

**Clinical Quality Workgroup  
Draft Transcript  
August 27, 2012**

**Presentation**

**Operator**

All lines are now bridged.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Thank you very much, operator. Good morning, everyone. This is Mary Jo Deering in the Office of the National Coordinator for Health IT. This is a meeting of the Health IT Standards Committee's Clinical Quality Workgroup. It is a public meeting and there will be time for the public to comment at the end. I will ask everyone on the line to please identify themselves when speaking for the transcript. I'll begin by taking the roll. Jim Walker?

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

Here.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Karen Kmetik? David Baker? Keith Boone?

**Keith Boone – GE Healthcare**

Here.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Anne Castro? Chris Chute? Jason Colquitt?

**Jason Colquitt – Greenway Medical Technologies**

Present.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

John Derr? Bob Dolan? Floyd Eisenberg?

**Floyd Eisenberg, MD, MPH, FACP – Independent Consultant**

Here.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Rosemary Kennedy? Rosemary, are you on mute? I think you're on. I know she checked in. David Lansky? Brian Levy?

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

Here.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Rob McClure? Galen Murdock?

**Galen Murdock – Veracity Solutions**

I'm here.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Gene Nelson? Eva Powell? Phil Renner? Eric Rose? Danny Rosenthal?

**Danny Rosenthal – Inova Health System – Director of Healthcare Intelligence**

Here.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Joachim Roski? Randy Woodward?

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

Here.

**Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology**

Okay, would staff on the line please identify themselves.

**Jacob Reider, MD – Office of the National Coordinator**

Jacob Reider, ONC.

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

Jon White from AHRQ.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Okay, back to you Jim.

**Rosemary Kennedy – Thomas Jefferson University**

Rosemary Kennedy.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Thank you, Rosemary.

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

Thanks Mary Jo, and thank you all for joining. We have a little bit of a light agenda today, so, either we have plenty of time to discuss governance principles or we may give you back a few minutes. But, let's start, as you see, we're going to update ourselves on the Value Set Authority Center, at least begin a discussion of value set governance principles and value set versioning and then Jacob will talk about Clinical Decision Support as just in time Quality Measurement. So, if everyone is good with that agenda, we'll start with the update, and that's slide number two.

So things have gone very well, remarkably well, and ONC has found funding to support National Library of Medicine as the authoritative source for meaningful use value sets. NLM has just about completed the initial validation of value sets and has identified some clean-up work that is needed for some of them and is coordinating that with the various value-set authors; so, all of that is moving ahead really remarkably briskly. Any comments on any of that?

**Jacob Reider, MD – Office of the National Coordinator**

I'll only add that the first shred of evidence of the existence of this thing is what we're calling the Quality Data Elements Catalog, which has now been posted to NLM's website and visible to anyone, and it was referenced in our final rule on Standards and Certification last week. So, there is a link to it in the rule and it points to a page on the NLM's website that really lists each data element. And if you think about each data element as essentially the name of a value set, what you'll then see is this thing will grow, I don't know, branches or roots or whatever metaphor you want to pick, so that there will be depth to each and every item on that list. So folks can start to see exactly what the breadth of the list is, and then you'll see the depth when the value sets appear underneath that when the final specifications for the CQMs are released by CMS in a month or two.

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

Great, thanks Jacob. Any other comments or thoughts? Okay. Well let's go to slide three then. So that excellent set of accomplishments sets the stage for the next bit of work that we have, which is to address value set governance and then longer term infrastructure needs, you see them there. In slide four then is a very draft set of value set governance principles. It's intended ... well, to be accurate as far as it goes, but to be very much a discussion starter. So, I think you can see them there, but really, the heart of this meeting is to talk about what additional principles would be needed, if there are some of those there that aren't really principles or that need refinement to make them more useful or useable.

**Jacob Reider, MD – Office of the National Coordinator**

Are there concerns or critiques? Do folks have questions about why this is important, or is everybody just on board with things and that's why it's quiet?

**Floyd Eisenberg, MD, MPH, FACP – Independent Consultant**

This is Floyd. I think obviously it's important and I'm looking at your five bullets, they seem to cover all of the highly significant areas that I've thought through.

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

Other comments? And since we are on the phone, and it's hard to see people's faces, both negative and positive will be helpful, just to get a sense of...obviously this needs to be built out, but we also want to make sure that it's right at the high level before we go further. So please, do comment.

**Rosemary Kennedy – Thomas Jefferson University**

This is Rosemary. I just wanted to concur with what Floyd said and also I guess it would be covered under mission and strategy, but the overall purpose or what the deliverable would be, and I assume that's kind of covered under that mission and strategy.

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

Thanks Rosemary, this is Jim. We'll make sure that that is captured. I think that was the intention, but we'll make sure of it.

**Floyd Eisenberg, MD, MPH, FACP – Independent Consultant**

And this is Floyd, one more time. I also assume, since we're talking about decision support as a real-time quality measurement, that the scope is also under the mission and strategy and does this extend beyond government programs would be listed there, I assume?

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

Okay, great. This is Jim again. Floyd, could you just elaborate on that just a little bit.

**Floyd Eisenberg, MD, MPH, FACP – Independent Consultant**

In other words, there are under government programs contracted measures and requests related for decision support related to that perhaps, but there are other measures that are not within government programs that will require value sets. Are those value sets submitted by outside stakeholders also to be covered under the Value Set Authority Center? It's obviously a scope issue and a funding issue, but that was...that's where the question came in.

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

Okay, thank you. Great point that we'll try to capture in the next version for discussion. Any other, this is Jim again, any other thoughts on what Floyd just said about scope, what should be in and what should be out, what the importance of the different components would be?

**M**

Go ahead.

**Christopher Chute – Mayo Foundation for Medical Education and Research**

This is Chris Chute. Sorry, I just joined so I only heard the tail end. But, it really gets at, if it's going to be a national value set center and if we're really trying to have comparability and consistency, then ought the notion of measures that are not national, so to speak or appropriate, is somewhat confusing to me, particularly when we're talking about having standardized value sets. I mean, I agree it's a scope issue but personally, I would be discouraged if the National Value Set Center started including what would you call them, idiosyncratic or non-standard or esoteric measures that are not recognized or sanctioned as a national resource.

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

Okay. Others? Someone else started there.

**Keith Boone – GE Healthcare**

This is Keith Boone. I guess one of the things that I imagine would be covered under policies for shared decision-making or somewhere in here would be issues of Metadata use to describe and access value sets. I don't see anything really in the governance principle identifying any of the technical artifacts that are needed.

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

Okay, that's great. Could you say just a little more about that?

**Keith Boone – GE Healthcare**

Well, in terms of dealing with value sets, we need to understand what's the structure in which value sets are accessible, are we storing them in Microsoft Excel, CSV files, are we downloading them in a technical format, do we need more specifications for what Metadata would actually be stored with the value sets, etcetera.

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

Okay. Great, thank you. Other comments, critiques, additions, refinements?

### **Jacob Reider, MD – Office of the National Coordinator**

This is Jacob. I would, so, Chris, does Keith answer some of your question, and I'm just reading between the lines here. If there were Metadata that would include some kind of certification or stamp of approval from some entity, whether it's the Federal Government or NQF or something else, and then that stamp of approval was attached to each thing, then could one use that Metadata to filter the right stuff.

Because...and I'm channeling...going to channel NLM here a little bit, in general it's a library, so, they don't like to say no to things, right, it's not their job to filter stuff coming in. In fact, if we make this right, then people could filter as they consume. So, you might have, I don't know, the value set for the kid's lemonade stand and it might actually be in the repository, but when you did a query, you might say, "give me all the federally specified Meaningful Use Stage 2 clinical quality measure value sets, and those would be the ones that you'd get. Does that make sense?

### **Christopher Chute – Mayo Foundation for Medical Education and Research**

I understand what you're saying Jacob and, to some extent, and by the way, I concur with Keith's assertion, now that I'm looking at the slides, that it would be handy to have terminology services specifications that would include, of course, the requisite Metadata. Would that resolve my anxiety about idiosyncratic value sets, possibly? But frankly, this is a political question. I understand the Library's philosophy and I would think that for things that are less sanctioned, I mean, that's what the UMLS is for, that's what other resources are for. But if we're going to have a national value set repository that is intended for interoperability, then putting the kitchen sink in there, or the kid's lemonade stand in there, it's technically possible, you could filter it with the Metadata. But, it seems to be softening or flattening the goal of establishing a national value set center that would serve the purposes and goals of interoperability.

The big problem with letting everybody in with their associated Metadata is that you will inevitably have redundant and conflicting content where you could use this or you could use that. And if you subscribe as I do, I think most of us do, to the goal of interoperability where there is a prescribed value set for associated findings and content, then you obviate all this ambiguity by having a fairly strong curation process for getting the content in there in the first place, and not letting the kid's lemonade stand, even if they have corresponding Metadata, into that particular collection. It's not to say NLM wouldn't carry that content, it's just that it wouldn't necessarily be in the National Value Set Center.

### **M**

Makes sense.

### **Keith Boone – GE Healthcare**

This is Keith. To carry Chris' sort of explanation a little bit further. We have two different things here; we have a library of value sets and we have a particular collection in that library that I think are the national value sets. And I think the requirements to be in that collection are much more stringent than what might be possible to be in a library, because all it has to do is be publically available, be published necessarily to be in a library. But to be in a collection, you need a much higher level of vetting process or, as Chris called it, curation.

### **Brian Levy – Chief Medical Officer – Health Language, Inc.**

This is Brian Levy. One other point is, is there going to be...let's say we have this collection of value sets, we need someplace where, for example, the vendors know which value set do I use where, and that might be a separate area. So we might have a large repository of all these value sets, but you still need some kind of instruction manual and say, okay, here's when and where you use this particular value set.

**Christopher Chute – Mayo Foundation for Medical Education and Research**

That is the binding Metadata as I would characterize it, and I agree, such binding Metadata is needed, whether it is part of the Metadata associated with a...or whether it is Metadata associated with the emergent information models or metrics. I mean, I suppose you could put it in both places. But, I had more or less envisioned that binding specification would be part of the user guide or profile associated with the data element or the metric, rather than an intrinsic property of the value set. And the reason I say that is, a given value set if it's well designed, could actually have multiple slots or use cases and that starts to get confusing if the documentation...conceivably, something like administrative gender could have hundreds of places where it would be bound and putting the binding data in the value set as opposed to in the data element has a potential for making that complicated.

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

So this is Jim. If I could sort of reflect on Chris and Keith's comments. It sounds like a governance principle might be to define criteria for inclusion of value sets. Is that getting at what you guys were after?

**Christopher Chute – Mayo Foundation for Medical Education and Research**

That would be good. And I think whether you call it vetting or curation, I mean, vetting is whether it gets in, curation is whether it's redundant or overlapping, I make the distinction, and so I think both processes should be added to that sentence.

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

Okay, great. Thank you. Other comments? Okay, I'm hearing pretty solid silence. We will try to take the comments, create an improved set of governance principles for maybe near final discussion at our next meeting, send that out by email pretty quickly here so that people have an opportunity to look at them, either make refinements or add things that didn't come up in the discussion so that perhaps at the next meeting, we can have final or near final discussion of the principles that we believe are important for governing value set activity. Thank you, great discussion. So then Jacob, you're slide five I...oh no, wait a minute, where are we. Slide four. No, I've lost your slide in here Jacob. I guess it is moving the bar on quality, slide five, sorry.

**Jacob Reider, MD – Office of the National Coordinator**

So what...I guess I'll first state the obvious, which, most of you know of course, but I wanted to be able to address some of what happened last week. So, the final rules are now public. Some of what we were aiming for here is reflected in the final rules in that we tried to describe both clinical decision support and clinical quality measures as related to each other inherently. When we had the hearing in the summer on quality measurement with the Policy Committee and this Committee, there was discussion of clinical quality measurement and clinical decision support being much more related than they had been discussed in the past. And so we heard testimony that, if you do a report doing clinical quality measures, six months into your project and then you look back and then you make an intervention and then you look again, it's years before you actually see improvements of clinical quality. So, if we shorten that timeline and we say, well, in fact, CDS is just exposing you to how you're doing relative to those quality measures right, and so the measure is supposed to be an expression of a goal that we're all trying to meet and so this is the concept that these things are really crazy glued together.

So, some core questions here, if you look at bullet number two, how do we figure out which are the right interventions to really move the bar in terms of quality. So, both giving guidance as someone mentioned earlier, guidance to an organization, I think Brian said the vendors need a road map or a manual. But how do the providers and the vendors work together so that they can best identify the right opportunities here, that align with national quality strategies and, of course, the goals of meaningful use incentive program. So, how can we do the technical work around clinical decision support so that folks can: a) better understand it, as we think about Stage 3 and better prepared to do these sorts of things, to do the real-time decision support, real-time quality measurement? So is it a dashboard, is it a dynamic template or a forum or something like that. So that's really, and I've probably said more than I needed to, a short paraphrase of what came out of the meeting and also what we're hearing folks in the CDS community express as we prepare for Stage 3. So, I'll be quiet there, if there are thoughts, comments or critiques or adjuncts, I'm interested in hearing them.

### **Keith Boone – GE Healthcare**

So Jacob, this is Keith. I would think that yes, you probably did probably say more than was necessary. In terms of identifying needed interventions, I think here is a case where what we really want is to look at what the market does with respect to innovation rather than necessarily being prescriptive. In other words, dashboards can be helpful, templates can be helpful, and workflow engines can be helpful. There are a whole lot of things that can be helpful, and we still don't even have, at this point in time, standards that allow us to interchange clinical decision support and interventions. So to start talking about, or providing guidance on what people should do with respect to clinical decision support, I think we're a little bit too early for that.

### **James Walker – Geisinger Health System – Chief Information Officer**

This is Jim. I think there are some things we could do to help this, to guide people's development is...I think everyone agrees that reimbursable meaningful use will not, cannot embrace all of the interventions that have been demonstrated in high quality clinical trials to improve people's health and well-being. And, granted that it would be useful if the sector had a validated list of potential health care interventions and the attributable quality adjusted life-years potentially capturable in the population, if those interventions were carried out. So that, for instance, the reason that cardiovascular rose to the top in one set of considerations was that there's fairly widespread sense that is reasonably evidence-based, probably very evidence-based, that some of those cardiovascular interventions present the largest opportunity to improve the health and well-being of the population as a whole. Although there are other things like say childhood immunizations that may have larger quality adjusted life-year impact in the population.

The problem is that nobody, NQF, NLM, ONC, CMS, anybody else has a validated list of the top four hundred by how many quality adjusted life-years in the population we can improve if we perform whatever the intervention is pretty consistently. And it seems to me that that would be useful both at the federal level, but also for HIT developers and care delivery organizations as they do what I think Keith was sort of indicating, what they're going to have to do, which is develop much of this on their own, either before or without the Federal Government designing them. But at least then we could do it in some kind of evidence-based, justifiable, transparent way.

### **Christopher Chute – Mayo Foundation for Medical Education and Research**

This is Chris. I don't think I disagree with anything that's been said, but I'm going to change gears a little bit and Jacob, I think this really gets at workflow expectations and methodology to somewhat...unfortunately, I'm trained as an epidemiologist so I'm deeply aware of study design issues and expectation. The way you phrased it, this notion of just-in-time dashboards or getting clinical decision support and outcome measures or related measures and metrics in near real-time, I mean I'm a great one for agreeing that where practical, we should have as rapid a turn-around on information flows as practical. But when it comes to workflow and making intervention changes or decision, retrospective is not a bad word. And in particular, for observational data which is not prospective clinical trials, you don't have literally a data monitoring board; in that context you're working with non-experimental, opportunistic observational data, which requires time to accumulate and achieve any kind of statistical power, reliability or predictability. And that de facto means that you're going to be accumulating data for, I don't know, in an ICU it might be hours, in an outpatient setting it might be days, weeks or months. But for some period of time, before you're in a position to hit the analysis button and have any prayer of coming up with a valid inference. So, I would not have an expectation that these are going to be real-time dashboards that as soon as the needle moves, you do something different. That actually would be quite dangerous and potentially misleading in the vast majority of cases. I really think while collecting data in a timely way or a near time way is fine, having an expectation that that's going to influence intervention strategy in near real-time is extremely naïve and extremely dangerous.

### **James Walker – Geisinger Health System – Chief Information Officer**

Chris, this is Jim. That's why...that's the intention of just in time, so that for a process like you're talking about, just in time might be months or years; if you're talking about drug-drug interactions, just-in-time would be sub-seconds. But the point is, that it's got to be appropriate to the, as you're saying, the quality of the evidence and also the urgency of the...the time sensitivity of the decision.

**Christopher Chute – Mayo Foundation for Medical Education and Research**

But I was having a knee-jerk reaction to the first bullet, which says, “retrospective reporting is too late,” like retrospecting ...

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

No, no, I agree with you. That’s...we didn’t edit that right. Good point.

**Floyd Eisenberg, MD, MPH, FACP – Independent Consultant**

This is Floyd. I just want to add to that, of course Chris said it much more eloquently than I could, but one of the issues identified early on in some of the measures with Meaningful Use 1 is; one they were process, but trying to fit an annual measure into a ninety day time period doesn’t work well and it’s hard to know how to address that. And based on that experience and some of these comments, perhaps as we’re looking at measures for meaningful use and programs, the measures could help identify what are appropriate points during the process where it is okay to evaluate your current status. Especially if we’re looking at delta measures change over time, is two months too soon, is three months okay but really we’re going to measure at six months. I think that kind of information, if it can be provided along with the measure would help as advice to implementers.

**Rosemary Kennedy – Thomas Jefferson University**

This is Rosemary. Just to follow up on what Chris and Floyd said. Is there an opportunity to use some of the measures as a trigger at the point of care to help guide and support some of that just-in-time decision-making, to trigger a clinician to take action and use some of this data infrastructure that’s being built, such as the value sets, as input data to help guide the decision-making more real-time.

**Christopher Chute – Mayo Foundation for Medical Education and Research**

Well I think what we’re conflating here is the notion of decision support and the notion of inferencing on a longitudinal body of data to identify changes to that decision support rule. I think Floyd said it very well, we really...having guidance associated with each measure as to what an appropriate timeframe of data might be to evaluate whether frankly the rule is appropriate. That’s the inferencing bit. But I think everybody expects that clinical decision support, once we have a rule set or a version of a rule, these things will be versioned and changed over time undoubtedly as we learn more, but I think the expectation is that that rule would fire real-time and inform the clinician in near real-time whether the patient is in conformance with a rule or not, or the decisions or orders or whatever the interventions are, are in conformance with that particular rule. But that’s distinguished from inferencing about generating a new rule.

**Jacob Reider, MD – Office of the National Coordinator**

This is Jacob. I want to kind of bubble this up, because I think this is important, but I think we need to translate our important conversations about how to interpret what I said initially to, is there or should there be action items for this committee. Because I think that was why I said the provocative things that I said and what came out of that hearing in June was potentially provocative, but potentially also meaningful in terms of action for this group. So Keith said one thing that I want to pick up on. Keith said well you can’t share stuff, and so the Health e-Decisions Project, which many of you know about, but perhaps some don’t, so I’ll make sure I mention it.

The Health e-Decisions Project is a standards and interoperability framework initiative that is focused on aligning the various standards, methods of expressing clinical decision support, interventions or artifacts so that they can be portable. As many on the call know that there have been many attempts to do this, Arden is one, GELLO might be another, partners has an L3 schema that they have discussed publically, and there are some others. And yet none has really taken off, none has been adopted by the Health IT community globally and so, if one was going to think about having Stage 3 include a requirement for CDS interventions to be moved from one place to another portably, we're going to need to align on something. And so that's part of the goal of the Health e-Decisions Project, is to align on something so that something may be available. So, though in addition to that, which I think was actionable in the sense of tracking Health e-Decisions and even supporting it in some way by providing guidance and recommendations from this committee to Health e-Decisions or from the committee to ONC, and then to Health e-Decisions. Are there other action items that folks see as necessary in order to get to where we need to be to prepare Stage 3?

**Christopher Chute – Mayo Foundation for Medical Education and Research**

Jacob, I like that emphasis. You basically, if I could re-interpret what you're saying, it's not so much providing input to one group or another, but if I could generalize it, it's really raising the specter of whether the Standards Committee should explore a Meaningful Use phase 3 specification for guideline interchange format, which is, as you correctly point out, has been a holy grail and not...there have been many runs at that particular windmill over the decades. But having enough critical mass and influence and tipping point to establish such a specification in meaningful use is a very attractive mechanism for doing so, would be good. I hesitate to say that though, because it is a difficult and challenging task, as you know. And I think if we're going to do that properly, that's going to take a significant amount of energy, effort, time, analysis, maybe even public hearings on what are...one, what is the state of the art of guideline interchange and two, what are the available candidates and three, what seems to float to...what are the criteria to distinguish among them or generate a hybrid among them.

**Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology**

That is precisely the goal of the Health e-Decisions Project and that is what the Health e-Decisions Project has been doing since its launch in May. So, spot on Chris.

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

This is Jim. If Health e-Decisions is doing that, what would be the value add of this group.

**Jacob Reider, MD – Office of the National Coordinator**

Well, I think two-fold. One, recognition; so if this group says, hey, Health e-Decisions, that's a good idea, but B, here's what we see as perhaps either a shorter path to the solution or hey, it doesn't seem like you've captured the need for X and maybe there's an unfortunately longer path or something that hasn't been considered by the Health e-Decision Project. I know some folks on the call are involved.

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

This is Jim again. So, is Health e-Decisions using the standards assessment tool or methodology that Dixie Baker's committee reported at the Standards Committee the last meeting or the meeting before that probably? I think that would be one first step is to apply that set of criteria to the Health e-Decisions work.

**Jacob Reider, MD – Office of the National Coordinator**

So, Health e-Decisions is following the standard S&I framework process. So, there's a sequence of pre-discovery, discovery, charter, writing use case definition and so there has been a fairly thorough analysis of what's out there and review of the various options. But I don't know if the tool that Dixie described has explicitly been applied.

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

I think that would be useful, partly, just so that we're eating our own dog food, but also so that it's expressed in a standard way.

**Floyd Eisenberg, MD, MPH, FACP – Independent Consultant**

This is Floyd. Jim, actually I wonder if that framework would be a good way for this committee to evaluate the work of Health e-Decisions recommendations.

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

This is Jim. That would be fine if Health e-Decisions doesn't want to do it, I want to make sure that we're not duplicating their work or really adding to it. But that would be great.

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

So, this is Jon White. Lots of things to say that I will not bore you with; however I will simply say this. I think that there are a lot of places where we don't know whether or not certain types of decision support work or not. But, I think the evidence would back me up to say that we're at a place where we can say that decision support does help us improve process measures, things like that. So, on the question of do we address this or not, I think it would be a shame to not take a run at least saying, are there standards for us to push forward that can help us come to a standard way to move this intervention that does improve quality.

**Galen Murdock – Veracity Solutions**

This is Galen. I'll add that...knowledge of what's going on in the Health e-Decisions Project. I'm frankly impressed with not only the work and the thoroughness of the research that they're performing, as well as the...but also the number of vendors that are participating in the process of deciding what those standards should be. And finally, frankly the overwhelming evidence that so many other parties are interested. I think at one point, and don't make this official, but there were hundreds of people on a particular call trying to either participate or provide feedback in some form. And so interest has reached a peculiar and important level to where we may indeed have a tipping point, with regard not only to defining a standard or identifying a standard, but with regard to adoption and use of such. I too wonder about what best this group can do. I wholeheartedly endorse an endorsement of Health e-Decisions and what they're doing and that we draw attention to it. And I am interested in exploring how this group can help either ratify, extend or at least explore what they're doing if I'm unaware of the relative authority of each counsel, of each group, but to the extent that we have some degree of clout, our voice I think should be heard.

A second question, if I could add to an earlier...if I could invite just a brief pivot, I think it's important to consider not just CDS, clinical decision support, but the near real-time nature of it. On a previous call we discussed real-time, near real-time; today we've I think appropriately adjusted the definition of just in time. But I see, if this group has influence, I see some value in describing the importance of near real-time to vendors who are considering going down this road, whether today or in the near future, specifically because I hear of some vendors excluding the need for near real-time and simply focusing on a long term longitudinal repository-based approach that's almost retrospective in nature. And I, as a software architect in one of my hats, would want to make sure that organizations include the near real-time component in their planning, if not in their execution.

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

This is Jim. My concern with real-time or near real-time is that I'm fairly sure that it comes out of a focus on clinical decision support as occurring at the point of care. And, effective clinical decision support is already in lots of organizations being sent directly to patients for them to transact outside of the point of care with appropriate keeping track and management. And we don't...I think we don't want to straightjacket ourselves into a view of clinical decision support that continues to jam the point of care with all kinds of things that many patients are thrilled to take care of outside of the point of care, and keep us from developing workflow engines or business process management systems that enable all of that clerical stuff to be done elsewhere if the patient prefers it, so that the actual point of care is focused on the patient's needs and preferences and unique situation and negotiating a care plan and so forth and so on. So, the idea of just-in-time is, if it's drug-drug interaction, it's got to be sub-second and if it's something the clinician really does have to do when the patients there, particularly inpatient, but even some outpatient, that it is near real-time; but in other cases, it may be weeks or even months. And the point is that it's appropriate to the need, not that we put it into some kind of straightjacket because we're worried about sloppy HIT developers.

**Galen Murdock – Veracity Solutions**

This is Galen. If you're proposing then that just-in-time encompasses the idea that near real-time is appropriate in some cases and not in others, as adjusted to the clinical need to best benefit the patients, I'm definitely in support of that and can, if you will, kind of put away my goal of focusing on near real-time as an emphasis and throwing my weight behind just-in-time, provided that there's sufficient emphasis on those things that do need to be near real-time as a part of just-in-time.

**Christopher Chute – Mayo Foundation for Medical Education and Research**

I don't think anybody would object to that, but if I could be...this is Chris Chute...if I could be more holistic. Jim, I agree with you about not just the physician encounter or the caregiver encounter, but the whole population health infrastructure really is a kind of decision support if you think about it, where you're matching over time, patients to a profile, a cohort of patients to a profile of expectations and rules. And those are also decision support and it gets at the whole question of alignment of knowledge and content and rules and I wonder...I presume that the e-Decision group has that in scope as well. Because clearly you don't want one set of rules firing in an acute encounter and then maybe a divergent and somewhat disconnected set of rules managing the population when they're not in an encounter setting.

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

Right. Jacob, do you know, or does someone know is that part of Health e-Decision's approach?

**Jacob Reider, MD – Office of the National Coordinator**

It's a...it's not mature enough yet, so we're not there yet, but I hope will be there in the next month or two.

**M**

Right.

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

I don't know, is that something that this workgroup wants to recommend to Health e-Decisions, or that assist their internal discussion at all?

**Jacob Reider, MD – Office of the National Coordinator**

I think it would. Always helps to focus.

**Jason Colquitt – Greenway Medical Technologies**

Yeah, this is Jason. So, I agree 100% with the discussion so far. I think the foundation of the interoperability and how we move these decision support rules back and forth are crucial, so I think as Keith started off the conversation, I think we've got to start there. We're a part, my company not necessarily myself, am a part of that Health e-Decisions Project, but I think that as the Standards Committee, it would be on us that we got all these parts and pieces of quality measures that we've been putting together as far as the infrastructure. So, I think it would be in part of our purview, and maybe I'm stepping outside my boundaries in saying this, but to make sure that we're informing them of what we're doing with measures. Because again, back to my software development hat and architecture hat, I would not want to build one set to do e-Measures and then another set of rules and processes to engage in clinical decision support.

So, I think we've aligned and got a good process and parts and pieces align to facilitate the measure, so I would think that we'd want to also inform the group that's working on the clinical decision support and make that part of our recommendation to that group. And I know there's a lot of cross-pollination between this group and that, so I don't know how...I know it might just occur on its own, but I think we as a committee should look into formally engaging that group.

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

Thank you. Other comments, thoughts?

**Keith Boone – GE Healthcare**

This is Keith...

**Floyd Eisenberg, MD, MPH, FACP – Independent Consultant**

This is Floyd, I just have another maybe it's a little deeper question about the Health e-Decisions and the other work on decision support. I agree with everything that's been said so far, and I think what one of the issues may be is to whom or what does the decision support send a recommendation. Is it to the patient as one role, is it to which type of physician, which type of care provider, other individuals. So, is there some way this group might want to look at how to define roles of individuals, the computer itself may be a role that needs to be informed. I'm not sure there's a clear standard on that, although others could specify it better than I.

**Jacob Reider, MD – Office of the National Coordinator**

Sounds like a role value set, closes the loop...today.

**M**

I'd be fascinated to...

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

This is Jim, I agree with your point Floyd, my concern would be that we know so little...that there's so little science about that, you know, there are some licensure rules I guess, but there's so little science about that that I would be a little concerned about trying to enunciate standards until we've done maybe some more research to...when we do that, we do exactly what we're talking about. We say, well okay, this is one we believe it's appropriate to go directly to patients and have follow up and we believe that if the patient doesn't respond in two weeks, it's appropriate to have a script that the call center calls and reads to the patient and so forth and so on. But, that's done, I guess on expert opinion or something much more than on any research that I'm aware of about what's safe and effective and so forth.

**Floyd Eisenberg, MD, MPH, FACP – Independent Consultant**

So I would agree with that. This is Floyd again. My question though is, should this group identify that as a gap and look for ways to identify the state of the art as it is.

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

This is Jim. I think that's a very good suggestion. We're up to two minutes from public comment. I think that the discussion sort of has us to the point where it's appropriate to consider whether this workgroup wants to recommend to Health e-Decisions a strong focus on CDS interoperability supporting what they're already doing and a recommendation that they consider seriously clinical decision support that is activated outside the point of care. So, I'm just going to take the prerogative of the chair and say, is anyone willing to make and second such a motion that we recommend those two things to Health e-Decisions?

**Christopher Chute – Mayo Foundation for Medical Education and Research**

So moved, Chris Chute.

**Galen Murdock – Veracity Solutions**

So seconded, Galen Murdock.

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

Okay, since we're on the phone, are there any opposed? All right, so we'll make that sort of expression of support and recommendation to Health e-Decisions. And next week, I think we want to go back over the governance princ...or next meeting, sorry, we want to go back over the governance principles and try to nail them and then I think, start to talk more about CDS interoperability, other topics that people think are sort of next up on the agenda, perhaps Floyd's suggestion that we talk about roles, at least in a best practices sense, sort of roles to receive CDS, particularly if Health e-Decisions hasn't already plowed that field. All right, thank you all very much for what I think was a productive meeting and let's go to public comment please.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Thank you Jim. Operator, would you 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.

**Mary Jo Deering, Ph.D – Office of the National Coordinator for Health Information Technology – Senior Policy Advisor**

Thank you.

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

Thank you Mary Jo. So, that leaves us five minutes, four minutes. Any other comments about next steps, other comments for the good of the order.

**Caitlin Collins – Altarum Institute**

We have received a public comment.

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

Okay.

**Caitlin Collins – Altarum Institute**

Carol Bickford, please proceed.

**Carol Bickford – American Nurses Association**

This is Carol Bickford from the American Nurses Association. Based on your conversation that you were having towards the end of the call, it would seem to me that you perhaps would want to do an outreach to the group that was working on the clinical decision support stuff that you were talking about, to get a sense of their thinking. That would then help you be more informative in providing them recommendations.

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

This is Jim, that was about the roles definitions or...which specific topic was that in relationship to? Thank you for the comment.

**Carol Bickford – American Nurses Association**

It was in relation to the discussion about the e-Decision group, I think is what was described. I don't remember the name of the other group that's making the initiative, but it seemed like they're...a presentation to help understand exactly where they are going and their thinking would inform your thinking in helping give them some other direction.

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

Thank you.

**Keith Boone – GE Healthcare**

This is Keith. I'd love to second the commenter's statement on that. I think just a general presentation from Health e-Decisions reporting on their current progress and what their current thinking is and where they're headed would help us quite a bit on our next call.

**Jacob Reider, MD – Senior Policy Advisor – The Office of the National Coordinator for Health Information Technology**

So, would folks like us to get somebody from that group to present next call, is that the question...or the...

**Keith Boone – GE Healthcare**

That was my intent, yes.

**Jacob Reider, MD – Office of the National Coordinator**

Consider it done.

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

Great, thanks. I think we'll want to make sure that the governance question is not time sensitive, but if that's not, because I think...this is Jim. I think we do want to give the Health e-Decisions presentation all of one meeting, I don't think we want to put it after something. Any other comments then, thoughts? All right, thank you all. Have a good day.

**Christopher Chute – Mayo Foundation for Medical Education and Research**

Thank you.

**M**

Bye.

**M**

Thank you.