

**Clinical Quality Workgroup**  
**Draft Transcript**  
**March 26, 2012**

**Operator**

Ms. Deering, all lines are bridged.

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

Thank you very much. Good afternoon everybody, this is Mary Jo Deering in the Office of the National Coordinator for Health IT and this is a meeting of the HIT Standards Committee Clinical Quality Workgroup. It is a public meeting and there will be an opportunity for public comment at the end. I will call the roll of the members and I'll also ask staff to identify themselves. So, Jim Walker?

**Jim Walker – Geisinger Health System**

Here.

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

Karen Kmetik?

**Karen Kmetik – American Medical Association**

Here.

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

David Baker? Keith Boone? Anne Castro?

**Anne Castro – BlueCross BlueShield of South Carolina – Chief Design Architect**

Here.

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

Chris Chute? Jason Colquitt? I think he's here. Jason are you on mute? I think you signed in earlier. John Derr? Bob Dolin? Floyd Eisenberg?

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

Present.

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

Rosemary Kennedy?

**Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University**

Present.

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

David Lansky? Brian Levy?

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

Yes, present.

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

Rob McClure?

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

Present.

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

Is that Rob or Robert, or Bob?

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

It's Rob.

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

Rob, I got it right then, thank you very much. Galen Murdock?

**Galen Murdock – Veracity Solutions**

I'm here.

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

Gene Nelson?

**Gene Nelson – Dartmouth University**

Here.

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

Eva Powell? Phil Renner? Eric Rose? Danny Rosenthal? Joachim Roski? Randy Woodward?

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

Here.

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

And Federal Ex-Officio Aneel Advani? Jon White? Patrice Holtz?

**Patrice Holtz, RN, MBA – Office of Clinical Standards and Quality – Centers for Medicare & Medicaid Services**

Here.

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

Kate Goodrich? Kim Schwartz? And if staff would identify themselves?

**Dana Womack – Office of the National Coordinator for Health Information Technology - Contractor**

Dana Womack, ONC contractor.

**Jacob Reider – Office of the National Coordinator for Health Information Technology**

Jacob Reider, ONC.

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

Okay, thank you, back to you Karen/Jim?

**Karen Kmetik – American Medical Association**

Thanks very much, Mary Jo, everyone hello, good afternoon, I'm going to lead this with Jim joining as he can, because Jim is in transit. So, hopefully you all saw the agenda and the materials. Today we want to talk briefly about the Tiger Teams which we are putting in motion very quickly now. We'll spend most of our time talking about your reactions to some of the specific items mentioned in the standards and certification criteria NPRM and then we will relay those comments to the HIT Standards Committee and then of course open to public comment.

So, without further adieu why don't we start with the Tiger Teams and I'll kick this off and then see if Jim does want to add. So, as you saw from Mary Jo, we have created 2 Tiger Teams and we've taken the liberty of dividing ourselves up into these two teams and one of the teams that I will chair is focusing on the characteristics of optimal clinical quality measures for Health IT and what we want to focus on is identifying the attributes of optimal clinical quality measures that are created newly for use in Health IT, particularly EHRs or those that we are calling re-tooled, in other words they were created originally perhaps for the claims environment and work has been done to make them usable in an EHR, Health IT environment.

And, I'll just say the reason we want to talk about this is I think as we raised on previous calls, there's a lot to think about when they look at measures where we know from the beginning that we want our data source to be EHRs and other health IT and so we want to think about are there specific criteria or items we should be looking at when we see these measures now specified for EHRs that maybe we did not think about before. For example, you can begin to make a list of all of the data elements that would be required in an EHR in order to report out these quality measures and, as you can imagine, some will be there today, some not there today, some require workflow changes, some require EHR changes, and so we'd like to speak with you all about how we should look at these measures and the attributes of the specifications for these measures. So, we've identified some of you who hopefully will be willing to work on that Tiger Team. First, let me stop and see if there are any comments or questions about that Tiger Team?

Okay, the second one, which Jim will chair. Jim, do you want to speak to that or would you like me to introduce it?

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

No, I'd be grateful if you would, Karen, thanks.

**Karen Kmetik – American Medical Association**

Sure, so in this team we're asking you all to think about some essential components for quality measures again designed for an EHR Health IT environment and we've talked before about the value of using standardized terminologies, the importance of having value sets, and just so we're all on the same page, what I think of there is something like there are multiple measures that might require a population of patients with diabetes in the denominator, and we would all want all measures stewards to be using the same set of codes and terminology for defining that patient population and could we create such a value set? How would we share such sets? Who would maintain that components of them? Who should be the custodians of them? Those are the kinds of questions that we'd like to pose to this second Tiger Team, which Jim will chair. And, again, we took the liberty of assigning some of you to that team.

If anyone feels strongly that they would rather be on a different team than we assigned you to, by all means just drop a note to me and Jim and we'll get back to you on that. But, any questions right now on this second Tiger Team? Okay, we look forward to talking with both teams on those very important topics and Mary Jo; I know you've scheduled those calls, correct?

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

I don't believe they've been scheduled yet, but we are in the process of reaching out to folks.

**Karen Kmetik – American Medical Association**

Okay, sounds good. And, as usual we'll send agendas out and outline those calls for you all. All right, then jumping into our next agenda item is that we've been asked, as a Workgroup, to the HIT Standards Committee to take a look at some of the specific aspects of the criteria in the NPRM and provide our comments to the Steering Committee who will then relay all of their comments to ONC. So, I know you've got some lengthy documents in front of you, just to orient you, the one very large table with the shaded headings is a template which has all the criteria listed and we'll use that to enter our comments on.

The other table, that Mary Jo sent to you, the one heading is ONC proposed criteria and the other column heading is HITSC recommended criteria, this is just to remind us of what the HIT Standards Committee recommended previously on these areas so we can see what was addressed or not addressed in the current NPRM.

But, I'm going to turn our attention to some specific rows of this long document that we're going to be asked to comment on today and I'll let you know it's going to be 4 areas, item #40, which is around the clinical quality measures, item #6 around clinical decision support, item #15 which is around clinical information reconciliation and item #43 which is on the problem list. So, I'm going to ask all to turn first to item #40. I'm looking at the large table with the gray heading and I guess it depends how you print, for me it's on page 20.

And so, I will just read this so we are sure we are on the same page and someone please correct me if I'm on the wrong row, but I have item #40 being that the proposed criteria is clinical quality measures, capture and export. Capture, electronically record all of the data elements that are represented in the standard specified in, there is a section, and electronically export a data file that includes all the data elements that are represented in the standard. This section also speaks to incorporate and calculate. Incorporate, electronically incorporate all of the data elements necessary to calculate each of the clinical quality measures included in the EHR technology and calculate, electronically calculate each clinical quality measure that is included in the EHR technology.

There's also a section on reporting, enable a user to electronically create for transmission clinical quality measurements results in a data file defined by CMS. So, these criteria cover capture and export, incorporation and calculation, and reporting. So, I'm going to open this up to comment.

**Keith Boone – GE Healthcare**

This is Keith Boone, just to let you know that I'm here, sorry I'm late.

**Karen Kmetik – American Medical Association**

Hi Keith.

**Gene Nelson – Dartmouth University**

This is Gene, it seems logical, the topics have covered and essential.

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

In case folks didn't notice the standard that is referred to there is the NQF Quality Data Model and so that is also open for change.

**Keith Boone – GE Healthcare**

So, thank you for that, Jacob, because I was about to go there. So, in the proposed rule there were actually a number of different proposals that were made in addition to the NQF Quality Data Model. Now, in speaking with a lot of people who were involved in the quality measurement in the industry, the quality data model is fairly extensive.

**Karen Kmetik – American Medical Association**

Can you say who is speaking?

**Keith Boone – GE Healthcare**

I'm sorry, I thought I had, this is Keith Boone.

**Karen Kmetik – American Medical Association**

I'm sorry, Keith, thank you.

**Keith Boone – GE Healthcare**

It's fairly extensive and it includes a lot of information elements. I think the examples that were given to me were nursing staff availability and stock on devices and other sorts of information which is entirely relevant to supporting quality measurement. But, those examples and other examples, which I've looked at personally, are not things that you track in your EHR, in your electronic health record. They are things that you would track in other information systems perhaps that would be available to an eligible professional or a hospital, or CAH. They're things that you would capture maybe in an HR system or an administrative system, or even in a billing system, but wouldn't necessarily be in the EHR. So, the idea that there is a constrained version of the QDM that is appropriate for the kinds of information that you manage for dealing with essentially the treatment activities that the EHR is responsible for capturing seems to be more appropriate than the full QDM.

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

So, this is Floyd Eisenberg, to give some comment on that, and I fully support the fact that some things like system resources, nurse staffing and the number of resources available may likely come from another setting and a resource management program. So, I would agree that some of that does seem off-limits for specifically Meaningful Use out of a single EHR or it and its components. I think there are challenges though where it does try to explain the depth of data that's needed to really understand quality and some of those things are not required by certification but are needed for quality even in the EHR. So, there is a medium, kind of a middle ground that has to be approached. But, I think there are some valuable components there to help identify what you would be looking for in EHRs for a standard.

**Keith Boone – GE Healthcare**

And, Floyd I absolutely agree with you which is why I was saying something that would be a constrained version of QDM would be appropriate.

**Gene Nelson – Dartmouth University**

This is Gene Nelson; one of the things that is coming to mind for me would be clinical quality measure that relies on patient reported information. So, for example if we're looking at depression and remission of depression, we would want to use patient reported information most likely an NQF endorsement measures such as the PHQ-9. Has the prior discussion implied that this kind of information would be ruled in or ruled out? The patient reported clinical information?

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

Okay, so this is Floyd, I think you may have different opinions here, my view on that is that the QDM does let you identify a, I guess we call it a health risk assessment, which would be a PHQ-9 assessment tool and as a smart form in an EHR potentially could be captured as the numerical result could be captured. The question is, can the provenance knowing that the source and the recorder of that information is the patient and if that is what you're looking for, it's not required in certification, but the QDM lets you state it, so that's a good question you bring up. I would think that if we want to support patient reported outcomes we would need that level.

**Gene Nelson – Dartmouth University**

Yes, I think, this is Gene again, that it's quite likely that we would be moving more in the future to the acceptance of certain patient reported measures of clinical outcomes because often times it is the only useful source.

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

This is Floyd again, I think we may be seeing similar requirements for functional status coming directly from the patient; you might call this a functional status in a way as well rather than recorded by others.

**Gene Nelson – Dartmouth University**

Yes, that is the way I might see it, this is Gene Nelson speaking again. If we looked at the promise NIH measures of functioning, one domain is mental health and within mental health depression symptoms is an example of that, PHQ-9 is an example of a tool to measure depression symptoms.

**Karen Kmetik – American Medical Association**

Gene, this is Karen, I'm just trying to relate your comment to Keith's comment, are you saying that we can't constrain it too much?

**Gene Nelson – Dartmouth University**

This is Gene; the suggestion would be that we would not wish to constrain clinical quality measures in such a way that it would rule out the patient's report on their health status when that is needed to measure health status or health outcomes.

**Karen Kmetik – American Medical Association**

Okay.

**Gene Nelson – Dartmouth University**

Is that clear?

**Karen Kmetik – American Medical Association**

Keith, do you concur with that?

**Keith Boone – GE Healthcare**

So, I think that would be something that certainly would fit into the model of a constrained QDM. Patient reported data is something that can be captured in the EHR during the normal provider workflow.

**Karen Kmetik – American Medical Association**

Okay.

**Keith Boone – GE Healthcare**

There is another comment and that is on C3, the clinical quality measures, in a data file defined by CMS which is further described elsewhere as an aggregated measure data file. I've heard comments from several folks and actually made some myself recently at a conference in Pennsylvania on the fact that it's very hard for anybody to comment on something that's basically left in as a TBD in the rule, we don't know what that data file looks like. As somebody who is working in the standard space, you know, my hope would be that we would eventually move toward the QRDA Category 3 as the necessary standard, but I know given where that work is at, that's not really something that's available for this rule. So, the suggestion that I would have is that we would stick with the existing PQRS XML representation that essentially being the only thing we have by default.

**Karen Kmetik – American Medical Association**

Okay and is it clear to everyone the difference between that, which Keith was just speaking of, which is the transmission of the results to above when it talks about exporting the data file that includes all the data elements? Is that clear to everyone?

**Keith Boone – GE Healthcare**

Well, actually I was speaking of the export format.

**Karen Kmetik – American Medical Association**

Oh, okay.

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

Well, actually Karen, this is Floyd, I do have a little confusion here. Is the export format intended to, if I were to export to another “module” that does the analysis and the aggregation and then the reporting is what is sent to CMS from that module? Are they different potentially? Because, I think one is patient level data and one is aggregate data and I'm not sure I understand if they're talking about one or both here.

**Karen Kmetik – American Medical Association**

Right, that's what I was asking because I wasn't sure myself.

**Keith Boone – GE Healthcare**

That's a good point, I don't get it either.

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

So I do think clarification would be very helpful.

**Karen Kmetik – American Medical Association**

Yeah, right.

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

This is Rob McClure, I've been following, just another element to that, which I think is saying the same thing, the difference between (c)(ii), which is this export, which is what you're referring to, and (c)(3), which is the reporting, maybe that's what you were just talking about, Keith, but...

**Keith Boone – GE Healthcare**

Well, I was speaking specifically of the issue of reporting the aggregated data and, you know, the options are QRDA or PQRS and QRDA Category 3 isn't really available, so.

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

But the choice of those two would be what would be needed in order to meet this 40(c)(3) part of this?

**Keith Boone – GE Healthcare**

Correct, and it's not in the export at all.

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

Right, okay, yeah, I would agree.

**M**

And I think what Keith's saying also, I don't want to put words in your mouth, that there is nothing else that seems to be out there that will meet 40(c)(3).

**Keith Boone – GE Healthcare**

That's correct.

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

Which leaves this issue...

**Karen Kmetik – American Medical Association**

I hear you all and I think one of our comments can be asking for some clarification.

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

Right, which leaves open this issue, is what is meant by 40(c)(1)(ii), because that is not clear to me.

**M**

Yes.

**Karen Kmetik – American Medical Association**

Yes.

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

Okay, good.

**Karen Kmetik – American Medical Association**

Agree.

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

Yeah, I just, this is Floyd, I just want to go back to that other comment of fitting within the provider workflow and this does apply to what might be required of providers. If we are to look for patient reported outcome, the data contains the provenance that came from the patient, it can fit in a provider's workflow that they look at such data and know it came from the patient. The question is how do you define provider workflow? So, I want to make sure we're clear on that caveat of provider workflow, because I'm not sure that either rule actually addresses that piece.

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

This is Jim Walker, I agree, Floyd, it sounds like we don't care about whether it's efficient for the patient. I wonder if we could say something like efficient care processes and be a little more inclusive...you know, there are nurses, there are care managers, there are pharmacist, there are home health nurses, there is a whole set of people whose work needs to be enabled by this at some point down the road, like yesterday.

**Karen Kmetik – American Medical Association**

Very true, Jim. Any other comments on item #40? We're about a half hour in and we do have three other areas.

**Jason Colquitt – Executive Director of Research Services - Greenway Medical Technologies**

So, this is Jason Colquitt, I just wanted to hit on something Floyd had hit on. I'm assuming that, see where it says EHR technology, I assume that could be a third-party like CMS's other programs, you know, that they have around PQRS, the data submissions vendor, so we could be aggregating outside of the EHR or have a tool set outside, so that is an assumption and I think Floyd was hitting on that as well, but I just want to make sure that's clear as well.

**Galen Murdock – Veracity Solutions**

And this is Galen Murdock, this is my first meeting and I'm comfortable with the language as is proposed in 40, though I am only in my beginning stages of reviewing the NQF Quality Data Model.

**Karen Kmetik – American Medical Association**

Thank you. Anything else on 40? All right. We will capture all good comments and forward them. Our next item is #6, clinical decision support. On my document it comes out on pages 3 and 4. I don't think I'll read this all, other to say under CDS we've got a section on decision support interventions, Section 2 is link to referential clinical decision support, Section 3 is configure CDS, Section 4 is automatically electronically interact, Section 5 is source attributes. And we are projecting that on the screen here as well. So, I will open this up for comments.

**Keith Boone – GE Healthcare**

So, again, this is Keith Boone, looking at evidence based decision support intervention, the way it's worded it says included in each one or any combination of the following, in that list there are high-priority clinical quality measures that address immunizations, but because you haven't included immunizations in

this list, some people might assume that you wouldn't be able to apply them based on how the clinical decision support specifications are worded.

The other thing is, I think that based on each one or any combination of the following, I think that wording is also a little bit confusing because it seems to imply that you have to be able to support an intervention based just on information in the problem list or just on information in the medication list, when in fact most clinical decision support interventions that I've ever seen always used two or more and so it's not clear what's actually being suggested there. I think it would be clear if it just said based on any one of the following data elements.

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

And, this is Floyd, so Keith, just to follow on your comment, the each one or ending combination, I can see the confusion, if the intent was two or more that would work or each one works, but the wording, I see how that is confusing.

**Karen Kmetik – American Medical Association**

But doesn't it mean any one or more?

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

Any one or any combination. There is something about the wording.

**Karen Kmetik – American Medical Association**

Okay.

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

Yeah, the other question was about the immunization and I suppose since it says medication list, the assumption is an immunization list would not be necessarily in the medication list, so that's why I think you're feeling it's excluded and you might want it. So, perhaps it does need to be listed separately.

**Keith Boone – GE Healthcare**

Well and there are specific, even NQF quality measures that are, you know, around use of immunizations in both pediatric and elder care settings.

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

Oh, no, no I understand, I think you're thinking though of the vaccine administration record being separate from the medication list and if that's true then it would have to be identified separately.

**Keith Boone – GE Healthcare**

Well, the other places in the rule do identify immunizations separately for medications except in one place.

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

Yes.

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

Right, this is Rob, there is another element to this too and that is that there are some systems that would record that you are immunized. So, I think Keith's right, it would be valuable to specifically support people's use of immunizations and whatever approach they take.

**Galen Murdock – Veracity Solutions**

This is Galen, I would agree on that point. As we're talking about one or more of these items, is it required that a given EHR system or clinical decision support system be able to support all of them? Let's say immunization data is not contained within a given system, are we expecting that subsets of these is also okay depending on the implementation?

**Karen Kmetik – American Medical Association**

I'm not sure I understood that, could you say that again?

**Galen Murdock – Veracity Solutions**

To put that more simply, if I have a CDS a clinical decision support system, are we describing the broad set that can be included or are we describing a broad set of data A through F including immunizations as well that have to be included? In other words, is there a minimum bar for entry into inclusion into this spec?

**Karen Kmetik – American Medical Association**

I see, I think it goes back to those words we said before are little confusing. It should be you have enabled it based on the data elements included in each one or a combination, yeah that could be clarified as well.

**Galen Murdock – Veracity Solutions**

The other concept I would offer is, in addition to medication allergies or other allergies, such as peanut or latex allergies also important, I've seen a lot of those in CDS systems as well.

**Karen Kmetik – American Medical Association**

Okay.

**Eric Rose – Intelligent Medical Objects**

This is Eric Rose; I had a couple of quick observations on some of the other sections here.

**Karen Kmetik – American Medical Association**

Is there anything else on Section 1?

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

So, this is Floyd, I would support other substance allergies then just medications. You'll find that also in a number of measures, peanut allergy, latex allergy that also relate to medications you would or would not use.

**Karen Kmetik – American Medical Association**

Okay. Why don't we go onto Section 2 and 3, so we get some order to this?

**M**

Okay.

**Keith Boone – GE Healthcare**

On section 2 you reference, again this is Keith, you referenced the context where knowledge retrieval info button standard, there is also an implementation guide that is a URL based implementation guide for that standard and most implementations of the info button actually rely on that implementation guide, so I would suggest consideration of that guide as the implementation guide to go along with that standard. For example MedlinePlus implements the URL, according to the URL guide.

**M**

Regarding the specific enumeration of data elements from which you have to be able to link to reference information I wondered about #4 demographics and #6 vital signs. I could certainly see that demographics would be a useful filter in searching for reference information on problem list, medications, allergies, etcetera, but I'm not sure in and of itself it constitutes a useful starting point for reference

information. A clinician doesn't say give me some reference information about females or, you know, elderly people. Vital signs also I think is kind of questionable in that regard although it might make sense as a filtering parameter for reference information.

**M**

And you'll note that the language in 2B is almost identical to the language in Section 1. I think there is some confusion around that, in each one or any combination of.

**Karen Kmetik – American Medical Association**

Yeah, depending on what end is being clarified as, whether or not we need to comment on demographics, okay.

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

This is Rob, let me pile on there, I agree, I think that there was probably a copy and paste and if there is some consideration here, we might want to say that the intent for referential clinical decision support, given the fact that we're assuming that it would be one or more, that we limit that list to those that we feel are really critical, and so if this is possible, it wouldn't make sense and you wouldn't get credit for using something that really doesn't provide a lot of value if that's the only thing you use, given the assumption it will be one or more. So, problem list, medication.

**M**

And lab results.

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

Well, and allergy potentially, but yeah I think if you wanted to be proactive we might want to make this list smaller.

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

Yes, this is Floyd, my challenge with the demographics as well and I guess I didn't speak up about it before is it's a rather broad category and it's not saying specifically what demographics, it potentially could be quite large. So, I do wonder about that one as well.

**Karen Kmetik – American Medical Association**

Anything else on Sections 2 and 3?

**Gene Nelson – Dartmouth University**

This is Gene Nelson, imagine that we wanted decision support for a smoker or someone who has a sedentary lifestyle or suicide risk; would those be captured in the problem list?

**M**

The NPRM for certification calls for a capture of smoking status as a separate data site and it stipulates seven specific values for it.

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

So, this is Floyd, in the QDM we might identify that as a characteristic that the patient could be considered a demographic, so the question is if we could specify which ones are important, that would be helpful.

**Gene Nelson – Dartmouth University**

I was thinking about the way we use decision to supports are oftentimes to trigger interventions or potential interventions based on the kinds of risk factors that may not be ordinarily captured in the list A through F so that's why I was opening up that question.

**Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University**

This is Rosemary, is your question about how smoking status is collected today within the EHR and how that aligns with how it's described within the QDM and the NPRM?

**Gene Nelson – Dartmouth University**

Yes, I was, this is Gene, the function of decision support and how it gets used and how it's enabled by language we know that it's often important to have decision support with respect to lifestyle risk such as smoking or with respect to mental health issues such as suicide risk. And I was wondering if the way this is written would easily accommodate those kinds of use of decision support or not.

**Karen Kmetik – American Medical Association**

Yes, Gene, this is Karen, I think I get your question; you almost want to see examples of what's under each of these, cross walk that to what we think we need.

**Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University**

Yeah, we could end up with tremendous variation or interpretation and then representation variation within the EHR.

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

Right, so this is Floyd, that was my reason for saying it would be helpful if we were more specific to what kinds of things they were required to access.

**Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University**

Yeah. This Rosemary Kennedy.

**Karen Kmetik – American Medical Association**

But we can certainly put that in our comments, it's not comprehensive, some examples.

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

Yeah, so Gene, I think you one example was suicide risk; another was smoking, and if there are other specific examples that might help.

**M**

Another one that people are quite concerned about right now are falls in the elderly both on an inpatient and outpatient basis.

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

This is Jim, I want to suggest that all three of those belong on the problem list and to put them anywhere else will contribute to the kind of confusion we're talking about, I mean, substance abuse, tobacco and instability either history of fall or risk of fall and whatever the depression, risk of suicide or whatever it is, those are diagnoses and we ought to keep them there.

**Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University**

This is Rosemary, I would agree with you Jim, that based on these findings and observations in the assessment of the patient they would end up on a problem list and around them you would have orders and interventions to mitigate the risk and then some sort of identified goal that you want to achieve.

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

So, this is Floyd, while I agree with all that, I think what I'm hearing is the rule is not that specific should it indicate something about the problem list as expected to contain items such as, that way you can address them.

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

Yeah, that might be the way to do it, Floyd, good suggestion.

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

Yeah, I don't mind it being in the problem list it's just a matter of...it becomes a circular argument and we really need to address those things that are important than it might be helpful to put that suggestion in here.

**Karen Kmetik – American Medical Association**

Yeah, or if it's listed somewhere else to reference that.

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

Yes.

**Karen Kmetik – American Medical Association**

Okay. I'm going to force us to move on so we get through. Any comments on 4 and 5? The interaction and the source attributes?

**M**

I think the term electronically may seem superfluous, you know, I don't think that the EMR is going to have the mechanical hand that comes out and slaps the provider.

**Karen Kmetik – American Medical Association**

All right, anything else?

**Galen Murdock – Veracity Solutions**

This is Galen Murdock, is it reasonable to assume that in 5, that all cases in which any of these decision support rules may be applicable? And in all cases an electronic interaction will actually happen? That seems to me to be a very broad expectation in 4 that is not 5.

**Karen Kmetik – American Medical Association**

Yeah, I could use a little further clarification on that myself. All right, anything else there? Are we ready to move to row 15, clinical information?

**M**

By that I assume we don't have to address 6B?

**Karen Kmetik – American Medical Association**

Oh, sorry. I couldn't see that on my printout.

**M**

I guess the answer is no?

**Karen Kmetik – American Medical Association**

6B says what?

**M**

Its drug-drug, drug-allergy.

**Karen Kmetik – American Medical Association**

Why don't we, while we're here drug/drug, drug/allergy interaction checks. Perhaps we add the same comments on 6B? I think that's pretty straightforward. All right, let's go to 15, it's on my page 12, clinical information reconciliation. On the certification criteria, enable user to electronically reconcile the data elements representative of patients active meds, problem and medication allergies is as follows, list type. We had three pieces, displaying the data elements, enabling a user to merge and remove and enabling a user to review and validate. Comments on 15?

**Galen Murdock – Veracity Solutions**

This is Galen Murdock; as before I would propose that the list of allergies be expanded beyond medication alone.

**Karen Kmetik – American Medical Association**

Okay.

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

And this is Rob, I think we had on the last in 6A, there was this expectation that this functionality could be limited based on role and function and I think that would be true here.

**Karen Kmetik – American Medical Association**

Can you repeat that, please?

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

That the ability to perform these actions should be controlled by the user's role in the clinical setting, the same sort of thing that is in 6A(iii), configure.

**Karen Kmetik – American Medical Association**

Yes.

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

So, my question here, this is Floyd, is if this is a certification requirement, so you're saying that the EHR must be able to let you configure it by role, is that the question?

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

No, that the ability to change, reconcile, so specifically it states reconcile the data elements that represents the patient's active medications, problems, and hopefully substance allergy list be controlled by the patient's role, now maybe that's a generic thing that happens throughout, but I did notice that it was in the 6A.

**Karen Kmetik – American Medical Association**

Anything else on 15? All right, moving on to our last one is 43, which is the problem list and again we referenced the standard there and the standard is listed.

**Eric Rose – Intelligent Medical Objects**

This is Eric Rose; I noticed that the phrase "in accordance with" here was also used in the Stage 1 or 2011 certification rule, but it's a bit ambiguous and I'm not sure I get exactly what it means to record in accordance with the standard.

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

So, this is Floyd, my question is was that intended to mean that a...international release January 2012 could allow it to align with future updates and versions, was that the intent of accordance? I mean we can ask that question.

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

This is Rob McClure; I have no idea what that means, but here's my guess, it certainly is possible and it currently occurs that users electronically record change and access a patient's problem list without directly interacting with SNOMED CT and interacting with an interface terminology. So, it may be that this is an attempt to allow for direct interaction of other terminologies with an expectation that they eventually get recorded using SNOMED CT. I don't know what is the right set of wording to support that, but it would need to do that.

**Eric Rose – Intelligent Medical Objects**

This is Eric Rose; I think that's perfectly reasonable and if that is the intent makes sense, it probably should be clarified a little bit like something to the effect of captured in a way that allows a SNOMED CT code to be accurately derived when it needs to be for purposes of display or exportation or whatever, right?

**Keith Boone – GE Healthcare**

So, this is Keith, on that one actually I would disagree with Rob's statement that it needs to be recorded specifically in SNOMED CT. There are a number of different ways in which the information can be stored such that you could get on exchange SNOMED code out and we should be careful about telling systems what they have to store in their database. What we are really interested in is, in terms of the interoperable outputs that are coming out, in terms of exchange, transitions of care. There are vocabulary systems that are more detailed than SNOMED that allow you to get quite accurately to a SNOMED code and I wouldn't want to say that you can't store it in something that isn't SNOMED.

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

So, Keith, just so that we're clear, because we're in violent agreement, so if others were confused, I apologize, what I was trying to say is that it needs to be...you can interact with whatever it is that you choose to interact with as long as you have the ability to...and now we are going to perhaps have to get to a point where we are very specific in an agreement, whether it's store or exchange, certainly the HL7 community is focused on exchange and tried to not be prescriptive with regards to store.

I don't know which this is and to be honest I'm not sure that I care, although perhaps we do need to actually be specific. And if we are not specific than we have to say both those things. But, we know that SNOMED CT has to be there some place. So, you either have to be able to exchange with SNOMED CT using SNOMED CT or you have to store using SNOMED CT, but that's what is being stated here or at least that is what the standard says. But, this particular element, what I was trying to give appropriate leeway and we do need to get this clarified, because I don't know what "in accordance with" means, but one, I'd be satisfied if what it meant was no matter what you interact with, interface terminology or whatever, than it can eventually lead to being represented by SNOMED CT.

**Karen Kmetik – American Medical Association**

Do others agree with that theology, lead to being represented by?

**M**

Well, I think the wording needs some work and that's the key point.

**Karen Kmetik – American Medical Association**

But the essence of what we're saying is instead of record, change, access in accordance with we need some other language that makes it...

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

Yeah, and I think we need to be informed as to whether the expectation is that it must be stored using SNOMED CT. I think there are some of us who feel that might be too prescriptive and therefore if not stored than it must be communicated with SNOMED CT. It has to be, I guess, one of those, and that's a little unclear and I think that would be valuable if that was clarified.

**M**

The requirement to communicate, I believe, is already mentioned elsewhere in the NPRM under the requirements for summary of care records.

**Karen Kmetik – American Medical Association**

Right...cross reference with other mentions of it, this has to do with the problem list.

**M**

Right.

**M**

I think the only problem is the use of the phrase “in accordance with” I think, you know, capture, I don’t have it in front of me, but you know, capture access, etcetera refer to actions the user is going to engage in with the problem list in the EHR and that all seems perfectly reasonable.

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

Yeah, this is Rob McClure, one last piece on this, because this does come up in the context of the use of SNOMED CT, and particularly when you’re interacting with a system that you’re not seeing SNOMED CT, but in fact the standard that eventually represents your intent as an encoded element is SNOMED CT. Another part of this “in accordance with” is there an expectation and I’m not sure where I sit on this, but I’d like I think the group to address this, whether the user has to know what the encoded piece of information is, in other words, if I’m interacting with an interface terminology but in order to qualify here and to be in accordance with row 43, what actually is stored, exchanged however you want to say it is SNOMED CT, but I never see that, are we okay with that?

**Karen Kmetik – American Medical Association**

Yeah, I understand your point. I think right now we’d be asking for clarification. I don’t know that we’re at a point of, unless others want to speak up, of making a recommendation.

**M**

So, I...SNOMED Code and so you put it into the standard at 205...

**Galen Murdock – Veracity Solutions**

This is Galen; I agree with the comments. Go ahead? Just to finish that comment then, this is Galen, I agree that it should be at the boundaries of communication not necessarily specific to storage we ought to allow continued innovation there, but the interoperability and the communication should be the focus. And, I’m specifically talking about interoperability with other electronic systems, not necessarily with people. I think for human interaction, I would not specify any SNOMED requirements.

**Jason Colquitt – Executive Director of Research Services - Greenway Medical Technologies**

This is Jason Colquitt; I agree with that, but the user may or may not be interacting directly with SNOMED and then storage of that within the EHR is not necessarily SNOMED but a crosswalk of SNOMED...

**Karen Kmetik – American Medical Association**

All right, I think we’ve got some good comments and in fact who knows maybe that is what they mean by accordance, but I guess we’ll find out. All right, I’m looking at the time here and we do need to go to public comment. Let me just say next steps will be that we will be pulling together all of the comments you made today so that we can send them onto the Standards Committee.

**Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University**

This is Rosemary Kennedy; could I just introduce one quick thing, clarification which is noted in here for longitudinal care, what does that mean? How is that operationalized?

**Karen Kmetik – American Medical Association**

Okay.

**Rosemary Kennedy – Vice President for Health Information Technology – National Quality Forum - Thomas Jefferson University**

It's not real clear what is meant by longitudinal care.

**Karen Kmetik – American Medical Association**

Got it. All right, I thank you all very much for that robust discussion. Mary Jo should we go to public comment?

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

Yes, please. Operator would you open the lines?

**Alan Merritt – Altarum Institute**

If you would like to make a public comment and you're listening via you computer speakers please dial 1-877-705-2976 and press \*1 or if you're listening via your telephone you may press \*1 at this time to be entered into the queue. We have no comments at this time.

**Karen Kmetik – American Medical Association**

All right, thank you all again very much. Feel free to e-mail me and Jim if you have any other thoughts and we will also share with you all the summary. Thanks everyone.

**M**

Thank you

**W**

Thank you.

**M**

Bye-bye.

**M**

Bye.

**Karen Kmetik – American Medical Association**

Bye now.