administrative exchange of information under HIPAA. For instance, diagnoses codes.

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

Yeah, although if we're keeping track of things we should kind of gather in order to make these recommendations that we're going to come up with, that's certainly one of them. But that was obviously in play in deciding that we needed to have more than one code system allowed is that there were...there's, you know acknowledgement of the demands that data is captured and submitted using certain code systems that may not be the clinical ones.

And so...and I don't have, you know I have my ideas about it, but to know it for sure is a different thing. So it would be I think useful if we could gather the regulations that implementers are forced to adhere to and what the proposed code systems are, for example in administrative submissions. I assume Nancy's right that there's a requirement that ICD, for example, be used for certain submissions.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

All right, and I would add to that and maybe we're getting into solutions when we're still just talking about the charge, but I know the last time that this group was convened, there were some decisions made that actually conflicted with the base standard requirements. And so it is...it's going to take a little bit of effort to make sure once we come to the sort of...I suggest we come to tentative decisions and then go off and examine the impacts of that, to make sure we're not trading conflicts, you know...i.e. administrative, gender, sex, as an example.

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

And this is Nancy Orvis again. I would ask one, to clear up how much emphasis should we do on the secondary questions because it sounds like it's asking for a cost or work impact analysis on retaining versus reliability and validity.

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

Right.

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

And how much should we spend on time capturing impacts and potential costs in this charge. It sounds like we have to pay some kind of impact analysis, we need to give some back-up to our recommendations in this area and my question would be, how are we going to get that?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Well, this is Chris; I'll just make some observations. To my knowledge, we are handed a charge but we are free to interpret it as we see fit. So I...argue...this point.

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

This is Rob and I think someone's taking notes, but there mic's open and so I can't hear Chris when that person's typing. Thanks.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

That could be a feature, Rob.

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

Could be.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

So as I was saying, I don't think we're at liberty to wordsmith the charge, but we are free to interpret it and that's what I think we should do. The question of competing regulatory requirement from HIPAA and Meaningful Use is interesting and having detailed background on that would be enormously helpful. I don't have that personally, but if we could request that that could be provided, perhaps by ONC, so that there's clarity with respect to the regulatory requirements for vocabularies and value sets vis-à-vis HIPAA for administrative interchange and, of course, those specified by Meaningful Use.

The question of whether within Meaningful Use the quality metric use case is distinct from the clinical use case is one I frankly think we should engage. Because as a provider, I can say it's enormously confusing to have different use cases requiring different vocabularies and value sets when from the perspective of a provider what is really sought is, how do we document healthcare in a way that can satisfy multiple secondary uses, including quality metrics. Having quality metrics as a single driver is, and perhaps even a divergent driver, is intriguing.

The question of how much energy and effort do we put on the secondary questions establishing validity, cost and the like I think is clearly contingent upon our coming up with a cogent recommendation in the first place; specifically a yay or a nay on the issue of whether alternative or transitional vocabularies are good for you, whether they're a good idea. I won't presume to answer that question at this time, but I submit that should be our first order of business and then contingent on some kind of recommendation in that context, we can proceed with understanding how much resource and capability we...and capacity we have for establishing validity and cost issues.

Finally, while many of these issues are determined by regulatory requirement, please remember we are a task force of the HIT Standards Committee whose job it is to make recommendations to ONC and HHS that may involve changes to existing regulatory requirement. Obviously we would not do that lightly and our...the consequences of our doing that downstream may yet be uncertain and we would want to be very careful not to impose substantial costs and disruption for arbitrary reasons; I think you all know that.

But nevertheless, the issue of whether or not we are completely circumscribed by existing regulatory requirements I don't think should constrain our opportunities to make recommendations that we feel are appropriate and in the public's interest overall. Any pushback on that?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

And Chris, this is Julia; I think that, you know I don't dictate the direction that the committee wants to take in terms of solving these questions. I think an alternative approach could be that you decide what are the options and then you sort of weigh the pros and cons. But you can also do that iteratively, so, I think what you've outlined there is going to be very effective.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Yeah, pros and cons to the alternatives is a very effective way of proceeding; I don't think anybody can object to that. Other pushback or commentary? Well, that being said, then let's consider if we would, some of the pros and cons of having transitional vocabularies in the first place. This might be a more concrete process if we could enumerate some of the areas where transitional vocabularies exist today rather than talking about it completely in the abstract. Is it possible to project a list of where we have transitional specifications? Is that data readily available?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

So if I remember...

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

We...upload it in the webinar; we could try if Julia has something that she can send us.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Well, if I remember correctly, I think that there's actually a list in the transmittal letter so it might be useful to show that.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Yeah, I looked at that transmittal letter shortly before this call and there is an appendix to it. I must say it wasn't entirely clear to me that that is the existing regulatory requirements today, but I may be wrong.

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

You know I think that this is in the blueprint and, you probably don't have ready access to that, Debbie does. I do.

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

...list of transitional vocabularies; I'm looking for it now.

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

Yeah Rob, this is Floyd, I would agree that the blueprint does list those that are in this transmittal letter; that's correct.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Right the blueprint is modeled off the list that came out of the Standards Committee.

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

They were...

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

Julia, this is Marjorie; is or is not?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

In the past...

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

Yeah, what did you just say, Julia?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

I said the list there was derived from the Standards Committee recommendations and through time we've had a question as to whether or not alternatives are permitted. That question has gone back to the original guidelines from the Standards Committee and those are enumerated in the blueprint, at least the last version that I reviewed.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Yeah, so this was exactly the table I was looking at and I was part of the Standards Committee at that time and remember this. A strict reading of this table does not specify alternatives per se...

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

Yeah.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

...for example, looking at patient experience you've got LOINC and SNOMED; well, they're specified for specific different use cases. Ditto non-laboratory diagnostic study, it...I don't...unless I'm missing something, I...alternatives and transitional vocabularies did not leap off the page.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

So the transitional terminology's actually in the second letter. So this letter describes what the enduring suggestions were for each data type and then the other document describes what the alternatives allowed are; I apologize if I said transmittal letter when I meant the other slide deck.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Okay. So let's go ahead and look at that other secret slide deck. That's...

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

Chris, this is Marjorie...

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

...the TVTF reference.

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

This is Marjorie; I wanted to give a little bit of background. So, because I do remember this and that the August 17, 2011 was the list that we generated and I believe we, and Floyd correct me, is we sent that out for comment. And based on the comments, we got a lot of feedback from the developers of the transitional vocabularies that made that recommendation, which then ended up in the September 28 communication.

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

That's correct Marjorie.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

So I put it as our path, go thr...beyond, you know, a recommendation or a comment that communication, I think the word is communication besides then being imported into the blueprint...

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

(Indiscernible)

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

...now, because if importing it into the blueprint does then that make it part of regulation or just advice?

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

So what I can...

M

Well incor...

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

...what I can share is in...it is the blueprint in these recommendations that the measure developers used to develop the value sets for Meaningful Use Program.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

I don't want to get...

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

...I'm looking at the blueprint right now, 11, so the latest one...

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

Right.

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

...and it's in Table 16, I mean it actually starts talking about this, the timing is before that, but Table 16 shows all of the...has the information we were just looking at, but it has a last column that says "transitional vocabulary," so it does show that. I don't know if you can get that and display it or if everybody has a copy of the blueprint. I know many of us on the call, but perhaps not all of us do.

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

Rob, this is Michelle; if you could send it to me, we could get it uploaded.

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

Sure.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Yeah and if you want the transitional vocabularies QDM concepts is slide 6 of the TVTF reference, transition vocabulary planning.

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

Oh, you have it. Let's look...

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Well, we found the slide deck...

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

In fact this goes further in the rest of the slide deck to talk about the specific code systems. So starting at slide 9, it talks about the specific uses of the transitional code systems for specific QDM data types. So for example slide 9 shows ICD-9 CM diagnoses, slide 11 or 12 shows ICD-10 PCS for procedures. Slide 13 shows...

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

Yeah, it's different.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

...CPT for encounters. So I think these are the recommendations that the charge is intended to refer to as opposed to the blueprint which sort of utilized this to create guidelines for the developers. Debbie, I don't know if you want to comment on this, but I believe the blueprint is not a statutory document; however, the contractors for CMS are required contractually to adhere to what the blueprint guidelines say.

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Right, that's correct. So the certainly the final rules trump what's in the blueprint. The blueprint is just supposed to reflect what's in the final rules and then...so they're both references for implementation.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

Julia, is this a list of...as we described it or is this more a oh, by the way for these transitional vocabulary recommendations we'll tell you about the existing mapping that occur because that's what it seems like it...where that exists, that's what it seems like it is to me, you know because you have the comment under each one about the readiness of the mapping. And then on a previous slide there were some mapping, you know some different institutions, like I think it said Kaiser and whatever else was you know as potential sources for existing mappings, one of them was commercial. So it seems to me like that's what this actually is is a list enumerating what the current, at the time, available mappings were.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Yeah that seems...

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

Right, yeah that's my read on this is that this is a potential solution; obviously mapping is the primary solution, right? So this is looking at, if one was to decide that support for multiple terminologies is important in the context of our charge, then one alternative to allowing multiple terminologies is the support for mapping.

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

This is Marjorie...

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

I just sent...so Michelle, I just sent you the 11...blueprint 11 and when you get it on page 241 is where that it starts talking about transitional vocabularies and a little bit farther past that there's a Table

14...Table 16, sorry, and that's the one we need to look at, I think, that just literally shows for each of the "general clinical concepts," so in CDM-speak that's called a data type, but kind of information that shows expected and then transitional vocabularies.

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

So this is Marjorie...

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Sure and then the other thing I'll just mention is that the other regulatory document that's probably relevant here is Standards Advisory document that ONC puts out; so that's probably something we should at least cross-reference as we're making decisions.

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

Yeah, and this is Marjorie; I just...back to Gay's point about the intent of this slide. Rob is exactly right and in fact, we edited this slide so that if developers or builds that were reporting quality measures could only capture the clinical concepts and the transitional vocabulary, but wanted to report this is how you would do that. And I also want to make sure that we all understand that these recommendations are based on what you report and not what you capture and I think that was a distinction that we learned after we sent the August 17 list out for comment. So that should be some background as we move forward.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

That's actually a very helpful clarification. I want to quibble a little bit with your contention, Rob that if we allow alter...or if we don't allow alternative vocabularies that we have the mapping challenge and I submit that even if we do allow transitional vocabularies, the mapping challenge still persists. Because...

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

So...

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

...to interpret numerators and denominators, you really need to have some comparability and consistency so that the measures are...have some commonality. And in my mind, unless I'm missing something completely, that means it's not a question of whether you do mapping, it's a question of when, assuming people are collecting in one system and final interpretation and inferencing is occurring in a designated system.

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

Yeah, no, I...I mean, as I'm sure you know, I can't agree with you more. In fact, I hadn't mentioned this but I think, and then we're kind of getting into the kind of discussions about the specifics at this point, but the biggest issue about...there are two big issues in allowing al...multiple terminologies. One of them is the idea of the user end and figuring out how to map to whatever you...what you collect versus what you're going to send. But there is a huge issue, I think, and this gets to this why we were asked the question, for measure developers and everyone that because of the inherent differences in what code

systems allow you to say, you have pretty significant differences between in analysis when you have organizations that submit different code systems to one, you know, for one thing where the analysis is supposed to be consistent. It's, I would suggest, very difficult to compare for one quality measure across data collection where the data is represented in different code systems. They just simply don't mean the same thing.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins
So now we're getting into the validity and consistency question. Let me just pau...make a bold statement, is there anybody on the call who disagrees with Rob's statement, that is if frankly you report information in different code systems that the ultimate interpretation and comparison of metrics generated from alternative code systems is really not possible?

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

I don't disagree but I would, I mean, I don't know about the "not possible," I would say it's difficult. You know, and I think that just by declaring one code system is not necessarily going to solve the problem either because from working at IMO and working with all these, you know the little tiny hospitals around the country that we don't often hear from, one of the things that they do, no matter what the value set...oh, this year I'm just going to use the most generic code in this value set, that's it. I'm going to make sure that that gets captured and so comparing that with another institution is apples and oranges, even with having the one vocabulary...system.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

I certainly agree there are...

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

Yeah.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

...multiple sources of potential error and misclassification including, as you say, picking the most generic code. On the other hand, the scope of our charge is really are there sources of inconsistency and incompatibility that we can do anything about and that's really the whole question of transitional vocabularies.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

Um hmm.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

And I guess I'm asking, is there anybody that disagrees with Rob's statement that assuming people are being diligent in their reporting, and that may or may not be a valid assumption, that reporting in different vocabularies sets introduces a challenge of comparability and consistency that is impossible is the wrong word, I accept that, but very difficult to overcome.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

I would agree with that.

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

This is Marjorie, I would agree with that, too. Just one more point, I don't know if this is something that we can address but even with one code system, I think it's the interpretation of individual users of those codes that also presents a problem. That might be off topic, but I think it's something that we need to consider as well.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

As well as the data quality problem, and I certainly agree with that, but whether it's within our scope is as you say, might be the issue.

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

Well I think part of what's going on no matter what, and everyone here's an expert and understands this is that there's always an interpretation process that's going on and how many different interpretations happen in this telephone game of going from what actually happens at the bedside to what actually gets reported is, you know that's the conundrum. And we're...I think it's the charge of this group to see if we can come up with an overall solution that reduces the number of stops in that telephone game so that while there's always going to be sloppiness in the interpretation process, we introduce substantial variation every time you go from one interpretation to yet another interpretation.

That being said, we also, I think probably all of us would agree that there...given the fact that there is that process, we're...if we, for example, chose to say that reporting should be consistent and focused in one particular code, then in essence we're pushing "the mapping problem" downstream. So, the obvious, well maybe I shouldn't put it so strongly, but to me the obvious driving force behind support for more than one code system in the reporting side, in other words, you can it's, and I think Marjorie you raised this and I think we really need to be careful about what is it that we're saying.

And presume...I presume that, in fact I'm pretty sure that the documents even say this, that the outcome of the current recommendations with regards to these standards and what we would do is to say, this is what you report in. We're not really saying what you capture; we're just saying that you can either report with alternative terminologies or a single terminology. And when we allow alternative terminologies, more than one terminology, then in essence we're...the receiver's taking on the burden of doing what we say is difficult, which is to try and create one uniform pile out of these different piles.

But we know that if we push that, if we say one only, we're pushing that burden back, and I'm sure that's why the slide that we're still currently looking at was addressed. Because there was a sense of if we push this on to our constituency, are we doing so and they have no tools to meet our need or are there tools that would allow them to meet our need.

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

That is correct...

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

I think...

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

...this is Marjorie.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

I think we should mention one thing, I don't know if it got missed from the slides or not, the measures don't necessarily actually capture equivalent data when they use transitional terminologies. Sometimes the different code systems capture different information, even just in their reports so it's not necessarily true that on the reporting end it can...two different code systems for the data can be mapped to equivalency. And that's one of the things we want the workgroup to talk about, the task force to talk about.

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

So are you saying Julia, when you say that, are you saying that that's an acknowledged and accepted burden on the part of CMS, I guess or any entity that's reviewing the data? Or is it that that burden should be reduced?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Well I think CMS would need to comment on whether or not it's acceptable to them to have different actual measures based on the fact that the logic is different in the code systems.

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

And you're...and also, put you on the spot, but is there an acknowledgement that CMS agrees that when they get mo...you know, data submitted in multiple code systems, they look at that and say, we really have different measure populations here or do they not think that?

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

I...I'm not the expert on this Rob but I would say that I'm thinking that we do not think that because I think the critical point is that what is captured in a measure and what is reported in the measure have as little variance as possible. And so I was surprised to hear that folks...Marjorie's comment about the, what is required to be captured is not necessarily what is reported. So, there needs to be as little variance as possible because these calculations are...and performance rates are being used for incentives and also, you know different value-based percentages and outcomes and things like that that are critical. So...

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Including negative payment adjustments, right Debbie?

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Yeah, I was looking for the word.

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

Well if I could jump in here Debbie, this is Marjorie. We learned about the thought of the data capture reporting dynamic when we sent our recommendations out for public comment and we got a lot of push

back from vendors who say, you know we capture in this particular vocabulary. I won't say a lot, but we heard significant comments like that. We wanted to make it clear, because you can't necessarily dictate how people natively capture information.

Then, you know, but we wanted to also make sure we provided recommendations on how to map and for whatever reason, and Floyd you might want to add some clarity here, we looked at sort of the transition from ICD-9 to ICD-10 and using SNOMED and I don't think we could recommend one vocabulary at that time, given the various stages of transition that organizations would be in. That said, I do think, back to Chris' question, I do think there is difficulty in arriving at equivalency on the reporting end, so if you have an infectious disease code that's coded in SNOMED, it might look very different or be as equivalent, but not exactly equivalent as it would in ICD-10.

So, I think there was a lot of considering where people were at that point in time, where organizations were at that point in time and we thought that these were the best recommendations, at that point in time. And we knew that this particular day would eventually arrive.

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Um hmm.

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

And this is Floyd, just to add to that; thanks for that, Marjorie and Debbie and Julia, too. I think the thought was how do people capture information? We've now moved forward a number of years and it's not just how they send information based to report the measures, but how they're expected to send information to other providers for transitions of care that Meaningful Use recommends.

And we want to...I think it's up to us to talk about that to say, are we looking for mapping from what is used to document versus what's used to transmit or report, which if there is a mapping, it should be the same that you're reporting perhaps as you're sharing with other providers. And I would also agree with Chris' comment that it's not necessarily equivalent what you've mapped and that it's a concern.

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

This is Debbie, I have one...

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

So this is Rob...

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

...quick question for Julia; I haven't read the latest certification rule but were there any changes to the vocabularies in this latest certification rule?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

The certifications have been to certify to what's in the measures. So that...in that sense, there's no reference in certification. However, this is probably a good time to bring up one of the things we've been noticing as we've been trying to harmonize our new FHIR standard of things like transitions of care, the Meaningful Use data set as well as the quality measure content is that the divergence of the data types is problematic when it comes to terminology binding. So in the Meaningful Use data set, problems exist...there's a problem list and problems must be coded in SNOMED, because in the quality measures,

there's a data type called condition diagnosis problem that brings together those three things into a single category and that's the place where transitional terminologies I think have the biggest impact, which is allowing ICD-9, ICD-10 and SNOMED, at least at the current time, all three to be reported. But the measure developers have said...assumptions to differ...in how...different...that do different...

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Julia, you're breaking up, I don't know if you switched headsets.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

(Indiscernible)

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

Can't hear you.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

...are using multiple...

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

Julia, we still can't hear you.

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

I have a feeling she's either in a car or entering the building.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

No I'm actually not moving...can you hear me now?

Deborah Krauss, MS, BSN, RN – Nurse Consultant – Centers for Medicare & Medicaid Services

No, can't hear you well.

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

Barely.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

How about now?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

That's better.

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

No, not very well.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Do you want me to call back in; I don't know what happened to my connection.

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

Oops, there it is, just got better.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Okay.

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

Okay.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

So what I was saying is that the Meaningful Use data set refers to only the category of problems and it requires all problems be in SNOMED. In the quality measure side, we lumped problems, diagnoses and conditions together and that's a place where the transitional vocabularies have a particularly big impact because some of the measure developers find they can't express the same clinical concepts the same way in multiple terminologies; I think that's what Marjorie was saying.

Particularly, for example, an attempt...the CDC was trying to identify patients who had a high risk for sexually transmitted infections but in ICD-10 they really just couldn't even bring together a complete value set of the concepts that they needed to pull patients in. So depending on which code system you're looking at, and the fact that diagnosis, encounters...sorry diagnosis, conditions and problems are all lumped together, there's actually a vocabulary mismatch in the certification program itself because the objective side of certification only looks for SNOMED when you're looking at problems whereas the quality measures are more loosely bound. That's preventing us from actually creating a harmonized set of profiles in FHIR.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

I think...

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

Just so I...one other, just...I hope we're kind of collecting all this, because we're getting a lot of really important pieces of information and we're going to have to go back through it and think about how they all can be utilized. But here's another piece to add to our woes, a lot of what we've just been talking about, it's pretty much what Julia was saying and also what Floyd was saying, and I think what often is in our minds is about trying to accurately capture the specific information about patients. And this is obviously really important in the context of transitions of care and exchange of information that are patient-centric.

But value sets and in particular those that are associated with quality measures provide an out, to some degree, for this conundrum that I just want to note and probably suggest that we set aside and don't use this out. And the out is that the intent of a value set is to say that all of the concepts in that value set

are considered equivalent in the context of use of that value set so for quality measures. And so when one looks at the scope of kind of patients that are represented by a set of concepts that are in a value set when you compare all of the concepts from SNOMED for this...is that all of the concepts from ICD-9 that are in this value set if you ignore the specific differences like oh there really isn't a good ICD-9 code for...that lines up well for the...with this SNOMED code.

But someplace in the value set there is an ICD-9 code that's good enough then the mismatches, in terms of representing patients when, you know the original question that we were asking Debbie about in terms of how this impacts analysis of data, actually damps down. There isn't a big difference; so even though you can't get a good line between a particular SNOMED code and a particular ICD-10 code, for example, in the context of quality measures you're looking at the entire patient population for each value set and there there's probably consistency and so there's less of an issue in terms of mapping.

And so one of the...the point that I'm making here is that as we ad...you know, look at what are the real important drivers for our decision in terms of the support for multiple code systems in reporting and things like that, I think we need to not think about that in the context of value sets. It's a lot harder, but I think we need to keep in mind the things like, for example, that Floyd was talking about where even though we may be thinking about this as an important element of quality measure reporting, we're really talking about patient-to-pa...you know, patient-specific information in transitions of care and Meaningful Use that way.

I guess I'd ask if people agree with that because like I said, this value set thought actually gives us a big out in terms of being exact in an allowance for multiple code systems and I suggest we look at that out and set it aside and not use it.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

This is Chris, I...

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

So Rob, this is Marjorie...Chris, go ahead.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Thank you. I'm not sure that I grasp the implication because in my mind it's relatively simple. If we consider the context of transitional or alternative vocabularies, then that would imply assuming that we want to get down to the value sets level of specificity that we would have a set of value sets, each one arising from a different source vocabulary.

It doesn't dodge the question at all, at the end of the day we're still confronted with a question of whether transitional/alternative vocabulary/value sets are something that we should consider deprecating or something that we should consider continuing. I mean for me that's the core question and it's completely independent of whether it's subsetted into the context of a value set or not.

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

Well this is Marjorie and I tend to agree with that and Rob, to answer your question, I'm not so sure that considering for the...in the context of quality measure reporting that the transitional and the clinical vocabularies should be considered equivalent really works. I'd have to be convinced of that. And one of the things I'd also like to share for background is I actually truly believe, and I'll look to Floyd and others again, when we started developing these original recommendations, I'm not so sure we were aware of the data capture and the data reporting dynamic. I don't think it was really clear at that time, until after we got the feedback.

And I really do think the reason for the...the original purpose and intent for the recommendations was to not necessarily for retrospective reporting where you go pick your codes and things, I think it was really to leverage clinical data that had actually been captured at the point of care. And ideally, you know the whole point of Meaningful Use was to foster the use and capture of clinical vocabularies. So I have a...I don't know...I'm not so sure I'm convinced that we should consider these as equivalent, for the sake of quality.

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

Yeah, again I won't raise this again. It's a nuance but it has to do with as you build value sets how, you know the patient population that falls inside versus the patient population that falls outside when data is captured with one code system versus another. And basically I was saying that value sets, because they lump a bunch of different choices into one big lump, the differences in terms of comparing populations that fall inside the value set versus outside may be less dramatic, those differences, when going from tran...code system A to code system B. It's obviously dramatic in certain situations when you look at code A versus code B.

And having now said that, I think this nuance as I was arguing shouldn't be considered. And so I think we're back to the point that you're making which is, we got to think about this as, you know our goal is one-stop shopping; people collect data for patient care; it is patient-centric. It is intended to support communication within the care team and across care teams, across institutions. And I think we need to focus there and decide whether it makes sense, given what's going on in data capture, as you were just noting, as a component of both patient care and the reporting on patient care and make sure that there are, you know if the burden of what's captured versus what's reported supports the ability to say no, we need to have more than one code system here because we do different things with it or not.

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

Um hmm.

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

Not then about quality measures and value sets and stuff like that.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

I would agree with that, other than there are implications of our decision. So, for example if we decide oh, you can only use SNOMED, and I sound like I'm against using vocabularies, you know a single vocabulary and I'm not, but just thinking of the issues and that is, so we say only you can use SNOMED and then if that would become rule, then all of the measures that use the other vocabularies in the

allowed populations and quality data elements will then be invalid and there will have to be a quick update with the next round where we take out all the allowed ICD-10s and ICD-9s, for example.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

This day was anticipated as somebody who also served on this task force and indeed on the Standards Committee at that time. I think the intention of the members was to recognize and acknowledge that the transition period would need to be in place and that people could not turn on a dime and this couldn't happen overnight. And that was a very pragmatic and I think realistic attitude.

The reality, however, is if we have an infinite progression of transitional specifications then there will never be any incentive, quite frankly, for vendors or providers, to harmonize on a canonical specification because there'll always be alternatives that they can use. And absent that specificity, absent clarity as to what the reporting requirement is, the collecting requirement will continue to be heterogeneous.

Now if we were to change this tomorrow, I still think we'd need a transition period because the reality is the community has never been confronted with the specter, as you say, of saying okay as of tomorrow we're going to use "X" and everybody else that's used something else, you're going to have to map to "X." That takes time, but that trigger has not been pulled. We're still in an acceptable transition behavior and I think as a consequence, the community continues and persists with legacy specifications to not make a transition at the collection end because, why not? It's a perfectly allowable reporting terminology and we'll never get out of this syndrome.

I don't mean to jump to a conclusion, although I'm obviously doing that, but I think we need to consider in a sort of a more detailed way, what are the costs and benefits of specifying that there would be a deprecation of transitional vocabularies and that a canonical specification would prevail over some period of time. And what would that do?

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

So, I mean for me again this is about aligning a lot of very disparate things. The big ones for me are SNOMED is frequently cited as a good terminology for exchange because...again, with the focus on patient care, because it through its breadth and depth can capture nuances that, as an example around diagnosis, I know we have transitions...sorry, transitional or alternative code systems for other areas, but it's a good point of discussion. And it's a reference terminology that has detail and the other primary terminologies, you know ICD-10, ICD-9 are classifications and by their very nature, they must consolidate meaning into a general class.

And so I think that we have a conundrum with the, in essence, again what you were talking about Chris, in that our desire to help the community kind of go in a particular direction, i.e. encode clinical data for care. And in doing so, identify and deal with the second half of this issue; so this one is capturing detailed clinical care or detailed clinical information for clinical care and the other side of this is, what do you need to report? Right? What are the drivers that have always been in place or, yeah, always, but for encoding data in general? And how do we create a simple bridge between these two activities? I think that's what led, obviously, to the initial allowance of alternative terminologies and that situation, so far as I can tell, continues and it still exists.

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

This is Nancy Orvis. I think there's another...the third piece in this is the fear and...that SNOMED is probably the right thing for transmitting clinical care information, but the data capture issue and the fear of providers that they're going to be led down numerous trees to be able to figure out this detail when they just want to put down a simple, you know a diagnosis or a problem in something and not have to worry about how it's coded, is the third piece of that; the workflow impact. Maybe we don't want to talk about that now and just focus on the transport and the reporting; but I think part of the education of what we choose out of this recommendation needs to at least acknowledge are we...is any of our impacts going to impact the workflow?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

That's a fair question, Nancy and I think we have to wrap that into our consideration of costs and, you know implementation barriers and challenges. I think we all agree that genuine SNOMED coding is actually quite tedious, if it's done manually by clinicians. Many of us have felt for a long time that the ideal, a bit Pollyannaish, is to have clinicians dictate a free sentence, a free language phrase of what they mean and to have machines do the NLP and mapping and matching to a constellation of SNOMED codes that capture the grammatical expression of the clinician, the English language expression of the clinician. We're not there yet, that capability is not in place but, the re...these things...

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Chris?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Yes.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

May I ask about that? Are there...I've heard that there are systems that are currently doing that now, like using a Dragon software and then mining for diagnostic codes and SNOMED codes and whatnot; have you heard that also?

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

There are.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Well we devel...we developed a prototype system 20 years ago that actually used Dragon and it was, you know it was primitive. The state of the art is obviously hugely improved, but the whole challenge of, is this a widespread technology, a commodity technology that is out there embedded in EHRs? Not to my knowledge; I may be misinformed.

Nancy J. Orvis, MHA, CPHIMS – Director, Business Architecture & Interoperability – Department of Defense

No, and just...this is Nancy again. Just to bring, I mean, I think we're talking about what will go in effect with Stage 3 and beyond, correct? Because Stage 2 today, you know I have legacy data for the next 5, 6 years that I'm going to have to map and that's barely going to be Meaningful Use Stage 2. I have a new EHR coming into play where I've asked the question on problem list and they said, well, there are some workflows that allow you to have a nomenclature-led way of going through to something. But I will tell you today, I'm in the midst of educating 20,000 physicians to say, you're problem list is going to show an ICD-10 code. But, I don't...but to support what Chris is saying on where we need to go, I think everyone and providers and all kinds of providers who do workflow, and this includes nurses and everybody else who are cataloging things, don't want to have to do that but they certainly want their EHR vendors in Stage 3 to be able to do a lot of this under the covers for them. But I don't know.

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

Yeah, let me just...I'm going to ask Nancy's question again because it was, I think, an important one to understand what our kind of parameters are because she started by saying, is this an MU3 thing? And I guess I hadn't thought about it, but I have to say, I assume it is; is that a fact? Or is there some other target for whatever we might propose?

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

I think part of the charge Rob includes feedback on what timing is appropriate for transition if a transition to single code system is appropriate. But I think yeah, the nut of the issue is yes or the nut of the answer is yes.

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

Okay.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

This would potentially be implemented only first in Stage 3.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Right, I think it's unreasonable to have this without that kind of a timeline. So we're back to the core question, and I think we're...we have 15 minutes left. Remember, once we come to some kind of conclusion and can enumerate costs and benefits, we then have to address the related issues of barriers, validity, cost and the like. And that's going to require some more effort and we only have a handful more of meeting; we have a final report due to the Standards Committee in December.

So this isn't something that we can debate infinitely. It's probably inappropriate for me to do so as Chair, but I'll be inappropriate; suppose we start with a premise that transitional vocabulary should be deprecated and that that would be the core of our recommendation and that we'd look at the cost, barriers and challenges and benefits as a consequence. Is that a position that this committee could get behind? Are we ready to make that kind of a recommendation or do we need more discussion among ourselves before we can really come to a conclusion on that core issue?

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

This is Gay. I would think that it's the only way we can start; we have to start with the assumption that that's what we're recommending. But not make the recommendation until we investigate the implications.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Other discussion?

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

So this is Marjorie; I think we could start with that and objectively move forward. I think that's what Gay is saying, you know, let's see where it...let's go through the sort of the secondary discussion points and really deliberate on what the implications would be, if we started with that.

Joseph L. Jentzsch – Principal Consultant – Kaiser Permanente

This is Joe Jentzsch; I agree with that.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Okay; thank you.

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

And this is Rob, I also agree. I think we could...we have to obviously allow ourselves the opportunity to say that we could run into a situation where we think that, you know, there's a couple of odd men out so where that particular spot, there's a very good reason that we don't do that approach, but yeah, my going in assumption is that a unified terminology that is focused on support for actual clinical care is the target that we've all been looking for and that that's what we have to have here.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

So I'm hearing general support, although with the caution that we should examine the consequences and be at least prepared to make a reconsideration; I think that's prudent. Any dissent? So hearing no dissent, then I think we are prepared to operate on the assumption that transitional vocabularies should be deprecated. Then the issue is when, over what period of time? And then a formal exploration of the secondary questions, which I think are really quite key; the issue of reliability and validity and the costs and implementation impacts; recommendations as to how to proceed on reliability and validity, short of doing an academic study, which of course would be my knee-jerk reaction, being a card-carrying academic.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

Well I think that, I mean I don't know if there's a way we can divide and conquer, but to review the different code system recommendations and I'd argue that this is not an academic...then and look at the base standards that are also recommended in Meaningful Use and, you know, in 3 and you know, where are we going to raise some discrepancies and that...to me that's the basic thing that we have to do.

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

I agree and just to add one more point, I do think we need to look at the transitional vocabularies, what's chan...has anything changed about them that has, you know, from when they were originally sort of recommended as transitional vocabularies? I can share, because I worked for the PCPI and I know my colleagues at AMA are building an ontology around CPT, maybe that's something to consider, well, I think that is something to consider as we move forward, you know, what else is happening with ICD-10, etcetera. So, that's just one vocabulary, but I think we need to do that for the others as well.

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

That's a really good point, Marjorie and as you say we all think ICD-10, but as Chris certainly knows, ICD-11 provides some things that could give us some guidance.

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

Well, and the ontology for CPT is based on, you know, SNOMED so, that makes it even more complicated, you know, as we look...really examine this.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

Well that's one of the big differences with 11, too, right, is it maps to SNOMED, right?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

It's actually defined in terms of SNOMED, yes.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

Yeah.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

But 11 is off the table, at least for the time being; it won't be at least until 2018 and I think the likelihood that it will become, after the trauma of the ICD-10 conversion, the likelihood that it will be adopted in the United States in my lifetime is probably quite small.

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

Oh Chris, please, it's got to. If we do nothing for you, we must do that.

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Yeah well, rational thoughts notwithstanding. Fair enough, so I agree looking at what are the, you know tangible implications of this, but I'm a little concerned with resource implications because that's why I was babbling about academic studies. To do this properly, we would really need a systematic review of content and its dis...and the dissonance that would be in place. And that, you know that's not something we're going to do on a conference call over the next three hours of conference call that we have scheduled. That is an offline task that requires resources and effort, so I'm not sure that...while I think it's a great idea; I'm not sure how to execute on that within the context of this task force.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

So Chris, this is Julia. Do you think that you could describe in a little more detail what an acceptable analysis might be that wouldn't involve several years of data collection, for example?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Yeah, no...

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

ONC might be able to help fill that gap if we can think of some analysis we can do with the interim period that we have in the task force?

Christopher Chute, MD, MPH, DrPH, FACMI – Chief Health Information Research Officer – Johns Hopkins

Well it really centers around the reliability and validity question, as I understand it. So demonstration, I mean it's been asserted many times on this call, but...and I've...I include myself, but it's been done without data that quality metrics or other inferences made from organizations that present in data set or coding system A will have a systematic bias and measurable difference from those that are reported by organization B using code system B.

I think a demonstration of what that difference might be, I mean, how is it that you would get a systematically different, you know make a hypothetical data sets; this is the way you do it academically and if you can think of a practical way to do it, I'd be welcome. You'd come up with a body of patients, you would code those patients in code system A, you'd code those same patients in code system B and then you would generate a whole pile of quality metrics drawn on the same patients and see whether the quality metric measures the absolute percents or whatever the ratios might be that you're looking at are systematically biased one way or the other, depending upon whether you measured those same patients in system A or those same patients in system B.

So if we happen to have available to us data that was dual-coded and genuinely dual-coded at the point of collection rather than simply mapped, virtually everybody that has dual-coded data these days it's mapped, then we could do it. If anybody has an idea of how we could do it more intelligently than my, you know, Pollyannaish academic approach, I'm all ears.

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

Well so part of the...so that, well, I think as Chris is...what Chris has described is exactly the sort of thing that would be really valuable but very difficult to do, and certainly not in our timeframe. So, I think one of the things, you know, given that we've just all decided that we think, while keeping our eye open for perhaps outliers specific situations where we wouldn't do this that we're going to target the desire that there would be one code system. And again, I actually think one of the things we really, maybe I'm just the outlier, but this whole issue of data collected with one code system versus reported with code system continues to gnaw at me.

But I think in terms of actual things that we could potentially even get in the timeframes that we're looking at, one of the pieces of information, and again, we haven't had a slide change, but it was obviously important when this issue was addressed early on, and that comes as no surprise, and it

remains important. And Marjorie alluded to another element to that is...and that is, let's...we need to know more about these code systems that we're talking about.

And in my mind particularly, I need to have a better sense of what's really possible when you map from one of them to another because we can decide, for example, that we're not actually giving recommendations with regards to data capture. We may be alluding to that, but that our recommendation is about data reporting. And in doing so, you know, well actually there's another piece to this; so one is mapping and the other part, and this one is hard but it is possible that we could get some of this data, and maybe it was gotten when the original work was done. And that is, what are people collecting?

You know, for every one of the items, you know the so-called data categories or data types or whatever you want to call them, that are in the blueprint that have specified code systems expected, transitional or not. I still would love to see a really thorough analysis that says this is how that data is currently collected. And actually, to be honest, I'd be interested to see in that list free text, right; so some review of the literature, because there'll be some literature on this. But also, I don't know where but if we could get something in terms of our current MU1, MU2 data that we're getting submitted, again worried about people doing what we've asked in the past and not necessarily telling us what they really do right now.

But I think it would be really valuable to know for each of those data categories, what are people actually using in their current EHRs? For example we know that for a chunk of them it will be things like IMO, it will be things like MEDCIN, it will be, you know there will be some others at the VA there's the VA systems. But if we knew that, if we got a sense of even scope, that would help us get a sense of well, if we're going to expect them to submit code system A and they're collecting in a code system that isn't even on our transition list, this gets to this whole telephone game point I was making, let's make one mapping be the mapping that we're essentially forcing on them and then think about, how hard is that mapping going to be.

So, I really I guess what I'm saying is I'd like to have a much better understanding than I currently have of what people are currently capturing now independent of any recommendation from ONC or CMS.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

Well I certainly agree that would be valuable, Rob. I'm...I am a little...we have four minutes, three minutes and I am a little concerned about what our next steps are. And so one of them would be, we could ask ONC if the kind of information you just described is or can be made available, at least in abstract form, not in a patient-specific form, obviously, but in a...

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

Right.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

...high level abstract form. I think the second thing we need to do is clarify the regulatory conflicts, if any, between or among HIPAA, specifications for quality metrics and specifications for clinical data exchange. I mean, is there conflict at the vocabulary level at those layers and if so, what is it and how do we manage that? The third issue is how can we scalably address the validity question? And maybe your point Rob was an effort to look at that short of a tedious data collection process. But I would say that...I

would wonder if there were data set available, and maybe that's exactly what you're saying Rob, maybe outside of Meaningful Use reporting that could be volu...we could ask for one and then...

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

Right, yeah, no it is exactly trying to get a sense of the validity of our recommendation given we have to know...have a sense of what the starting point is.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

So it's been suggested to me, well fair enough, I'll pursue that at another time. We have a closing two minutes; are there other action items or next step items that other members want to suggest?

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

I just wanted, well first I wanted to ask will there be...are there going to be, besides the recording notes captured that will be shared with at least the core group here? That's my first question and the second question is, I think an action item would be, you know I hear definitely the important aspect of the reliability and validity and seeing how...what people are actually capturing is very important but that's a longer term thing, what about the short term of making sure whatever we're recommending is how it conflicts or aligns with the current Meaningful Use recommendations. And I think that's a much smaller task that we should definitely examine.

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

Yes and this is...

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

That's my second to do item, so I agree with you completely.

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

And this is Marjorie drilling down on that maybe, I mean I'm willing to do sort of a comparison of some of the transitional vocabularies sort of a then and now, you know at a very sort of qualitative kind of review of that. I do know what's happening with CPT because I work closely with those folks, maybe there, you know, I could do something with ICD-10 or whatever, just to report back at our next meeting.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

That would be helpful.

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

Sure.

Gay Dolin, RN, MSN – Clinical Integration Specialist – Intelligent Medical Objects, Inc.

I mean I could get some statistics probably from IMO, I'm guessing, I don't know. I think with our problem product it's been 75% of the EHRs across the country and what that means is those folks are just capturing a concept, a term, a text thing and behind it, it goes to all of the different vocab...code systems. So that adds, to me, an interesting wrinkle, it's like well maybe those folks don't even care, at least from the clinical end, you know, from the behind the scenes end it obviously makes a difference;

the IT folks will have to make sure that they only send this code from all the possible map types and map.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

All right, thank you everybody. We're slightly over time. I look forward to our further deliberations and Floyd will Chair the next meeting. So with that, we're adjourned, thank you.

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

No, no we need to go to public comment, no, no, no.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

Forgive me.

Public Comment

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

Operator, can you please open the lines?

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

Right.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

I messed up.

Lonnie Moore – Virtual Meetings Specialist – Altarum Institute

If you're listening via your computer speakers, you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the telephone and would like to make a public comment, please press *1 at this time.

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

Sorry Chris.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

No, thank you.

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

While we wait for public comment, it sounds like we probably need to do a little follow up offline to figure out next steps for our next meeting on November 4.

Julia Skapik, MD, MPH – Medical Officer, Office of Standards and Technology – Office of the National Coordinator for Health Information Technology

Sure and Michelle, I can help to work with the Chairs and the workgroup members to make sure that we know who's doing what and then bring that back together for the next meeting.

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

Thanks Julia. And it looks like we have no public comment so thank you everyone.

Christopher Chute, MD, MPH, DrPH, FACMI – Professor – Johns Hopkins

Thank you.

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

Have a great day.

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

All right, thanks.

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

Bye.