HIT Standards Committee
Clinical Quality Workgroup
Transcript
November 7, 2013

Presentation

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Thank you. Good afternoon everyone; this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Clinical Quality Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Marjorie Rallins?

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Danny Rosenthal?

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Hi Danny. David Baker? Keith Boone? Anne Castro? Chris Chute? Jason Colquitt? John Derr? Bob Dolin?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Here.

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Floyd Eisenberg? Hi Bob. Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
Present.

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Rosemary Kennedy?

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
David Lansky? Brian Levy?

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Rob McClure?

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Galen Murdock? Galen – I'm sorry, Gene Nelson? Philip Renner? Eric Rose?

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Joachim Roski? Randy Woodward? Kate Goodrich? Kim Schwartz? And are there any ONC staff members on the line?

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Thanks, Julia and I will now turn it over to Marjorie and Danny.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Thank you and this is Danny, is it a problem that I'm actually on the public line?

Caitlin Collins – Project Coordinator – Altarum Institute
We moved you over because you should be here.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Oh, good, thank you.

Caitlin Collins – Project Coordinator – Altarum Institute
You're in the right place.

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

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
So, then why don't you go ahead and start today?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Oh, good, so we've gotten feedback from the group that we want more clarification about our specific charge. So, what I want to do is spend a few minutes of trying to answer that question and we're going to get feedback from Julia on how well we are reflecting the charge to the group before we jump into our other agenda items. Navigator can you go to the second slide deck on the direction slides?

Okay, so basically what we did was we went back to ONC and asked for clarification. We got a number of different thoughts and we sort of called them together, Marjorie, Julia and I to represent what the current ask is.

So, Doug Fridsma suggested that we frame the questions with the broader scope of what does it mean for our group to be successful and here were the three bullet points that he said we should be striving for, quality improvement, measurement and reporting should use standards that are consistent and harmonize with each other and a lot of these are repeats obviously.

These measures and their standards should support incremental and iterative development, else each iteration starts from scratch, which is not very efficient. And lastly, systems to support quality should be modular and maintained over time as requirements and thus the nature of quality evolve, else the systems are not agile and do not support quality initiatives. So this is what we're sort of striving for and all of this obviously, in the short-term, is in the context of Meaningful Use Stage 3. Next slide.

So, more granularly we have these 5 bulleted items which were part of the Health IT Steering Committee work plan and these are, as we know, general topics and there are specific questions that we're elucidating for each and every one of these topics.

So, today we'll be talking about – begin to talk about just that first bullet point over there measuring and reporting quality that's the most pressing issue right now. Subsequent topics, clinical decision support, APIs, defect reporting and registry support, but today we're focusing specifically on measuring and reporting quality. Next slide.

So, what does that actually mean, because we can really talk for probably a few months on that topic over there? So, what we tried then to do was try to identify where are gaps that we've currently got for measuring reporting on quality and these can either be real or perceived gaps. What are the gaps that we're sort of hearing on the street as we're preparing for Meaningful Use Stage 3?

So, the first one – and basically there are three gaps around HQMF, QDM and QRDA. Again, these maybe real and some of these maybe perceived and we have to either address or clarify. So, today we'll be addressing HQMF gaps.

So, from a perspective of HQMF are one the feedback we're getting and these are all in lay terms is that it has a limited an logical expression, i.e., it takes a lot to say a little or the QDM we hear feedback that it has limited ability to express concepts. For example if you are defining laterality it can get complex with larger value sets.

And then from a QRDA perspective we've heard that there are concerns that some of the standard development may actually be diverging from C-CDA and what are the associated implications there. So, this is what we're sort of hearing on the street so to speak, the gaps that we have right now with measuring and reporting quality. Today, we're specifically talking about HQMF R1 versus subsequent releases. Can you go to the next slide?

So, as you can see we're sort of drilling down further and further specificity. So, the specific question that we want to answer by the time we disconnect today off of our telephone call is, and we may only start this conversation, which version of HQMF is sufficient for Meaningful Use Stage 3? If none, define the successful outcome for an acceptable version.

Some considerations, well, what do we mean by sufficient? Well, at a minimum we're hearing it needs a more standard way to represent logic and at a minimum it needs more advanced logical functions such as to support area under the curve or more advanced risk adjustment because there are actual measures now that have that need.

What are the options that we're going to be talking about today? Well, R1 is the current option, R2 and then a modular version of R2 or going forward with 2.5. We will have recommendations from our conversation today.

And then the feedback they're also looking for is, in a perfect world what more could we do with the standard? What else would we change and what's our wish list for HQMF features that we would like for Meaningful Use Stage 3? But at a minimum we're addressing the top question today.

In order to answer that question we're basically going to step through each one of these five. Is the gap a real gap? Have we really – is this the question we're trying to answer? Do we have all the considerations on the table? Are these the right options for us? Have a discussion and then what are our recommendations? Can you go to the next slide? Okay, so –

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
This is Eric; can I ask a question at this point?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Before we sort of jump into anything further we are going to have a presentation now by Bob to sort of educate us a little bit further about the HQMF and where it is in various stages of development. Before I hand it over to Bob questions for clarification on our mission for today's call?

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

Robert McClure, MD – Owner/President – MD Partners, Inc.
This is Rob –

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

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

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
Well, this is Eric, one thing that I wonder if it's appropriate to include in that charge or maybe to infer but it wasn't called out, is identifying what are the obstacles to success with just the scope of quality measurement that has been slated for Stage 2 of Meaningful Use because, you know, I have a little bit of concern that if we focus on – you know, what are the things that we want to do in the future and what are the enhancements and so on and so forth we might not be addressing the rather substantial problems that I think exist with just what people are trying to do today and how do we fix those. So, was that intended to be part of the scope of the discussion?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Well, Eric if – right now our focus really is Meaningful Use Stage 3 but I would suggest that any obstacles that we're having right now for Stage 2 should certainly inform what we recommend for Stage 3.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
Right, okay, so what I would say is it's not just about adding new stuff or new capabilities it's maybe trying to make the stuff that's there now work better.

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Is that Eric? It's very hard to hear you.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
Yes it's Eric Rose and I'm sorry for the audio quality.

Robert McClure, MD – Owner/President – MD Partners, Inc.
This is Rob McClure, so, I want to chime in and support of what Eric is saying. I think – and I understand that we need to keep Meaningful Use 3 in mind, but I'd like this to actually get more than just well, you know, we should make sure – you know, we'll hit all the important spots for the current difficulties in meeting MU2 expectations if we just go onto MU3. I think that's actually wishful thinking.

So, I'd like for us to makes sure that whatever we do we think of both of those as equally important and if that's not our specific charge then let's finish this charge and go back and finish the one that we currently should be working on which is making sure MU2 works and then combine the two of them. I don't care which order we do it in, but I won't be satisfied if we don't do MU2 too.

Julia Skapik, MD, MPH – Office of the National Coordinator
Right, Rob, this is Julia Skapik, and I would say that the gaps we've listed here don't remotely represent all of the gaps that exist. We certainly can't move to Meaningful Use 3 without addressing the gaps that have currently created problems for us too and I think Bob is going to address some of the improvements that are already slated which attempts to try and address some of those previous gaps.

Keith Boone – System Architect – GE Healthcare
So, this is Keith, I want to challenge the previous statement about we need to decide at the end of this call whether R1 or R2 of HQMF is appropriate. We are having this introduction into the HQMF material because many of the committee members asked for it and I think we need to give people time to digest and understand material, and make a decision in a thoughtful way based on principles which I hope we'll be discussing next week rather than coming to a rushed decision.

And I'd also like to understand the timing about which we're talking about for Meaningful Use Stage 3. We have impacts of the shutdown to consider and impacts of other things that are going on that all have to fit together and without understanding the timing around which things might happen we may not understand what the status of these standards is going to be with respect to that timing. One of the things that we heard was, things need to be tested.

Well, if we're in a situation where HQMF release 2 wouldn't have been tested because we're going to publish something this year, which I know we're not going to, but I'm just giving that as an example, we wouldn't select it if we were operating based on the principle that it needs to have been tested. So, it's important for us to also understand the timing.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
So, Keith, this is Marjorie, if I may ask a question that's related to timing and MU3, I think, you know, that's a question that encompasses, you know, a lot of efforts and initiatives as it relates to MU3. I don't think – no one knows the timing – there hasn't been anything published on the timing or the change in the timing of MU3. Is that what you meant?

Keith Boone – System Architect – GE Healthcare
Well, I can't make a decision about what's supposed to happen by an unspecified date when we're talking about work that's still in some ways progress and ongoing.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
Right and I understand that.

Keith Boone – System Architect – GE Healthcare
I can't – there's no way to establish "well, when's it going to be ready?"

Julia Skapik, MD, MPH – Office of the National Coordinator
Keith, this is Julia Skapik, I can say that no timeline has been finalized at this point and part of the reason for this discussion is to give people making those decisions as much information as possible. I would say in terms of needing to make a decision today that's not necessary. The way I think we should envision it is in a couple different layers.

Layer one being if we had forever what would we envision the next step being in terms of the standard that would address the gaps and problems we've come to in the past and those that we anticipate for new measure types like risk adjustment.

And then, secondarily to that, assuming that there is going to be a timeline, there is a deadline, what are the steps that we think are required for us to be able to implement that standard in a way that has a good level of quality.

So, certainly, I think a good piece of feedback would be to say, you know, you support this version of HQMF and you would consider the minimum and necessary amount of testing to be blah. So, that's something that we should talk about.

I think this is intended to be a discussion so that we can get opinions and information and use that to inform the larger discussion and selection of standards and the timeline that have yet to be made but are sort of eminently pushing forward without our input.

Keith Boone – System Architect – GE Healthcare
Thank you.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Julia, this is Danny, so if our recommendations are whenever we sort of get to that point, you know, after another few phone calls, if our recommendations are conditional we recommend x, y, z with the assumption that it has "x" number of months of testing "x" number of months of so on and so forth would that be the kind of feedback that would be helpful?

Julia Skapik, MD, MPH – Office of the National Coordinator
Absolutely, because the expertise on this committee is exactly the kind of expertise that could really speak to how we should do that testing and what problems we could envision arising and how we might go about fixing them.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
This is Floyd Eisenberg with a question.

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

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
Thanks, my question is – I'm listening to everything that's being stated and is it a foregone conclusion that we must choose either say HQMF R1 or R2, or QDM as is, or is it possible that we might come to a conclusion, based on principles, that neither is available ready yet and then make a recommendation?

Julia Skapik, MD, MPH – Office of the National Coordinator
I don't speak for the committee so I think that the committee should come to whatever conclusion it does and if – even if opinion is divided and there's not 100% consensus still that feedback is helpful in the decision making process.

Galen Murdock – Veracity Solutions
This is Galen, Galen Murdock, I have a similar question in that I honor the need to provide feedback with conditions on timelines that if say R2 or R2.5 were released what type of testing, how do we adapt it and match it to the principles that Keith did a great job of talking about last time, but I too want to know today – I need to become better educated on HQMF and see how it matches to the concerns and the gaps that we have in MU2 and 3 as well as how it matches to the principles.

And then I believe it's a true statement that it's not really a choice unless we've got alternatives and I want to go on record to say, I'm not invested in any alternative other than an effective one for Meaningful Use, but I know that there are other – in terms of choosing between standards not just revisions of different standards, sorry revisions of the same standards, I know that there are other alternatives that are being actively pursued by the ONC and it would be interesting to understand what that landscape looks like.

I'm only aware of two, today we're only discussing one, there maybe three that require consideration and I feel as though we're moving a little too fast toward a recommendation without, at least on my part, and perhaps I'm ignorant and I'll own that, but without a proper understanding of the alternatives and the consequences.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Absolutely, so thank you, Galen, this is Danny, let me retract my prior statement that we need recommendations by the end of this phone call. What I should have said was that our eventual goal is to have recommendations however long that it takes us.

So, yes, so there is no rush to have recommendations by the end of this phone call and obviously we want to be as educated as possible.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
And this is Marjorie and I'd like to also support that and say that I think it's also important that we consider our recommendations in the context of MU2 as well as MU3.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Great, so I just want to see if there are any other comments about what we're going to be discussing on today's call which sounds like is really education for us around proposing current changes to HQMF and Keith we're going to follow up with you on our next call for a review of the standards for best practices, correct?

Keith Boone – System Architect – GE Healthcare
That's correct.

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

Galen Murdock – Veracity Solutions
This is Galen, I have a request that we carve out just a little bit of time today to design the next two or three meetings if nothing other than an agenda or discussion topics so that we as a team can be aligned around the trajectory not just the end goal, you know, for example, I'm from the West Coast so I get to be a little brash today. No, I would love to, you know, if there is an alternative to HQMF and any of its good releases that whether it's HeD or son of HQMF, or ABC I frankly don't care.

But I need to understand that today we're going to be focusing on HQMF and learning about its excellent strengths and some of its gaps perhaps, next time we're talking about the principles, is the meeting after that one on the standard ABC and the one after that on HeD so that I can begin to plan my time as well as my homework to make sure that I'm making an informed recommendation.

So, if we could reserve some time today on today's agenda to reach some level of consensus around the next few meetings that would be helpful to me.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Galen, how would you feel if we defer that conversation to our next meeting and you can certainly push back, the reason why is because everything that you're sort of seeing today is begged, borrowing and stealing from the attention that we can get from a busy staff. So, this is –

Galen Murdock – Veracity Solutions
I'm very comfortable with that Danny.

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

Galen Murdock – Veracity Solutions
As long as it's in the works it does not have to be today, thank you.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Okay. It's my understanding that ONC is going to be meeting I believe next Thursday or maybe next week to sort of add more specificity to each of these bullet points and so what we can do is once we have that information we can add that as a standing agenda item to the end of all our calls to sort of plan out the next call.

Galen Murdock – Veracity Solutions
Thank you so much. I'll yield.

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
This is Michelle; I just want to add that during the Standards Committee next week there is a plan to talk about the work plan as a whole for the Standards Committee and identify what each Workgroup is working on and kind of re-assess the timeline for each topic that the Workgroups will be working on. So, I'm assuming that something will come out of that meeting that we can then bring to this Workgroup.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Great, thank you. So, if there are no other comments I think we can jump in with Bob.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Excuse me, okay, hi Danny how are you?

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

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Let's see, okay, you have the slides there, great. Okay, so what we're going to try to do here, let's see how much time do you want me to spend on this?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
It's 26 and your slide – you right on time so you have 25 minutes.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Twenty-five minutes, okay. So, what we're going to try to do here is describe a little bit of the history and trajectory of HQMF, we're going take you through version 1, how version 1 evolved, we'll do that kind of quickly, we'll then show what the major enhancements are in HQMF release 2 and then we'll talk about a potential trajectory for future enhancements. So, with that – let's see do I advance the slides myself or does somebody have to do that for me?

Caitlin Collins – Project Coordinator – Altarum Institute
You can –

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
You can just let us know.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Okay, next slide, please. Okay, so here's the – these are the ones we're going to talk about HQMF release 1, after HQMF release 1 became a standard through HL7 CMS and ONC and others convened the eMeasure Issue Group and they reached a lot of consensus and so the actual implementation of HQMF under Meaningful Use Stage 2 is not just about its standard but the eMIG-enhanced HQMF.

And actually from there then we worked very closely with the National Quality Forum to implement, in the measure authoring tool, a series of patterns for the data criteria so that's what I am referring to as the QDM-based HQMF release 1 plus the measure authoring tool implementation that's actually what's in Meaningful Use Stage 2.

I will go through each one of these in a little bit more detail to show you what features were present and how the standard has been progressing. Then we'll talk about HQMF release 2 and the QDM –

Keith Boone – System Architect – GE Healthcare
Bob?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Yeah?

Keith Boone – System Architect – GE Healthcare
You said that's what's in Meaningful Use release 2 but HQMF is not in Meaningful Use release 2.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
For the 2012 QDM-based HQMF release 1 + MAT those are the quality measures that are cited under Meaningful Use Stage 2 that's the –

Keith Boone – System Architect – GE Healthcare
Okay, thank you.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Yeah.

Keith Boone – System Architect – GE Healthcare
Not in the standards and certification but the quality measures that are delivered are in that format, thank you.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Yes, that's correct.

Julia Skapik, MD, MPH – Office of the National Coordinator
Right, and just to clarify, this is Julia Skapik; HQMF is actually not specified as a standard in the rule itself but the measures are published in that format.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Right. So, and we're going to step through each one of these to try to give you a little picture about what actually are the features and how are we progressing. We'll then cover HQMF release 2 and the QDM-based HQMF 2 which is due to be published next week and then things become tentative after that.

And I'll talk a little bit about a potential HQMF release 2.1 and what that might look like and I'll talk about a potential HQMF release 2.5 and what that might look like. So, that's what we'll cover over the next 25 minutes. Next slide, please.

HQMF release 1 was the first international standard for the formal representation of clinical quality measures, metadata, data elements and logic. And to me I know that there were high hopes for having an expression language that could fully encode all of the logic in quality measures.

I'll be, you know, the first to acknowledge, maybe the second to acknowledge that we didn't completely meet all of the objectives, but on the other hand I would say that HQMF release 1 turned out to be an incredibly important standard because at least, from my humble opinion, for the first time we've gotten international consensus around what are the various types of measure types, what are the various types of populations, what are the various ways, what are the formulas by which you calculate a performance score for a proportion measure.

We also standardized the – well we took a stab at the look and feel of quality measures and we tied the data elements to the HL7 reference information model. So, while it didn't meet all of the goals that people had for a standard I think it was, you know, it was a version 1 and so therefore it had some good things such as standardizing definitions.

From there then if we go to the next slide, oh, but actually, sorry, the other thing about this which is really where I think the challenges have occurred is if you look under the logic the capabilities of HQMF release 1 are broad and expressive but unconstrained and what that means is that while you can do a boatload of complex logic operators in HQMF release 1 two different people might choose to do it in two different ways and that's really, in my opinion, what's resulted in the lack of computability for HQMF release 1 is not that the expressivity per see isn't present in the standard but that the expressivity is so broad and so unconstrained that that posed a real hurdle, it's not like a programming language where you know up front what it is to expect.

So, if we move to the next slide what happened was then in 2011 CMS and ONC convened the eMeasure Issue Group and the eMeasure Issue Group was a, I don't know if people here are already familiar with the eMIG, but briefly it's a group of all of the measure developers, all of the ONC measure developers and the CMS measure developers and some other measure developers so that as a group they could all come to consensus where there were ambiguities or things in the HQMF standard that were unspecified.

We worked through the eMIG and that was the time in 2011 that we first added the chapter to the blueprint for the CMS measures management system to describe HQMF, to describe the metadata. We were able to achieve clarification across CMS alignment about the metadata for quality measures.

We embellished, we started nailing down the data elements by defining supplemental data elements so for instance that's where we decided that all quality measures under Meaningful Use would also report race, ethnicity, sex and payer.

And the logic – we didn't really tweak the underlying logic of HQMF release 1, but we did achieve some greater consensus around what the human readable representation of an outputted eMeasure should look like. So, you know, baby steps.

Then we hit 2012, if we could go to the next slide please. Here we were working very closely with the National Quality Forum, Floyd and Danny were intimately involved in this work as were I'm sure many of you, and what we did was we took the quality data model that had been developed by the NQF and we started creating XML-based patterns for each one of those quality data types.

So, for instance there was a quality data type for, you know, discharge diagnosis or a quality data type for active medication, and in each case what we did was we took those quality data types, we aligned those types with what the corresponding representation looked like in CDA, Consolidated CDA, and QRDA and we constrained the HQMF release 1, we constrained the data criteria section of HQMF release 1 so that rather than just inventing any potential representation for a discharge diagnosis or an active medication you would always be using these particular patterns that were derived from the QDM and aligned with the corresponding Consolidated CDA and QRDA templates.

Finally, for this 2012 version the logic, which was expressive but unconstrained in the base standard, was constrained based on the way that the measure authoring tool implemented it. Now some people had some issues about that not to say that the MAT implementation was right or wrong, in fact, it was, you know, a good implementation, but what people were concerned about was where's the source of truth, you know, there is no HL7 standard that I can go to that describes precisely how these quality measures are going to look, all we have from HL7 is the 2010 HQMF release 1 standard and yet the quality measures that are cited under Meaningful Use Stage 2 have actually now been constrained based on the MAT implementation and based on the QDM and that was a little bit confusing to folks. And I'll tell you, as we go forward with HQMF release 2 how we're addressing that.

Let's see if we could go to the next slide please. So, again, this is the basis for the quality measures that are cited under Meaningful Use Stage 2, it's a graphical representation of what I talked about on the last slide. What we did for Meaningful Use Stage 2 quality measures was we based what we did on the National Quality Forum's Quality Data Model.

We took each of the quality data types such as discharge diagnosis, active medication, resulted lab tests and we created XML patterns for each one of those. Those XML patterns were derived from looking at the corresponding CDA templates that were used for Consolidated CDA or for QRDA. So, we created a library of XML patterns and then those patterns were applied to eMeasures to form the data criteria.

Actually the patterns, you know, discharge diagnosis or active medication, the quality data types could be associated with a particular value set and it was really the association between a pattern plus a value set that would form a quality data element or that would form a data criterion.

So, for instance, you'd have the quality data type of discharge diagnosis that might be glued together with a value set for pneumonia, so then you'd have discharge diagnosis of pneumonia that would then form a data criterion in a particular eMeasure and then that data criterion could be used within a population to say that, you know, you have to have that and that or that in order to meet for instance the denominator population or the numerator population.

By the way, interrupt me along the way if this stuff isn't clear, I'm afraid – I'm assuming you guys know a lot of this stuff, but please interrupt me if I need to embellish any more on this.

The bottom line or the key point that we were trying to illustrate on this slide was when we created QRDA and when we created HQMF and when we created Consolidated CDA, while I don't think that everything aligned perfectly, clearly our overarching design objectives were to have, you know, a high degree of inter/intra-specification, consistency so that, you know, if you receive an eMeasure and it includes a data criterion for a discharge diagnosis of pneumonia it would be clear to you how to report that in a QRDA and it potentially would be clear to you how to determine whether or not that criterion was satisfied if you had Consolidated CDAs.

And I think we're going to get even better and tighter in our intra-standard consistency across eMeasures and Consolidated CDA and in fact the direction we're going, that we'll talk about in a minute, with HQMF release 2.1 and 2.2 is to get even further consistency not only across quality measurements and Consolidated CDA but now we're going to throw decision support into the mix so that we're really talking about a pool of data elements and then a common query syntax.

But, anyhow where we were for Meaningful Use Stage 2 was we had HQMF release 1, it was constrained by QDM, it was implemented in the measure authoring tool and for each one of the patterns in the eMeasure there is an association with a particular CDA template.

So, maybe let me just pause there for a minute to see if there are questions about what we did for Meaningful Use Stage 2 quality measures.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
Bob, this is Floyd, can I ask a question?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Please?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
So, I understand clearly, because I have some history with it as well how you implement it in the standard, but your comment about a condition, say a discharge condition and use it or bind it to a value set that says pneumonia is helpful and perhaps consistent in how the HQMF-based CQMs were published, but is there any information about whether the CQMs were actually implemented using that concept of any diagnosis at discharge and I know where to find it so I can go using whatever value set is bound and I can find it in a consistent way?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
I can tell you my, you know, my personal experience about how much of this has – how much of this version of HQMF has been implemented but I can't tell you from any type of systematic survey. What I can tell you is where people have really struggled with this version of HQMF is the complex logic for the population criteria.

The data criteria – I know for instance a couple of natural language processing vendors that parse the data criteria and then they use that in order to surface up to an abstractor, hey we think this quality data element is present and then the human interprets it. I know of only a couple of folks that have implemented the logic in the population criteria.

So, my sense is, you know, the data criteria is pretty easy. I know of a couple of people who have implemented it and what I've heard is that the XML for the population criteria has been hard and has been a barrier for adoption and in general what people do is they read the measures on the left and then they program in the logic by hand on the right.

Some people will parse the data criteria such as the natural language processing vendors but very few people are actually trying to automatically import eMeasures and process the population criteria in order to do, for instance, any type of automated data extraction from an EHR.

And I don't know if anyone has the same or different experience but that's kind of my sense of where we are and that's kind of why we're being driven to continue to enhance HQMF because people have really wanted us to get to a point where –

Keith Boone – System Architect – GE Healthcare
Bob?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
The population criteria can be processed as well. Yeah, Keith?

Keith Boone – System Architect – GE Healthcare
So, in GE we've got an analytic center of excellence that's been working with QRDA and HQMF, and QDM and our experience in the HQMF release 1 is very much as you described we can do something with the data criteria that was in HQMF release 1 and that is a significant benefit but actually being able to compute on the logic – one thing that you expressed was range of variation was a problem but then we also found for many measures not just range of variation but ambiguity in how the computation was to be performed for being specified and so some things that you'd actually have to manually compute differently might be reflected in a way that would make them appear the same in different measures. So, we found being able to use the logic and release 1 to be rather difficult as you've expressed –

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
Keith can I ask a question?

Keith Boone – System Architect – GE Healthcare
As did our –

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
This is Floyd in your analysis did you find that the data criteria consistently applied the QDM-based HQMF components so that if you –

Keith Boone – System Architect – GE Healthcare
So, we had several challenges in the data criteria and that continues today and that really has to do with some semantic differences in QDM and CDA, QRDA, basically HL7 clinical statement modeling and that's something that we've been able to overcome at this stage but we're very hopeful that some of the work that HL7 is doing to align those is going to make our lives a great deal easier.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Well, let me – Floyd let me give some concrete examples to the committee to make sure that I'm understanding, you know, QDM is one type of abstraction and CDA or Consolidated CDA may have had a different abstraction.

So, for instance there might be a particular quality data type for devices and yet devices, you know, there is durable medical equipment, there are, you know, devices used as implants and so just the fact of knowing that the QDM type was a device didn't necessarily tell the EHR where do I look for that.

I think the other example might be medications versus vaccines, correct me if I'm wrong, but there was one QDM type and yet in Consolidated CDA we had one template for medications and one template for immunizations so that was a little bit of a challenge, you couldn't necessarily just take all of the quality data elements push a button and automatically extract them. In some cases you really had to look precisely at the measure, study the measure in order to glean where exactly you go to query your EHR for that particular piece of information.

The other piece that was complicated a little bit with the data criteria was the precise filtering rules so that for instance while you could go ahead and query for where the discharge diagnosis is pneumonia it was in the population criteria where we say, well there has to be a discharge diagnosis of pneumonia during, you know, this type of encounter during this timeframe and so the very precise filtering rules for knowing exactly which discharge diagnosis of pneumonia was potentially relevant can only be gleaned by parsing the population criteria and so that's also been a barrier.

Okay, maybe I should, in the interest of time, move on if there are no other burning questions here?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Yeah, thank you.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Okay, next slide please. So, I have two slides that summarize the key enhancements in HQMF release 2 and the QDM-based HQMF release 2, they were balloted separately in HL7. HQMF release 2 is due to be published I believe next week.

QDM-based HQMF release 2 I believe is due to be published later this month and the primary enhancements, I summarized the metadata and the data element enhancements on this slide and then the next slide will summarize the logic enhancements.

You know the metadata and the data elements were pretty good it was the logic that really was the primary focus of this 2013 effort. What we did find was that in the prior MU2-based eMeasures that for instance for a lot of these hospital measures there was no explicit differentiation between person-based measures and event-based measures. So, if you have a patient who is hospitalized 3 times the question was, you know, if he met the criteria during one hospitalization but didn't meet the criteria during another hospitalization do we count that patient, do we count each hospitalization event separately.

We currently, under Meaningful Use Stage 2 have to have a supplemental guidance document but in HQMF release 2 we'll make that explicit. The other thing we've done, which will come into play for HQMF release 2 is we had provided explicit guidance for calculating the performance score for proportion measures, what we've since done is also nailed down the rules for calculations for ratio measures and continuous variable measures and we've made sure that we can glean that information from the QDM-based HQMF release 2. Data elements will have been updated based on the December 2012 QDM and if we could go to the next slide please.

Here's the main logic enhancements, the first bullet constrained based on an HL7 IG to me is going to be pretty important to implementers because now there will be an HL7-based source of truth, again, not to say that the MAT output wasn't good, but I think vendors really were looking to see a source of truth describing exactly how do we interpret these measures and they were looking to HL7 for a standard.

So, the HQMF release 2 standard coupled with the QDM-based HQMF release 2 guide provides those rules such that the current measure authoring tool or for that matter any authoring tool could theoretically generate conformant eMeasures.

By, the way Keith, chime in on this if you'd like, I mean Keith did just a boatload of work on helping to clarify the logic in HQMF release 2, in particular leading the charge to simplify the XML so that, you know, the actual number of lines is smaller, but in addition to that the XML element names in many cases are far more intuitive and in many cases the models underlying HQMF release 2 has been flushed out so that there is far less wiggle room, two people asked to express the same thing could have expressed it in many different ways in HQMF release 1 and a lot of the potential variability and representation of a given notion has been constrained in the HQMF release 2 model. We have this –

Galen Murdock – Veracity Solutions
Bob?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Yeah?

Galen Murdock – Veracity Solutions
Bob, if I may, this is Galen Murdock, this is great so far in terms of understanding the high level and the conceptual side, are we also planning today to look at examples of how that XML has been simplified about how expressivity is being increased so that we can get down to some of those brass tacks? I realize that might be burdensome for some who don't like that much technical detail, I didn't know what the goals were for today at the level of detail or are we looking at it at a qualitative level?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
I was – just because they told me I had 20 minutes I was just doing qualitative level today. I can certainly work with the committee to bring back or provide a lot more of the technical detail and we can make that available and then plan to talk about it some more. But, I'll – Danny and Marjorie I'll defer to you how you want to respond to that?
Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
This is Danny; I think that at this level the detail is necessary in order for us to make informed decisions as a group. So I'm inclined to let you keep going with this. Marjorie, thoughts?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
Yeah, no I agree with that.

Keith Boone – System Architect – GE Healthcare
So, just to follow-up on your invitation to talk a little bit about it Bob, this is Keith, so in developing HQMF release 2 we were really looking at how to make the logic computable.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Right.

Keith Boone – System Architect – GE Healthcare
And there was a lot of extensive work done in ensuring that the expression of the data criteria and the expression of the components of the measure logic were very distinct and so that you didn't have filtering logic and data criteria and you didn't have data criteria specified in logical expression. So, we did a lot of work dividing those pieces up.

And then we also made sure that the mechanism of computation was expressed to a point where you could actually do the computation and we took some example measures and I built some software tools that were able to go through those measures and actually show that you could then turn that into a software implementation that was based on for example the work that MITRE had done with JavaScript and popHealth and be able to extract a measure using a MAT reduce-based technology or you could extract the information from a measure based on a sequel database of clinical data –

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Yeah.

Keith Boone – System Architect – GE Healthcare
Or you could extract information from a measure based on a collection of CDA documents using the same declarative specifications and that you'd get essentially the same computed result. This has since been used in the Query Health work and so they're actually pilot testing, I believe it's in New York, use of HQMF to express not really so much measures but queries about population data that you can think of in terms of measures because you're dealing with things like numerators and denominators and those sorts of queries.

Galen Murdock – Veracity Solutions
And –

Keith Boone – System Architect – GE Healthcare
So there is some work in testing on it not on the final published version but on what was actually published for draft, published for balloting.

Galen Murdock – Veracity Solutions
And Keith, thank you that is helpful. I sense that with my computer science background I have an inclination to want to dive in deeper than is appropriate for today's meeting and maybe with our offline discussions or whether other people share that proclivity it can become an interesting question, but would not impose upon the whole group to do that now.

Keith Boone – System Architect – GE Healthcare
So, I can also offer up a series of about a dozen or more blog posts that I've written about the development of HQMF release 2 and I'll put that in the public comments technical questions and maybe that can be shared to the group.

Galen Murdock – Veracity Solutions
Thanks, I'm reading those as we speak actually, thank you.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
And we're happy to point you to the standards to read them; it depends on how deep you want to go, yeah.

Galen Murdock – Veracity Solutions
And again, I'm doing the same, thanks.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
This is Eric – that point, I think, you know, that ultimately I think what this Workgroup is I believe trying to do is to identify whether – give advice to the larger committee as to whether adopting one standard or another at a certain point in time is going to help achieve the – you know, the goals of HITECH overall with – or the goals put forth by the Policy Committee without undo negative impact.

I mean, I think that's kind of the overall that's an – mandate and I think that what we – the devil may be in the details if there are issues here that are going to affect either, you know, the potential for negative impact in adopting one or another standard or even its ability to achieve the required goal, those are probably where we may need to dive deep as a group, that's my thought anyway.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Yeah and actually Eric it's a really good point and maybe this helps address that. One of the things, you know, it's not just improving the logic for the sake of improving the logic it's improving the logic so that on the one hand, you know, it can be computable but it's also expanding measure support for the real world quality measures that we're seeing.

You know, we had, in Meaningful Use Stage 2, you know, most of them were the proportion measures but there were some continuous variable measures. Now what we're seeing coming out are sort of these risk adjusted outcome measures, ratio measures continuous variable measures and so as part of the HQMF release 2 development we've really, you know, studied the requirements for risk adjusted outcome measures, ratio measures and continuous variable measures and the HQMF release 2 standard then provides, you know, explicit mechanisms for implementing these particular types of quality measures that, you know, people are proposing are needed for Meaningful Use Stage 3.

So, on the one hand we can say, you know, the XML is better and it's computable and that's I think very important and we can talk about expression languages and that's also important, but here this may be addressing your question is that a lot of what was driving this was we needed to do some of this stuff in order to support the types of quality measurement that people are asking to have supported for MU3.

M
Thank you.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Maybe in the interest of time I should just kind of jam through the last two slides unless there's any other burning questions about the logic enhancements for HQMF release 2? Okay, the next slide please.

And I want to point out again HQMF release 2.1 and HQMF release 2.5 don't exist and there is no project scope statements in HL7 to develop an HQMF release 2.1 or to develop an HQMF release 2.5 rather based on some discussions that had occurred in some ongoing discussions we're trying to think, you know, gosh we've been focusing a lot of energy on aligning quality measurement with transitions of care, you know, we want to make sure that the data criteria in quality reports somehow align with the templates in Consolidated CDA but what about decision support and do we really want to go forward with quality reporting with one expression language and go forward with decision support with a different expression language, what kind of burden is that going to be putting on implementers.

And, you know, now that we're thinking not only about measurement but also about interventions, you know, can we set a course, again, I don't know what the timelines are here, this is something that, you know, has to be debated by CMS and ONC and this committee.

Can we at least begin to lay out a potential course that leads us to this alignment and in that spirit we've been thinking about an HQMF release 2.1 and an HQMF release 2.5 and what we would be envisioning for an HQMF release 2.1 is really a fairly minor change to HQMF release 2 but we would simply break it into discrete modules so as to set the stage for clinical decision support alignment.

We've always kind of conceptually thought about HQMF as having three separate layers the metadata layer, the data criteria layer and the population criteria layer so we don't believe that it's going to be a very large effort to formally break it down into discrete modules metadata layer, the data layer and the expression layer.

Keith Boone – System Architect – GE Healthcare
A lot of that, this is Keith again, a lot of that analysis in divvying up a lot of the prework is actually happening in other projects in HL7 that are looking at trying to describe an appropriate framework for dealing with clinical decision support, logic, information modeling and etcetera, so we're sort of trying to lay that foundation so that we can have a framework of standards-based parts from which you can say, you know, how many patients who should have had their A1c checked got their A1c checked as a quality measure and you can also flip that around and say, is this a patient who needs to get their A1c checked let's issue a reminder when they're next in the office to do that test on the clinical decision support intervention side.

So – and I applaud the idea of in our thinking and making recommendations back to the HIT Standards Committee that we think not just about Meaningful Use Stage 3 but what's sort of the program and the roadmap for quality measurement and decision support so that we're actually moving in a direction and thinking beyond just the deadline of Stage 3 but more thinking about where are we headed and what's the right direction that we want to go so that when it comes time to answer those same questions for Stage 4 we've actually already done some thinking about it.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
And the other thing I would add to what Keith just said is – or emphasize against what Keith just said is while we're going through this thought exercise now with HQMF the decision support community is going through a parallel thought exercise where they would take for instance the Health eDecisions standard, but frankly they're also, you know, looking at Arden Syntax, GELLO, etcetera and figuring out how they can break it into these same three modules and that allows us to then flush out these layers and achieve more consistency.

So, here 2.1 which would possibly be a relatively, in comparison, small amount of work would be to set the stage by breaking these things into discrete modules and then if we could go to the final slide please. Then HQMF release 2.5 would actually then modify, oh, I'm sorry, one thing I forgot to mention about 2.1, if you could go back for a second.

The metadata layer, one of the things we've been studying more recently is our composite measures and I thought it would be important to point out I do think that we've identified some requirements for composite measures that haven't been formally addressed in HQMF release 2.

So, the other thing that we would work to achieve in HQMF release 2.1 is to have flushed out the requirements for the composite measures presumably working through eMIG and then making sure that those requirements for the composite measures get baked into 2.1.

So, 2.1 would be modularizing but it may also be an opportunity for us to, you know, if we've identified any additional gaps kind of squeeze those in before we actually start producing Meaningful Use Stage 3 measures so it's worth noting that HQMF 2.1 if we want to target that – if we want to weigh the pros and cons or do we want to go with for instance QDM-based HQMF release 2 for Meaningful Use Stage 3 or do we want to go with 2.1 for Meaningful Use Stage 3, 2.1 may include not only the splitting apart into discrete modules but there is probably going to be a few other little requirements here and there that we've identified that we're going to try to work into the standard. Now if we could go to the last slide.

Finally, HQMF release 2.5 then would have these defined metadata, data and expression layers where they would then be modified based on an alignment with clinical decision support standards. Probably what I find most interesting about this is not only does this align HQMF and decision support but I think to me it kind of brings me back to the old Arden Syntax days and the curly braces problem.

I don't think that this is just a matter of aligning HQMF and the new Health eDecision Syntax, I think what we're doing is we're setting a model here whereby we can have a data layer that not only pulls together decision support and quality measurement but also factors in transitions of care, Consolidated CDA today maybe FHIR resources later.

We have a notion of how do we link an abstract data element to a particular instantiation in CDA or in FHIR and then we separate from there the expression layer where we can have the logic and we do that in concert with the decision support committee and this would be then the target for something like an HQMF release 2.5.

Keith Boone – System Architect – GE Healthcare
So, Bob, where does the QDM/clinical statement harmonization effort come into play in all of this?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
In my mind it's here in the data layer.

Keith Boone – System Architect – GE Healthcare
But is that a 2.1 or a 2.5 timing thing?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Gosh, I – my belief is that that can take place much more rapidly than can harmonization of the expression layer and could potentially be part of 2.1.

Keith Boone – System Architect – GE Healthcare
Okay, because I know, I know that the Clinical Quality Improvement Workgroup is working on that now and I can't remember what their calendar cycle is but I think they're talking either January or May.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Right, right, I mean, I'm still naive enough to believe that that's a relatively easy problem to solve and that the hardest piece is going to be alignment of the expression language.

Keith Boone – System Architect – GE Healthcare
Yeah, we know where the pain is with that one at least.

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
Yeah.

Keith Boone – System Architect – GE Healthcare
Yeah, thanks.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Hey, Bob, this is Danny; does that finish up your presentation?

Bob Dolin – President & Chief Medical Officer – Lantana Consulting Group
It does, thanks.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Thank you Bob for sharing all that with us. So, as I'm looking through things I'm trying to – I'm going back to the original question of which we're trying to get to at some point, not on this phone call, which is which version of HQMF is sufficient for MU3 and so the question that I pose to the group is, in addition to getting more information about each of the HQMF releases, what additional feedback are we going to need from the Health IT Steering Committee in order to give us the necessary guardrails to answer that question?

For example, I would say if someone said to me, Danny for MU3 we absolutely must have alignment with CDS and that would be a fairly easy determination that only, you know, that hypothetical 2.5 would sort of serve that and that would need to happen before "x" date depending on these factors.

If they were to say, hey, you know, that doesn't have to happen for MU3 but we really do need separation of the metadata layer from the data layer, from the expression layer. Then we would say, okay our recommendations are then as follows. So, that's the way that I'm thinking through this. Other thoughts from the group about what type of guidance we're going to need to give meaningful recommendations?

Keith Boone – System Architect – GE Healthcare
So, this is Keith, I like the idea of being able to offer up a set of alternatives and dates and benefits, and deterrence in terms of choices. So, to sort of set out sort of – you know, if this is your date, you know, this would be our recommendation in terms of what's going to be closest to meeting the objectives.

And I think in terms of the guardrails rather than trying to set up some very crisp clear guardrails for what has to happen for Meaningful Use Stage 3 tell us what the end goal is. Tell us what – tell us where the goal line is where we're not going to be asking any more questions about this as far out as they can go and at that point we can tell them, you know, how far down the field we think the various standards will have made it along a particular timeline and what they'll offer and what will still be outstanding.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
So, this is Floyd, I would agree with Keith, I think we need to keep in mind though that the Standards Committee generally is reviewing the requirements from the Policy Committee and so some of the end goals are defined for the Standards Committee from Policy as I understand it.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Got it, so Floyd the implication there would be essentially that the Policy Committee says, I don't know for MU Stage 3 we have to be able to do risk adjustment in the eQuality measures, correct?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
Not at that level, they would say that you need to support this type of quality measure perhaps. They often don't get that deep.

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

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
But then the recommend measures that include those components. So, it's a communication.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Got it, got it. So, they would say for example, we want to support the area under the curve quality metrics for a therapeutic window for example and then that would sort of give us guidance, oh, okay if you need to do these things from a policy perspective this is what would have to happen from a standards perspective in order to meet those goals.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
So, given that I think this is a question perhaps someone from ONC can answer. I think the Policy Committee is still considering what measures they would like to have completed in Meaningful Use 3 and can we get enough information on those so we can understand, as Danny was saying, an area under the curve is a big issue –

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

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
To assure we know what our end goal is.

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
This is Michelle from ONC I would say that the Quality Measure Workgroup on the Policy side isn't that far along yet. They've been working with the Meaningful Use Workgroup currently who is talking about deeming which is something else that we can get into, but they haven't quite gotten as far along to their recommendations for quality measurement itself. I think possibly by the January timeframe they should have something, at least that's my expectation at this time.

Robert McClure, MD – Owner/President – MD Partners, Inc.
So, this is Rob McClure, I absolutely agree with what Keith and Floyd have said, and others. We have to have – I mean, we're kind of the end of the chain here and in particular because we're looking to identify I'd say, well sometimes subtle, sometimes not so subtle differences among our recommendations in terms of standards. They should be targeting very specific things and where those get determined along the way is clearly unclear, but they need to have arrived to us, you know, so someone needs to have said something very definitive that would result in like saying, okay, those quality measures need these kinds of – this kind of functionality.

What I'd also like to hear, because – and unfortunately, what we just heard makes me question how we'll hear this is, it's one thing to say our goal is to be able to have these quality measures, it's another thing to say is why are those quality measures your goal, because I'll be honest with you I'm unclear why MU – what the goals of MU3 are in comparison to MU2.

And I kind of go back to the point, I think it was Eric, but whoever, said, hey we need to, in this process, make sure that we give recommendations that solve known problems in our current requirements, MU2, and I really still want to make sure that we meet those and in order for us to I think to give the best guidance we can not only do we need to know the specifics like these quality measures, you know, are important and they have these capabilities or they require this functionality that we don't currently have, but I'd like to know why we're doing that in MU3 and I'm very unclear on that.

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
This is Michelle from ONC again, I can say that part of the timing issue is that we've been, at least for the Meaningful Use Workgroup perspective, they've been pushing really hard on getting e-specified measures that focus more on outcomes and currently the list of measures isn't as far along as they were hoping, as, you know, was originally planned MU3 was supposed to focus on outcomes so there was really a hope there that the measures be ready and so that's why the Quality Measure Workgroup hasn't come to recommendations as of yet because they're waiting for measures that are e-specified and they're working through all of that.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
This is Floyd, I think –

Robert McClure, MD – Owner/President – MD Partners, Inc.
So, I think getting a holistic approach to this, I mean, kind of turning it on its head, I mean, I get, you know, certainly appreciate outcomes is important, I think hopefully that was also important in MU2, but the fact is that – kind of a hidden message here is I want to really make sure that we make recommendations that we can meet that actually have meaningful implementation capabilities and meaningful impact on healthcare.

You know, it doesn't take much work, like for example, the latest New England Journal, to find concerns being voiced by the community both the practicing clinicians and also the receiving patients and I'm worried – you know, I don't think anybody on this committee is in a bubble and isn't cognizant of that, but I really want us to act on it.

And so we need to get some clear guidance from our, you know, the HITSC and the HITPC in order to be able to give that kind of support and focus on making sure that we really put the stake in the ground in a place where we can, again, really think most importantly improve on MU2 delivery and focus that in an area that allows the implementing community to feel like they're not in a moving ship and they can get something done that's actually going to have an impact on care.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
Yeah and so this is Floyd, just to add to Rob's comment, I think missing that we're at the risk of repeating the issues of the past where measures will be developed that won't be consistent with what standards have been developed because it hasn't been considered for them and we're going to be at a mismatch between standards and what has to be implemented. So, it would be best to avoid that.

Robert McClure, MD – Owner/President – MD Partners, Inc.
Yeah, I guess, if I was going to summarize, this is Rob again, I would say let's not overreach. That doesn't mean that we want to actually endorse a standard that is insufficient in order to be able to even do what we're currently doing. For example, I think it's quite possible that we may feel that the functionality that's described for something like HQMF 2.5 is necessary to fix what we're doing and, you know, where we should be for MU2.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
So, for our next phone call, I believe its next Thursday, correct Julia?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
This is Marjorie that is correct, yes.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
So, unfortunately, we're not going to have clarification to these answers yet we still have a phone call. I think we all know the type of questions that we're going to be asked and the level of granularity in which we're going to need to respond to them, which I think is going to be which of the releases of HQMF is going to be sufficient for needs x, y, z.

I still feel like I'm in the learning mode and would like to get into a little bit more detail on the granular differences and what each of these can and cannot do. Other thoughts about what would be helpful for our conversation for next time?

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
So, this is Marjorie, what I also heard was that it appears that in order to – if the end goal is eventually MU3 we need to – it seems like there is a progressive trajectory that contemplates MU2 and maybe we need to slow our train a little bit that what's I'm hearing.

In order to get to MU3 we need to address the issues with HQMF or whatever standard that impacts MU2 and that's what I'm hearing from the committee. We didn't, you know, take a formal vote or anything but that's kind of the sense that I'm feeling.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
This is Eric Rose, I would agree with what Marjorie just said and I think that between now and the next call one of the things that maybe helpful is dealing with some specific examples of challenges that currently exist with trying to make the stuff work for MU2 and getting advice from experts like Keith and Bob if he's available to help us understand whether, you know, these problems go away or are mitigated with any of the options available to us.

And just the kind of example that I'm talking about is the quality measure in MU2 for mammography screening, one of the exclusion criteria is a patient having had two unilateral mastectomies and on the surface, although that sounds well, you know, pretty straightforward, but actually to try to figure out from EMR data where there may be multiple references to a unilateral mammography having been performed to try to determine if the patient really has had, you know, two instances of that procedure or whether there are just two references somehow to that procedure that's a really tricky problem.

So, I think getting down to that level of here's some of the real practical problems just trying to get the stuff to work and do we have a way to, you know, to address those with any of the options that are available to us to recommend.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
Okay, so this is Marjorie again, and so that – Eric it sounds like that's a very granular example that we'll need to work our way towards because we need to put that in the context of the standard itself. I'm not so sure with some – and it might be, some of the concerns that you raise relate to the standard itself that – you know, or is that a separate issue.

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

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
But having said that – you know, what I mean?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects
It's just a symptom it's not a diagnosis.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
This is Floyd – to explain further on his comment. I think some of what he's referring to is related to being able to express what's needed so that you could express various –

Robert McClure, MD – Owner/President – MD Partners, Inc.
Yeah, this is Rob McClure, I mean, you're exactly right Marjorie and I think you know this as well as anybody, and it is – you know, again, the devil is in the details, we're being asked to do things in the hope that we can kind of do it quickly, easily and simply, and sometimes that's a reasonable hope, sometimes it's not.

Part of – well, what we need to really be clear on is this end goal which is, you know, another way of saying what we talked about a bit ago in terms of what are our real kind of marching orders, what are we really trying to accomplish.

Let me put kind of a fine point on that exact issue that we described. I'm not in any way suggesting this is possible, but in part some of the difficulties that we may be having is that we haven't had, I'll just use this word and be careful, but a template of how to apply existing HQMF functionality so that it's consistently and completely applied to answer the question, which I think is exactly what you were just referring to.

In other words, I mean, I don't know the answer to this and maybe somebody does, but I'm guessing it isn't there, but HQMF R1 may not provide kind of a way of describing all of the information necessary in order to distinguish between whether, you know, a unilateral mastectomy is just being referred to or is actually performed and so that shows, you know, a gap in the standard that would need to be made, but it in fact may not even – doing that may not be sufficient in that it might still also require a very clear, again I'll use this word in a generic sense, templated approach so that now that you have access to these things you've got a very clear sense of how to implement them.

And I know that in part that's what the work that was done in templating based on C-CDA elements, the work that Bob referred to, but, you know, unfortunately we have a very complex problem in front of us and that's in part why people are asking for more detail and asking for, you know, a relatively clear set of goals, because I think we can deliver on those, but we, you know, don't want to just kind of run amuck and kind of do whatever we want to do.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
Okay, so we're about to run out of time and I think we have a sense of – we need to drill down and learn a little bit more and Danny you were going to make some comments to that and I apologize for cutting you off on that one –

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
No, that's okay.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
And I think that's true and then we need to identify maybe, you know, a little bit more granular sort of some of the issues that are challenging right now for implementation such as, you know, expression related issues that, you know, solve some of the examples that Eric presented.

So, I think that maybe gives us an agenda for next week. I think we'll need to think about – we'll work with ONC staff to figure out how we actually roll out that agenda, but do people agree with that?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant
This is Floyd, I'll say yes.

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

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
I do think that from the discussion I've been hearing there is also a governance process we need to advise on use of whatever standard does get chosen, if one does, so that it's uniformly applied and that needs to be – whether template or instruction.

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
Okay which might be part of the discussion next week or the ongoing discussions as well, but that's so noted. ONC staff what do we need to do next? Danny do you have any other comments?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
No I don't, thank you Marjorie.

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

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Okay, so are we ready for public comment?

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

Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association
I think we are.

Public Comment

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Okay, operator can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute
If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have no public comment at this time.

Michelle Consolazio – FACA Advisory Committee Program Lead – Office of the National Coordinator
Thank you everyone.

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

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System
Thank you everybody.