

**Clinical Quality Workgroup**  
**Draft Transcript**  
**July 25, 2012**

## **Presentation**

### **Operator**

Mrs. Robertson, all lines are bridged.

### **MacKenzie Robertson – Office of the National Coordinator**

Thank you. Good afternoon everyone; this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee's Clinical Quality Workgroup. This is a public call and there will be time for public comment at the end and the call is also being transcribed so please make sure you identify yourself when speaking. Before I go through the roll, Jim if you can hear us through your computer speakers, if you can go ahead and dial in to the speaker line we can see you logged into the computer but we don't have you on the phone yet. I'll start taking roll and then check back to see if you've joined at the top. Karen Kmetik?

### **Karen Kmetik – American Medical Association – Vice President of Performance Improvement**

Here.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Karen. David Baker? Keith Boone, I know, isn't able to attend. Anne Castro? Christopher Chute? Jason Colquitt?

### **Jason Colquitt – Greenway Medical Technologies – Vice President**

Present.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Jason. John Derr is unable to attend. Bob Dolin? Floyd Eisenberg?

### **Floyd Eisenberg – National Quality Forum – Senior Vice President of Health Information Technology**

Present.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Floyd. Rosemary Kennedy?

### **Rosemary Kennedy – Thomas Jefferson University**

Present.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Rosemary. David Lansky? Brian Levy? Robert McClure?

### **Robert McClure – Apelon, Inc. – Chief Medical Officer**

Present.

### **MacKenzie Robertson – Office of the National Coordinator**

Thanks, Robert. Galen Murdock?

### **Galen Murdock – Veracity Solutions**

I'm here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Galen. Gene Nelson?

**Gene Nelson – Dartmouth University**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Gene. Eva Powell will be joining later. Philip Renner? Eric Rose - I think Eric might be on mute? Danny Rosenthal?

**Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Joachim Roski?

**Joachim Roski – Brookings Institution**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks. Randy Woodward?

**Randy Woodward – Healthbridge – Director of Business Intelligence Systems**

Here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Randy. Kate Goodrich? Kim Schwartz?

**Kim Schwartz – Roanoke Chowan Community Health Center– CEO**

Present.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Kim. Are there any other Workgroup members on the line?

**Eric Rose – Intelligent Medical Objects**

Eric Rose is here; can you hear me now?

**MacKenzie Robertson – Office of the National Coordinator**

Oh, yes, thanks, Eric. Are there any staff on the line?

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

Jacob Reider at ONC is here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Jacob.

**Jonathan White – Agency for Healthcare Research & Quality (AHRQ)**

Jon White is here.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, Jon.

**Lauren Richie – National Quality Forum – Project Manager, Performance Measures**

Lauren Richie.

**MacKenzie Robertson – Office of the National Coordinator**

Lauren Richie, thank you.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Hi, MacKenzie, Jim Walker.

**MacKenzie Robertson – Office of the National Coordinator**

Hey, Jim, glad you joined.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Thanks, I got the impression from the operator that I could do it through my computer speakers also.

**MacKenzie Robertson – Office of the National Coordinator**

Ah, gotcha. Okay, so I will turn the agenda over to you then.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Thanks, MacKenzie. Thank you all for joining, we have a full agenda today, some updates from the Optimal Clinical Quality Measures Tiger Team and then some actionable steps from the June 7<sup>th</sup> Clinical Quality Public hearings that I think will give us important opportunities to process that and identify potential actions going forward and then just a fairly quick update on the value set authority center which is moving ahead very nicely, and then some opportunities that that presents us to sort of take the next step and think about the framework in which that set of activities will go forward over several years, and then Jacob will be talking to us about the re-envisaging clinical decision support as one of the components of quality measurement or vice versa. So, if we can move to the second slide or the third slide, the next slide. And, Karen, you're on?

**Karen Kmetik – American Medical Association – Vice President of Performance Improvement**

I am.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Great, so we'll have Karen tell us about the Tiger Team's work.

**Karen Kmetik – American Medical Association – Vice President of Performance Improvement**

Thanks, I just wanted to let everyone know that the Tiger Team that was looking at the characteristics of optimal clinical quality measures from the perspective of leveraging EHR data met several times by phone and we talked about optimal characteristics being usability, feasibility, accuracy, standard terminology, again from that lens of making these measures implementable but also leveraging data within EHRs for measurement and also thinking about workflow involved and we got tremendous input, very thoughtful conversations, I want to thank the Tiger Team members who are on this call.

We, unlike the group that Jim led that looked at value sets, we did not put forward at this time a formal letter of recommendation for consideration because part of what I was thinking, after digesting all the good comments, is that I really think it would be helpful for the next part of that conversation for us all to take a look at some testing feasibility, reliability results from measures that have been implemented into EHRs and I'll continue to work with ONC staff to see how we might do that. We certainly have some from our work; many others out there may as well.

So, it seems like a next step there to move towards some more specific recommendations would be to look at some work that's been done against the good recommendations we received so that we can move toward some more defined recommendations. So, I wanted everybody to know that's where we are, that's why you've not seen something formal from us. I think this is a very complex but important piece of work and we'll continue to explore it.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

This is Floyd, are you taking comments or waiting until later?

**Jim Walker – Geisinger Health System – Chief Information Officer**

Absolutely, that's the next thing, Floyd, so I'd be happy to have the committee comment on any of this.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

So, I think this is very helpful and as I look at it, it aligns well with basically how measure evaluation has occurred although not necessarily in the context of e-Measures, so usability, feasibility, but then it departs a little bit because there's also the concept of validity as probably a mix of accuracy and standard terminology, but then there's a reliability, in other words, if I find it in the EHR in a specific place is it authoritative and can I rely on it to mean what the measure was intended to mean on a data level and is the measure reliable to provide the kind of information needed to evaluate performance.

So, there's some...and also I question there's a data element component to all of these characteristics and there's a full measure component and I think they're different, so just to throw that out for discussion.

**Karen Kmetik – American Medical Association – Vice President of Performance Improvement**

Yeah, Floyd, I'll just comment, certainly agree with you about the difference between data elements and then the measure, the calculation, formation of the measure, and certainly agree with you regarding the importance of the reliability. I think maybe this is short-hand for...you might recall very detailed tables that we had worked through to try to define each of these and so maybe we can in the future re-issue those tables and make sure that we've got all that captured.

**Robert McClure – Apelon, Inc. – Chief Medical Officer**

This is Rob McClure, I absolutely want to jump on, that is I think the idea of adding reliability to this list is really important because I don't think it's the same as accuracy and having gone through this process of looking at this retooling and I think the entire issue of restructuring the way we think about e-Measures as opposed to the way we used to think about quality assessment is going to require thinking about reliability and that's I think a different set of things to think about than just thinking about accuracy. So, I really do agree.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

And I really, this is Floyd again; I really think we do maybe want to separate the measure characteristics and the data characteristics because I've been doing some thinking about that for another group recently and they are different. Usability of a data element is different than usability of a measure and same with feasibility, validity. So, teasing those out I think would be really helpful, especially I've heard suggestions that before developing a measure a measure developer should know that the elements, data element is feasible and useful before they actually create the measure, so to do that we would need those definitions.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Great, any other comments? Let me ask the group, any comments on Floyd's, what I think is probably a valuable suggestion, that we use validity perhaps as a more general term that includes accuracy but also generalizability and probably the idea of maintaining its accuracy in different kinds of context. Is that what you intended Floyd and other comments?

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

Yes, just to answer, it was. So, if I were to say I really want to know that this is an active diagnosis. If folks are saying, well I find that sometimes in a problem list and other times in this thing we call a diagnosis list, and other times I find it in a third place, and all of them would be reliable and I can count them as authoritative then it might be three ways you could find in addition it would have to say problem list, but you would need to validate or, well I don't want to misuse words here, you would have to be sure that that's authoritative, it's valid, it's reliable, it's whatever. So, that is what I was thinking about, there's not always one place that you find something but you don't want to find it everywhere and go back into abstracting the entire EHR.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Great, there was another comment?

**Eric Rose – Intelligent Medical Objects**

This is Eric Rose; I agree completely with Floyd's suggestion. I would suggest that we be careful in our use of terms because in the world of measurement the words reliability and validity each have a specific meaning and they roll up, they each contribute towards accuracy. So, reliability...and we are talking really about a type of test because quality measures are presumably a set of tests that measure quality, so reliability of a test means that each time the test is run under the same conditions that the result will be the same and validity means that the test measures what it's really supposed to measure.

So, for instance, measuring temperature with a mercury thermometer under the tongue is a very reliable test, it is not necessarily a valid test for sepsis. Measuring a temperature with a digital thermometer under the arm is neither reliable nor valid as it tests for sepsis, so that's...I think we should address all of those, but we should just be careful about use of the terms.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Thanks, Eric, great point. Other comments? So, Karen, this is Jim; was the conclusion of the Tiger Team that there wasn't enough agreement on anything to comment on or that what there was agreement on really didn't move things forward? I'm not clear exactly what drove the decision not to report anything.

**Karen Kmetik – American Medical Association – Vice President of Performance Improvement**

Sure, so we had agreement on the characteristics that are important to consider and the more detailed definitions of each of these, which are not reflected here, and also a good discussion around the importance of when to evaluate these things. But we were asked to say, you know, what would be optimal looking through that lens of EHR and workflow, and so it was very hard without seeing some tangible results to know, well what would you do with the results of this information? So, in other words, if through feasibility, implementation, reliability testing we got information about data elements and measures, and we've said that's important to get that information, well the results will vary, right?

So, we might find in some locations with some particular systems and some particular workflows that the data elements are feasible, in others today the data elements are not feasible or we might see some of them are provided by one source, some by a different sort. We might find in some cases high reliability of data elements in an EHR compared with an automatic review. You might find high reliability looking at two different abstractors looking at the same EHR.

But, until you look at some results, some outputs it's hard to then say well what is optimal, you know, or where do we say if we get this level of feasibility or this level of reliability we have a certain comfort level, or what does it tell us in terms of what different stakeholders need to do next, is it an issue for the EHR vendors, is it an issue for measure stewards, is it an issue for providers entering data.

So, we just...I mean, I felt like to take it the next step, which is the important aspect of, great we all said these are the characteristics we need to find information on, this is important, we need to do it early, it needs to be part of the flow, I wanted us to also get to then, what do you do with those results? How do you interpret those results?

**Jim Walker – Geisinger Health System – Chief Information Officer**

Great, thanks. Any other comments, winding this up? So, this is Jim, I'm thinking that the sense of the discussion has been that we would add two sub-bullets under accuracy, one would be validity, one would be reliability just as sort of memorializing this, Karen is that okay? Anyone on the committee want to comment on that?

**Karen Kmetik – American Medical Association – Vice President of Performance Improvement**

Yeah, I certainly agree with and understand the comments, I would just like the opportunity to go back and look at our Tiger Team tables because we did talk about this and maybe...and just want to make sure we capture it in a similar way as the Tiger Team was thinking about it.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

Yeah, and this is Floyd, I think it would be helpful to compare it to existing definitions for measures and since there are no definitions for data elements there might be suggestions, but it probably needs wider vetting than just this group. And going back to Jeff Rose's comment, which is what I was trying to address, accuracy is a mixture of several things, it's not in itself that accuracy of measure is not...I mean, it's a mixture of reliability and other factors. So, I think there are a lot of different terms and they can easily be used for different meanings unless we're really clear.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Right, and this is Jim, that's my interest in this, it seems to me, Jeff made a good point and that we would want to capture that at least in our work or refine it further if it needs further refinement, it struck me that that was a pretty accurate characterization and that if we at least agreed on the language we at least would know what we were talking about.

So, Karen, why don't you check it against yours and Floyd if you want to, you know, do the same thing, you know, and maybe next week or next meeting we just have a quick report on how that looks to us and see if we can establish a way of talking among ourselves that is close enough to standards that it will be useful to other people.

**Karen Kmetik – American Medical Association – Vice President of Performance Improvement**

Happy to do that, Jim.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Great.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

And the same.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Okay, thank you all. So, then the next slide we move to I think the themes from the June 7<sup>th</sup> public hearing and, well maybe I'd better read them for the record, you can see them there obviously, but, so the first was recommendation to develop methodologies for identification of focus areas with the greatest opportunities for improvement and I think the meaning there was population health improvement.

And then number two shifts focus from reporting to implementation of tools that are usable in the flow of care, to proactively monitor improved performance. Now, maybe we could start with the first one. Any comments on that, thoughts about how we might move that forward?

Well, this is Jim; I will make one maybe to try to start the conversation. The example is to resource intensive procedures with high variation, resource, I'm sorry, hyphenated, resource-intensive procedures with high variation. One of the things that has struck me is that if we knew the number of quality adjusted life years in the population that an intervention could be predicted to add that would provide...and easily understood by healthcare workers and many lay people, and also rigorously measurable criterion for identifying greatest opportunity, but I wonder, you know, if there are any other thoughts about that, if we want to try to go a little farther than just say greatest opportunity and try to identify how that would be measured.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

So, this is Floyd, I have a question...because I don't...I'm not sure I clearly understand from the statement develop methodologies for identification of focus areas with opportunity, is this focus areas of clinical care or is this focus areas of capturing and managing data within EHRs? Because they're two different things and I think I've heard the latter more than the former.

**Jim Walker – Geisinger Health System – Chief Information Officer**

All right and how did you interpret the examples in that light, Floyd?

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

Well, so when I look at this I'm not sure how that example fits but I would say, so if we really want to trust conditions on a problem list what's the methodology to be sure we can trust it?

**Jim Walker – Geisinger Health System – Chief Information Officer**

Yeah.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

Or if we wanted to do medication adherence, what kind of data do we really need and where are we going to find them? The way I interpret this is what are procedures that need new measures and that may be there too, but then it's a matter of can those measures be feasible within an EHR going back to the earlier discussion. But, I think there are a lot of things that can be interpreted here.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Yeah, no I agree with you, it's a lovely open-ended statement. Jacob, do you know what the group was thinking here?

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

Yeah, I was scratching my chin here as we were trying to muddle through this one, Jim, and I don't, I don't remember what...I don't remember the context of this bullet.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

Yeah, so this is Floyd, let me just say this was a combined hearing of Policy and Standards Committee and I'm not exactly sure of the context, but I get a strong feeling that it might actually deal with both meanings for Policy Committee to consider what are things that are important to...for measurement that should be part of Meaningful Use, but then for Standards, how do you get to the things that you need to do the measurement. So, I actually think both meanings just depends which committee is going to address which one.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

Yeah, standards...

**Robert McClure – Chief Medical Officer – Apelon, Inc.**

This is Rob.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

Go ahead, Rob.

**Robert McClure – Chief Medical Officer – Apelon, Inc.**

Rob, the... I mean, I agree with Floyd again, I think this was probably attempting to do both or address both things. I think Jim's right actually and when you talk to folks outside of the informatics community they're... I mean they sense the importance and are often times actually versatile a little bit about well you're changing or you're asking me to be engaged in processes, but what I care about, you know, if they're so inclined, you know, might be defined by how I can change things for my patients in terms of, you know, quals.

And in part our difficulty here is that we've tended to focus on trying to change the infrastructure, you know, how do we really capture the right problems on the problem list and capture other workflow elements in an EHR so that we can do these e-Measures but we don't describe that effort that we want people to go through as a way of improving their own quality adjusted life years for patients.

And so, in a real nutshell, this really describes our issue, is if we could figure out ways to talk about, yes we need to capture workflow timestamps, yes we need to do a better job of capturing accurate problems on the problem list but not everything that you actually think about for a patient and in doing so you're going to make your patients healthier, that last "and in doing so" part is really hard, but it's so important for anybody, I almost want to say, that isn't on this phone call, right? So, I see it as both and I see it as our biggest stumbling block.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Okay, others? All right, well maybe Jacob and the team can find out more precisely, I mean, I think Floyd and Rob's interpretation is fine, but we probably wouldn't want to cite the hearings as support for it without being confident that that is something that actually came out of the hearing.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

So, I will work, Jim with Lauren, who I think is on the phone, we'll huddle with Kevin Larsen and team who have been staffing the HIT Policy Committee Quality Measures Workgroup our sister Workgroup and make sure that we align with them and I think that's a good plan.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Great, okay. So, then the second on this slide focusing on tools for monitoring and improving performance just in time. Thoughts or comments on this?

**Eric Rose – Intelligent Medical Objects**

This is Eric Rose; I wasn't present at that discussion but this does concern me a little bit in so far as, you know, this seems to have overtones of trying to promote a particular way that healthcare organizations would go about trying to increase adherence to evidence-based quality standards and a lot of the innovation that has gone on, at least in primary care practice, has, in the last few years, has been to take some of the sort of check box type work out of the stream of acute patient visits and deal with it in a more systematic fashion for people that are not necessarily providers.

And so that... this would... not that we shouldn't try to alert providers when they're about to make an error of omission or commission, but I wonder what the larger context was here and, you know, whether this really is trying to mandate a certain way of approaching clinical practice.

**Jim Walker – Geisinger Health System – Chief Information Officer**

This is Jim, I'd support that Eric, I think many of us are thinking more in terms of clinical decision activation support or something like that where many of the clinical decisions that are most relevant to the quality measures, you know, ACE inhibitors and heart failure, smoking cessation counseling for smokers are decisions that increasingly organizations make as a matter of practice and policy and process design, and are increasingly... you know, if the best place to do it is not in the patient physician encounter than moving it somewhere else in the patient's experience that actually works better. So, I agree with you.

And, I have one other question that I think may just be expression and not perhaps what came out of the hearing, the way this is stated it's almost as if we're choosing between reporting and changing the process of care as it's going on, and it seems to me that probably what we all want to be saying is that we want to improve care processes, understanding that much of those processes are transacted elsewhere than in the office, and do that in a way that reporting is a natural part, and a critical part of that care process.

And, also, I think we probably would do well to distinguish between internal reporting and external reporting. I mean, clearly you can't run 100% process if you don't have superb just in time reporting internally to all of the different actors in the process, patients and their lay caregivers, and the clinicians, that's a different question than external reporting, which has, you know, different time constraints, difference purpose and so I wondered if people who were there had any sense of that and if we could refine this a little bit so that it doesn't sounds like either/or but an improvement where we do actually both better than we do them now and also more efficiently.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

Yeah, and this is Floyd just with a comment. So, I'm having trouble with actually now the second issue, the comment on the slide, the second thing sounds like mom and pecan pie, to use something other than apples, but I'm not sure it's actionable about it, it says it's an actionable step, but I'm not sure the statement is sufficiently stated to think about how one would act as a committee and that's what I'm concerned about.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

Floyd, I think that's a great point and it actually might be something that's more actionable by the Policy Committee than by the Power Group, because let's say the Policy Committee defines different goals for quality improvement and those different goals might be things other than quality measurement and I think that was the point of the second bullet at the hearing, was when you measure quality and then 6 or 12 months later you look at those measurements and then you scratch your chin and come up with an intervention, and then you measure again, you know, that lifecycle is so drawn out and painful, but it's all based on sort of legacy paper ways of thinking about things. We don't have to endure those things, so there might be better ways to do that.

I think the ask to Policy Committee and the Quality Measurement Workgroup was can we think about more rapid cycles, can we think about this in a different way and might that even be clinical decision support and might you think of clinical decision support as just real-time measurement, that was the conversation. So, I think Policy Committee might take action and then we might be asked, okay, what are the things from a standards perspective that would enable EHR technology to incorporate those principles?

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

So, Jacob, I think that's exactly what I heard at the meeting and that makes perfect sense, I would question though are there any examples or taxonomies or methods to consider how one would go about considering measuring whether it's a full blown endorsed kind of measure or real-time measurement that the CDS was successful, and I don't want to be proprietary on the call, but I will say that there was a taxonomy published in 2010 based on an expert panel about how to identify the components of CDS to enable that effort.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

So, I know you weren't trying to lead the witnesses, so I'll ask others on the call; would we want to review that taxonomy as a group? Would folks have interest in that, in reviewing that taxonomy, because I think that might be of value?

**Jim Walker – Geisinger Health System – Chief Information Officer**

This is Jim, I think that's a great idea, perhaps we'd want to check with Policy or with David's Workgroup to make sure that that's something that would support their work as they envisage it.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

So, this one is tricky and since we're in public I will say publically recall that that Workgroup is focused on quality measurement, so that's the Quality Measurement Workgroup and our Workgroup is the Clinical Quality Workgroup which has slightly broader scope, and our scope, as we've defined includes decision support and their scope, as they've defined does not, so we might actually want to talk with Paul Tang or leadership of the Policy Committee because it might be the Meaningful Use Workgroup that has these kinds of things in mind because the Clinical Quality Measurement Workgroup may actually think that it's out of scope for them, which just means it's in scope for somebody else over there.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Right. This is Jim, just one other comment, because it comes up in I think the next slide also, I think we would do well to think about what we mean by real-time measurement. I think just in time is probably a more useful construct, lots of processes, particularly when you move them out of the face-to-face patient clinician encounter, but even other processes prevention is a classic example, do not require real-time responses and real-time measurement would not be quite the point, and when you say real-time I think to computer engineers they believe you mean sub-second response not within a day or a week or whatever is appropriate from the stand-point of the care process. And of course that's important because real-time is vastly more expensive and harder to manage. Any thoughts on that or anything else on the second one then?

**Galen Murdock – Veracity Solutions**

This is Galen; I offer favor the phrase near real-time to point out that it doesn't have to be sub-second as an engineer, as a computer scientist that at least leaves the question open, but we're talking about something that would affect current processes and current decisions, and timeframes much closer than say a day or a week would suggest, and I favor near real-time in this case, because I hear a lot of value from providers, and from vendors in moving the standards, and actions of vendors in general in the industry toward near real-time as opposed to leaving the field of interpretation so broad.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Okay, other thoughts?

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

This is Floyd; I second that motion of near real-time. Of course, I don't know exactly how to define near, but that's okay.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Yeah, this is Jim, that's one of things I would like to get clear is that that just needs to be defined. If you're talking about making sure a patient gets a colonoscopy every 10 years the time scale is obviously different than if you're trying to prevent a drug-drug interaction for example, and I think if near real-time...the point is that the time should be appropriate to the process as you were saying sort of fast enough to make the process a 100% process in an appropriate time scale, but that very often...the requirement that all of that be, you know, even less than a day will have big impacts, costs and others that we may or may not actually have thought all the way through.

**Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System**

Hi, this is Danny; I think a way differentiating this could perhaps be to differentiate it based on patient level versus population level. I think that the intent of this is to really focus on actions that can happen at the individual patient level and it just so happens that those patients tend to be in front of us in real-time or near real-time, so making a differentiation between patient level and population could help clarify.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

This is Floyd; I fully agree but can I make a friendly amendment to that comment?

**Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System**

Of course.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

Instead of patient the focus of measurement because it might not be a patient but a specific procedure that you're doing this for and it's sure at the time of caring for a patient but sometimes you're not focusing on a patient characteristic but a procedure.

**Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System**

Sure.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Well, and again, if you're saying we're going to send clinical decision support directly to patients and invite the patient to have a...for their annual 10 year colonoscopy, and we're going to have a trigger that if the patient doesn't respond to that invitation within 2 weeks the call center is going to call them, and, you know, so on and so forth, play it out. We just need to, you know, be aware that the time scale for that, even though it's an individual patient, is still different than not prescribing something that's going to interact with the warfarin. But, is near real-time acceptable to others? Any other comments on that one as a recognition that we're not always talking about sub-second response?

**Eric Rose – Intelligent Medical Objects**

This is Eric; I think, no comments on the near real-time issue, I think that for number two in general, I think that there's a lot of opportunity there to reduce the signals and noise problem that is, you know, that otherwise could result from a kind of indiscriminate exposure of sort of a real-time version of every clinical quality measure to providers and I don't know if that's something that this Workgroup should get into.

But, you know, for instance a rheumatologist who doses methotrexate on a daily basis probably doesn't need to get the same real-time clinical decision support that a family practice doctor does, and so there are, you know, end-user attributes that, you know, that might be used to filter... I don't mean to ramble about it, but I don't know if that's sort of what we want to delve into.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

This is Floyd, just a comment on that, it's very valid, I think the question is if we're looking at the standards, it's the standards to deliver the information in which the art locally or maybe generically and locally is what to do and not to do, but then in developing a measure to see if the standards are properly used you clearly have to take some of that into account and without getting into all of the trouble that we seem to get into when we deal with exceptions and exclusions, so it's going to be an interesting process to figure that out, but I think it's worth doing.

**Jim Walker – Geisinger Health System – Chief Information Officer**

So, this is Jim, maybe the sense of the committee is that as we make this shift we're going to have to be sensitive to the context specificity of time scales and make sure that we do our best at least to represent that in some kind of adequate way as we define these processes and the measures for them.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

I also think it's going to bring to even greater light the issue of exceptions and exclusions.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Right.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

To make sure that it can be properly implemented if we want to get into that much detail. So, maybe it's a frequency rather than an exact as you look at it, but that's something that will need to be considered.

**Jim Walker – Geisinger Health System – Chief Information Officer**

And I think we do want to... my guess is it's probably out of scope in any short-term but capture that sense that one of the contexts is some kinds of measures of... like how often you prescribe methotrexate that would become measures that would help us increase the signal and decrease the noise in all kinds of communications with clinicians probably and patients also, certainly patients also. Okay, why don't we go onto the next slide; oh, we're within 3 minutes of public comment. Let's see, Jacob, I'm not... yeah, why don't we go on through. I'm not sure there was anything that we were on the griddle to decide today. We will have some sort of the later slides we'll need to address in the next meeting, but any thoughts on these next two steps then?

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

You said my name and then any thoughts, were you asking me?

**Jim Walker – Geisinger Health System – Chief Information Officer**

No, I'm sorry, I was just rambling along.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

That's fine...which is just fine, Jim.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Okay, so any comments from the committee on actual steps 3 and 4? The first is focus on operational improvements as a core competency of care delivery organizations and then four is a little complex, maybe we'll come back to that if we... probably three is all we're going to have time for today. Any thoughts about that, focus on operational improvement, what that would mean, how this committee might contribute to that?

**Gene Nelson – Dartmouth University**

Hi, Jim, Gene Nelson, that second bullet develop visual displays that show real-time or near real-time in addition to retrospective performance, my sense is that that's a very, very powerful and important direction to move towards in improving care for patients one by one to make that information environment highly visual, instrument panel-like to really improve the care that's delivered and the ability to monitor and change outcomes by having good care plans that are well attended to.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Okay, other comments?

**Danny Rosenthal – Director of Healthcare Intelligence - INOVA Health System**

Yeah, hi, this is Danny, you know, I still struggle with this a little bit in the sense that I think that the roles of the quality community is to sort of set the bar, but how that is implemented locally with visualizations or with local strategies is really almost independent of the metric that is being conveyed and so I think that some of this is our people sort of gripe that their own IT departments aren't giving them the data that they need. So, I struggle with how can we help solve that particular problem with quality measures.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Okay, great, other? I'll just comment quickly, Gene, you know, I think my concern with the visualizations particularly is that I think many organizations are trying to make this disappear from the clinicians and patients when they're the acting care team member view in the sense that if a patient needs a foot exam or an eye exam or something we're prone to send an order set to the in basket and say, you know, the patient's overdue, it looks like they probably need an eye exam so all the clinician does is sign it or not, and so I guess I'd agree with the concern about prescribing too closely how this gets done, because I'm confident that in 5 years all kinds of things will be managed in business process management systems or workflow engines, whatever you want to call them, and rarely, if ever, come to view in any way except as just the actionable thing to authorize.

**Gene Nelson – Dartmouth University**

This is Gene again, I see the reservations that you're bringing up, I'm thinking for example of the Swedish Rheumatoid Arthritis Registry where by monitoring in a visual way the patient's current and changing status against their medications as a country they are moving towards faster improvements on disease activity scores using visualization as a data in near real-time as a primary mechanism, so I was focusing on this issue of operational improvement that can show patient benefit and the important role of visual displays in accomplishing that.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Okay, good point. Well, I thank you for the excellent discussion I think we need to be fair with public comment and move to that, but in our next meeting you can see we have some other issues to work through and I hope we'll see you all there.

**MacKenzie Robertson – Office of the National Coordinator**

Okay, operator can you please open the lines for public comment?

## **Public Comment**

**Caitlin Collins – Altarum Institute**

Yes. If you are on the phone and would like to make a public comment please press \*1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. We do not have any comment at this time.

**Jim Walker – Chief Information Officer – Geisinger Health System**

All right, Jacob, MacKenzie any final housekeeping?

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

I think my only housekeeping thought is really just a bit of reflection that as we meander into the autumn months the Policy Committee, for those who aren't familiar with what's going on over there, the Policy Committee is ramping up their work for Stage 3 and so the sequence of events that is going to occur is that they're going to start to consider a very draft view of what Stage 3 looks like in August and over the course of the fall will solidify that picture of what Stage 3 looks like, and then following that solidification, probably November/December or so, they will then ask the Standards Committee to plan for, you know, what the technical and standards infrastructure would need to look like in order for certified EHR technology to be capable of permitting meaningful users to meaningful use the systems in the context of that Stage 3 vision.

So, I think what we may have is, while I won't say we'll be idle, there will be less pressure on us to produce now as much as there will be in the spring when there will actually be quite a bit of pressure on us to respond to the requests of the Policy Committee if that makes any sense to folks, just want to give that head's up.

**Floyd Eisenberg, MD, MPH, FACP – National Quality Forum – Senior Vice President of Health Information Technology**

And this is Floyd, just a quick question on that, I want to make sure that there is at least enough cross pollination of the discussion in what's happening in policy that there are feasible requests being made to Standards Committee.

**Jim Walker – Geisinger Health System – Chief Information Officer**

Yeah, this is Jim, I mean, there is absolutely careful work going on to try to make sure that we do a little less playing telephone, a little more direct communication, get their ideas early in the process so that we can start feeding them back to feasibilities as we go, so we're working hard to work...I guess to multi-thread much more closely than we've done in the past. So, I think... and I think that's the message probably, Jacob, is that right now it's not real hot but fairly shortly we'll be given a pretty clear set of tasks to work through so that they can get their work done faster so that we can provide something to the country in time that people can actually implement it.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

Precisely, yes, we are trying to be more agile about this process as we are in the industry, well put Jim.

**Jim Walker – Geisinger Health System – Chief Information Officer**

All right, thank you all for your time, have a good day.

**Jacob Reider, MD – Office of the National Coordinator – Acting Chief Medical Officer**

Thank you.

**MacKenzie Robertson – Office of the National Coordinator**

Thanks, everybody.