

Vocabulary Task Force Draft Transcript January 21, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Let's just go around the table here. This is the vocabulary taskforce of the clinical operations workgroup of the standards committee. Jamie Ferguson will be chairing this meeting, and we'll go around the table. Then we'll ask members on the telephone line to introduce themselves as well, so Jamie Ferguson.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Jamie Ferguson from Kaiser Permanente, also chair of the clinical operations workgroup.

Marjorie Greenberg – NCHS – Chief, C&PHDS

Morning. I'm Marjorie Greenberg from the National Center for Health Statistics.

W

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Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

Chris Chute, Mayo Clinic.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Stan Huff with Intermountain Healthcare and the University of Utah.

Chris Brancato – Deloitte – Manager, Health Information Technology

Chris Brancato, contractor of ONC.

Marc Overhage – Regenstrief – Director

Marc Overhage, Regenstrief Institute.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And on the phone?

Judy Sparrow – Office of the National Coordinator – Executive Director

Who do we have on the phone from the workgroup? I think, Ken Gebhart, you're there.

Ken Gebhart – National Institute of Standards & Technology

Yes. Ken Gebhart at NIST.

Judy Sparrow – Office of the National Coordinator – Executive Director

And Mr. Vreeman.

Daniel Vreeman – Regenstrief Institute – Research Scientist

Dan Vreeman from the Regenstrief Institute.

Judy Sparrow – Office of the National Coordinator – Executive Director

Robert Davis?

Bob Davis

Yes. This is Bob David representing ... right now.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay. Anybody else?

Donna Pickett – NCHS – Medical Classification Administrator

Yes. Donna Pickett, National Center for Health Statistics.

Operator

Excuse me, Ms. Sparrow. We have Patricia Grimes as well.

Judy Sparrow – Office of the National Coordinator – Executive Director

Patricia Grimes, yes. That's fine. Just let me remind you all. Please identify yourselves when speaking since we do have a number of members on the call. With that, I'll turn it over to Mr. Ferguson.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Good morning, everybody. Jamie Ferguson here. I want to thank everybody for their time, thank you in advance for your time and for participating here today. I am truly excited about this meeting and the fact that we're now able to launch the work of this vocabulary taskforce within the framework of meaningful use and the interim final rule.

Today's session is intended to be primarily a planning session so that we should – my main objective is to walk out of the room today with a firm grasp and a common understanding of our objectives for approximately the next six months. Hopefully consensus on the sequence of priority items that are the responsibility of this taskforce, particularly related to meaningful use and the interim final rule. So then given that sequencing, we can then plan for a series of public meetings that we'll hold on a monthly basis. The schedule has already been determined where we can take testimony, public input, and have potentially panel discussions on particular items of interest related to the needs of meaningful use and the interim final rule.

Those are my overall objectives for today, and that's really what this agenda is intended to accomplish. So we have a meeting of the HIT Standards Committee yesterday, of which we are a subgroup. Some of you were there, but some of you weren't. We discussed the plans for going forward in terms of both the long-term and the short-term, but the long-term in this case being only approximately then next six months and the short-term being the comment period for meaningful use and the interim final rules.

The focus in the very short-term will be to have one or more calls to see if we want to make comments on particular items in the interim final rule, if we want to forward those to the standards committee for consolidation in standards committee comments on the interim final rule, and that's a very short-term focus, but there are also a large number, at least in my mind a large number of things that are implied or required by the interim final rule where subsets and value sets of controllable vocabularies are required, and the purpose of this taskforce and our agenda today is to figure out and get a common understanding of our responsibilities related to those requirements and set our plan forward.

One of the things that somebody said to me at the standards committee meeting yesterday was that the focus has really shifted with the publication of the rule from the policy goals of meaningful use and the objectives to compliance and what do people have to do to get aid, and nobody is really paying attention to the policy piece. And that, to some degree, may fit the short-term versus long-term thinking where certainly we do want and there are goals of enabling the maximum number of providers to participate, eligible professionals and hospitals to participate. We certainly want to support that, but, at the same time, taking our input from the HIT Policy Committee, I think we also need to keep our eye on the longer-term policy goals, as we develop our recommendations and processes going forward. So it's not just about the short-term compliance needs, although obviously we certainly want to help implementers, those who want to do that with a view to those broader policy goals that have been outlined by the policy committee.

Just a quick agenda review, today we'll start off with what I think will be a very brief review of the vocabularies that are adopted in the interim final rule, essentially that section ... 2A, seeing if there are any questions around the table on that. Then we'll spend, I think, a good chunk of time led by Betsy in a discussion on definitions of value sets and subsets of vocabularies and get a common understanding of the processes that may be needed, and that may extend, to some degree, into a discussion of variation of those processes for the different needs in the different vocabularies or for different meaningful use functions.

I put a break on at that point. Then, after the break, we'll hear from Floyd, who I think this will be another good chunk of time walking through, in some detail, the processes of developing quality measures under meaningful use, the relationship of the vocabulary value sets in particular, to the development process and the needs for coordination of multiple value sets of numerators and denominators ... for those measures.

Then we want to come back and talk about, given those things as background, really the next items are not so scripted. It's more of a discussion in the group of the scope and process of developing our recommendations and the sequence and priority of that work, so I expect that to be a pretty lively discussion about what's needed and how to approach it, and that can extend to even specifics about how we want to take input from both recognized experts and from the public in terms of these recommendation....

Then before we leave the room, since everyone is here, hopefully with your calendars, I want to set a schedule for at least a couple of months worth of meetings. I think, in addition to the full meetings like this that are being scheduled, generally the day before each of the standards committee, I think we're going to need a series of calls. Our previous discussion will determine, I think, how many phone call meetings we'll need in between ... meeting. There's probably going to be at least one, and maybe even two or three phone calls in between each of these meetings, at least initially, to develop our comments on the IFR. Then, in the long-term, I think we'll probably want to have at least one workgroup meeting, one taskforce discussion in between each of the in-person meetings. Any comments or guidance or needed revisions to the agenda for today?

M

I think, as we ... I want to ... opportunity to sort of interject from the plans that we have in ONC to help operationalize what's been coming out of the IFR and committees. I think, one of the things that I'm hopeful to get guidance from this group is how best do we take the recommendations and the work that needs to happen with regard to value set determination and sort of the semantic piece of interoperability, and integrate it into the framework that we're trying to construct here to help operationalize this and support not only 2011, but 2013 and 2015 as well. When we get to that point, either today or in a subsequent meeting, we can....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. And I think that speaks to what I was thinking of and what we, I think, previously discussed as sort of the longer-term plans for this taskforce where I'm really talking here today more about the next six months about the IFR particularly. But I think what you're talking about, as we get into 2013 and 2015, is more beyond the next six months. Although it may be that there are considerations about the long-term that become extremely important in the short-term....

M

I guess an issue is that, in the next six months, there are some short-term goals that we have to reach. It may be that those are one-off from what we're trying to do in terms of process or in terms of how we want to develop the value sets, but I think we need to think about that in terms of how we're going to go forward. We certainly don't want to delay the ability to get things that are going to be helpful for the uptick of meaningful use. But the pace at which everything works, we have to be very careful that ... everything doesn't become a one-off ... we're going to have to figure how ... to get it all integrated and make it work. So that's part of the conversation we have to have, even in the short-term, to see how that relates to what the medium- and longer-term plans might be.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Any other sort of introductory or opening remarks on anybody else? Then why don't we go to our second item on the agenda, which is the vocabulary in the interim final rule? There were handouts here, and also electronic distribution of a number of tables in the IFR and the NPRM. Really, here, I think probably everybody in the room has ... but let's just read through and ... on the vocabulary items in Table 2A of the IFR. Starting with row one, which is the patient summary record, we see problem lists there, ICD-9 or SNOMED CT is adopted for stage one. Stage two adopts ICD-10 in accordance with the HIPAA change or SNOMED CT as an alternative.

Medication list, the code sets that are identified within ARRA as being complete data sets within RxNorm for stage one, and then a proposal to move to just RxNorm for stage two. Medication allergy list, no standard at this point in time, but doing medication allergies at the ingredient level using UNI for stage two. In terms of procedures, ICD-9 or CPT-4 is listed in the table. I think HCPCS perhaps could have been listed in the table also.

M

Originally we had HCPCS one and two.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

M

...original....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Because, I think, just based on the ... regulation, I think if you refer to it, I think it really would say ICD-9 of CPT-4 and HCPCS. Then the same thing with ICD-10, according to the HIPAA change for stage two. For vitals, no standard is adopted at this time. Standards that are used on CDA templates for proposed for stage two.

M

Jamie, I'm sorry. I guess I don't have it clearly in my head what kind of feedback you're looking for on this.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Well, I just think....

M

Because I think there are a lot of questions that you could raise. I'm just not sure, you know....

M

...review them first and then come back for questions, or do you want questions as you sort of read?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

How about if we read through the table once, and then come back through for a discussion if that's okay?

M

That'd be....

M

Sure.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Then for units of measure, UCUM for stage two, no standard for stage one. For lab orders and results, stage one is LOINC when the LOINC codes have been received from a lab. Stage two is LOINC. Then

for electronic prescribing, also RxNorm, and then also the same for submission of lab results to public health agencies from affordable labs. LOINC when the code has been received from a laboratory. Stage two LOINC and UCUM and SNOMED or applicable requirements. And then for biosurveillance, no specific vocabulary is mentioned, but ... applicable public health agency requirements moving to GIPSE for stage two. That's the list in the table. We have some questions or discussion about what's been adopted in the IFR. Marc, do you want to start?

Marc Overhage – Regenstrief – Director

Well, I guess it's a broad question or comment is if our goal is coherence or to accommodate everything, and one of the things that I fear a lot, and we saw a little bit of this with the HITSP work, all these sort of little niches that get created. Just the last example of GIPSE is a good example of, is it solving a problem, or is it, you know, and so I worry a bit that in here – and HCPCS is a good example too of, okay, frankly, you've got to throw that out at the end of the day because you don't need three ways because HCPCS can describe drugs. We need a very narrow channel, and so that's one overarching, and maybe I should pause there. I see some heads nodding in agreement.

M

I agree with you, Marc, and I think that the real problem, sort of political/social problem, and ... there have not been redefined standards. People have been trying to solve problems for years. They've developed things to solve their focus problem ... array of things, and everyone ... category. People at this table, and lots of people elsewhere not at this table ... looser or tighter allegiance to the things they've developed or hitched their wagons to.

To me, it says I'd rather take the discussion up a level for a moment and ask the question, do we, as a group, want to make a recommendation that looks something like this. That, at the end of some specified period of time, not 3 months, not 50 years, there will be a standard in a cluster of defined areas, and that we recognize that right now there's either an array of possibilities or nothing in most of the defined areas. And we want to create a series of defined steps and timeframes that get us to a standard in a defined timeframe. Before we talk about it and start arguing on each of our positions about each one of these, I'd rather elucidate that principle, and then we can have a more focused discussion.

M

If I could ratchet it up even a little higher because I agree with you, and I'm an agreeable guy this morning. I agree with everybody, but I'm concerned from what I heard at the meeting yesterday that if this IFR has already been published, our degrees of freedom as a consequence of the IFR having been published, are deeply constrained.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

M

I guess, before we decide that we want to reinvent the universe, which I'm always a fan of, what are our practical limits in terms of how broadly can we achieve the kind of agenda you're...?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes. I think, especially for those who were not at the standards committee meeting yesterday, we've heard repeatedly and clarified many times in different ways the general principle that in terms of the standards that are adopted in the IFR, we can constrain, restrict, or subtract, but we cannot add.

M

Can I make an administrative note? For the benefit of the people on the phone, can we introduce ourselves when we...?

M

Fair point. Sorry.

M

The point, though, that you can also include is that these are the adopted standards, but you aren't restricted to just table one and table two. If, in the preamble, it says we evaluated three different standards, and we elected not to adopt standard three, it's in the IFR, and so that becomes something that then can be commented on with respect to adopting standards.

Betsy Humphreys – National Library of Medicine – Deputy Director

I also think that we, as explained in the preamble and so forth of the IFR, the candidate standards are listed there in some sort of a signal, but with an absolute statement that they may change for 2013.

W

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

So I think that you could consider the 2013 standards to be fair ... any type of recommendation, and particularly the kind that I think where Marc was going to where, in 2013, we can have ... do little things that could easily be consumed from some of the larger things, from my perspective, that....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Also, this is Jamie.

Betsy Humphreys – National Library of Medicine – Deputy Director

And that was Betsy. Sorry.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

This is Jamie, and I just want to perhaps amplify and agree with what ... said about moving towards a more singular set of targets in the future. That is the essence of the recommendations that came out of the standards committee with respect to both content exchange and vocabulary. And I do think that that's very well supported by the framework that's in the IFR, and we can change, so things can change over time. So we do have a starting point. As Chris explained, our degrees of freedom in terms of recommending changes to the starting point are limited. But that doesn't mean that our degrees of freedom are limited in terms of the endpoint necessarily, and narrowing our convergence to....

Daniel Vreeman – Regenstrief Institute – Research Scientist

This is Danny. I'm going to be modestly aggressive, which is to say, I don't actually agree with you, having been outside the process of developing this IFR. I don't think it's as clear about what I was saying ... single endpoint and simplify ... possible ... that's why the confusion in, well, the larger world, which ... in, and that's why all the anxiety. And so if this workgroup wants to ... sort of re-recommend, let's go outside the policy. If that's the policy, let's recommend it ... clear and explicit ... and then try to build our recommendations in that clearer framework.

Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards

This is Chris Chute. In defense of Jamie, the 2015 recommendations, I think, did give a clear compass direction, and for reasons that I whined about yesterday publicly, they were evidently deleted in the IFR.

Daniel Vreeman – Regenstrief Institute – Research Scientist

Right. I mean ... accident or was that not an accident ... and I don't think ... accidental.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Let me see if ... slot for a minute to talk about some of the constraints of the rulemaking process that form some of the reasons for which those future directions that were recommended, even though this is why they weren't in the IFR, but also, in my view, I guess I'm asking you, Doug, to say, but that doesn't necessarily constrain us from continuing to recommend those as....

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

No, I think the reason that that column came out was because there was uncertainty about what 2013 would bring and even more uncertainty perhaps around what 2010.... And Dr. Blumenthal was very, very clear that the federal advisory committee ... important part of the process ... get input, and we thought we could probably say something about 2013, given the discussion, but based on the feedback that we get from the 2011, based on the continued deliberations, it was hard for us to put in there that stage three is going to be ... because the deliberations ... all those other things ... impact and discussions that happened within the federal advisory committee. And so, that was part of the reason that it's out there. People are talking about it, but we didn't want to put it into regulations, if you will.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well....

M

I'll be aggressive. True, true.... And the reason I say that is your 2013 column has already posted a candidate and, hence, is not binding. And if you could have given the signal similarly with the 2015, I'm not aware, thank heavens, but to my knowledge it wouldn't be binding either.

M

No, and that was the rationale. I think part of the comment that could come from this group is to say, gee, we really wish you would have put it in stage three to give us a better compass direction ... and I think that's a reasonable suggestion that comes back. It doesn't necessarily affect the regulations per se that go into 2011. But it certainly sends a message to the ONC that says, hey ... your timeframe isn't sufficient, and we really want.... And I think that's reasonable.

I can just sort of tell you that the reason was ... we were afraid that if we signal too far ahead, the advisory committee is going to say wait a minute. You guys are telling us 2015, we haven't really even talked that through yet. And so I think that was part of, and maybe that was wrong, but that was part of why that column came out. We thought it was just too....

W

Let me just say from a point of view of people who have gone through ... government, the more work that are on the page, the more difficult this is to.... So if you think that some words are not actually necessary on the page, that factors into it too.

M

This was an easy one because we are going ... right.

M

So the thing is that that's really good. There may be other mechanisms that we can provide that kind of forward-looking statement. And if that's an important thing that this committee believes needs to be out there, that's feedback that we need to get, either through formal review of the IFR, or through kind of what comes out of this committee in terms of the recommendations....

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

Jamie ... cut me off if ... discussion, but this is Andy Wiesenthal talking. I'm mindful when I say these things of the development cycles for software, which everybody's teenage son in the basement, notwithstanding, are actually quite lengthy. If you want to talk to the larger vendors who really occupy most of the current space here, it's a year to 18 months before they can get something in. If you tell them today it's going to be 2011, 2012 before something happens, if they don't have a set of relatively clear targets, they sit and wait. That's the.... That's what they say, and so that's the countervailing pressure, as far as I'm concerned. If we don't set up a series of fairly reasonable, yet ... I don't know what the right mix is, target for 2015, they're going to sit and wait, and we have lots of discussions. It would be too late for something to actually happen for 2015 because it's got to happen in 2013 ... significant play in the hands of lots of practitioners and hospitals.

M

I think we're in agreement. I guess the question is, that needs to be probably brought up at the.... We're probably not going to solve that problem.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

No, I don't suggest we're going to solve it, but that's what worries me about not....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

This is Jamie. I think that if we're in agreement with Andy's general point, then just kind of backing up the calendar, what that means is over the course of this year, of 2010, over the course of the whole year, we really should have a goal then of this taskforce in making a coherent set of recommendations really for 2015 vocabulary. I'm just reflecting that that's going to require more engagement with the policy committee as opposed to the standards committee in terms of the goals and objectives of meaningful use for the future, not necessarily so much the transmission and transport and even constant exchange standards would have to carry vocabularies.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd. Not to ... make this sound even harder, but I fully agree with the issue of getting things into software, but if we're just talking about software being ready and deliverable by 2015, getting it implemented, used, and all that is another timeframe beyond that, so another reason for....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

What I thought I heard Andy say, and maybe I misunderstood him, but what I thought it was that if it's going to be implemented in 2015, the software has to be generally available in 2013, which means that the vendors need to have a very clear set of instructions in 2011.

M

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Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Now let's back up then to table 2A, and see, in terms of the particular things that are adopted now, what other comments or considerations do we want to make, as we go through it. Yes?

M

One of the things that jumped out at me was the gap that was created by identifying the last ... lab, it was a very narrow set of clinical observations and the fact that, like for vital signs where there is, I think, a pretty clear an obvious choice ... templates. And vital signs is one, I think, there's actually a lot of issue. IEEE is going off in one direction. There are a bunch of tugs and pulls on those, and that's one of the areas where I think there's real risk at fragmentation is going to hurt us. And so sort of a two-parter, I guess, which is, there is. And, Betsy, you may have, you know, there's a broad range of clinical observations, including things like vital signs and nursing assessments, and the care measures that CMS is developing and things like that. Radiology, a big chunk of things that just is not on this roadmap, so that may fall in the realm of things that we can't add.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

But it may be a set of priorities for us to for 2013 recommendations.

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, I mean, we could add a row if we sense nothing until 2013, I mean, in terms of the recommendations.

M

I think that would be worth it if we could.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. I mean, it wouldn't need affect this table because this is telling you what you have to do in 2011, but in terms of putting forward a recommendation, we could say, well, here are the other categories that we think something should be done for 2011 and 2013, and this is what we need. But I'm right with Marc that when it comes to vital signs, there may be an argument around the fringes of which one to use for which thing, and I know what some of those issues are. But the ... template, it seems to me, is not one of the candidates in my mind.

M

The other one that was mentioned yesterday that's sort of confounding is the use of the UNI codes for ... allergies.

M

Yes.

M

And that just doesn't fit the use case. It's not fit for use.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right, and that's one where, again, back to the guidance that we heard about commenting on things that are in the preamble being in the rule. We did recommend actually out of the standards committee medication allergies being done at the clinical drug level and non-medication allergies being done with UNI. So I'll have to check the preamble to see if that ... exactly what....

M

Have we still got any wiggle room in there?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

No.

M

No.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

This is Doug Fridsma. As we take a look at the list, you could take each one of the recommendations, or you could take all the recommendations together, and you could do, you could certainly categorize, put them into a bucket. You could say we're okay now, or we're going to get into trouble when we get into 2013 or 2015. You could say we're not okay now, and that we need to really think about how we're going to fix this in terms of an IFR modification that says we can't use – this is a bad idea to do whatever the recommendation is for 2011. You might say that it's perfectly okay. We're fine now. We're fine in the future. We don't have to worry about it.

You might also say that there are things that are missing, that there's something that was omitted here, and we can't add it in necessarily, but this is something that we need. And some of that may go to policy that we say we want radiology to become a policy objective or meaningful use, which would then flow down through the standards. Then for each one of those, you could probably assign a risk, like for example, you could say we have to get this fixed for vital signs because if we don't do it now, we're going to have huge trouble down the road.

Others might say, you know, there isn't really another alternative here, but they're not ready for primetime, so if we wait until 2013, it's okay for us to ... but it seems to me that given the timeframe that we've got, and sort of go back to the comments about 2015 is upon us now. Having some way of triaging the stuff that's there and figuring out what do we have to change now. What we do we have to change for 2013? What are the ones that are the high value, high impact, critical issues that we need to deal with? I think that kind of influence from this committee becomes really helpful because then it says, okay, well, what are the things that we ought to work on now to try to solve this problem, or we're going to have a huge

problem in 2015. What are the things that are going to be moving along right, but it's just going to take the ... a little time to operationalize it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And this is Jamie, so let me slightly restate your three categories. What I heard was one category is based on the IFR, we're fine now, and we think we'll be fine in the future. Another one is, the second one is, we may be fine now, but changes are needed in the future within the scope of comments that we can make for the things we can change for the future. We want to recommend changes because we need something different for different path or a path where none exists, and that would include things that have been omitted from the IFR. So the second one is recommendations that we want to make about perhaps 2013 and beyond. Then the third category would be things where, and vitals may fit this, where we think there's a serious problem in the rule, as published, and we want to make some recommendations or comments on the rule kind of in the immediate term. So we did hear – sorry.

Betsy Humphreys – National Library of Medicine – Deputy Director

This is Betsy. Can I just clarify that last one?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

So when we say we need to make changes in the immediate term, we're talking about something that's wrong or that we consider a serious problem for 2011.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

For 2011, yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

So I think we ought to say a 2011 problem.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. Okay. So a 2011 problem, so maybe it's even simpler. Maybe category one is no problem. Category two is anything that we can change for 2013 and beyond. And category three is we really want to recommend an immediate change for 2011.

M

I'd just like to make a comment because I realize we're looking at the IFR. If you look at NPRM from CMS, and it talks about quality reporting, I understand that that's attestation in 2011, but after that, you're supposed to actually be reporting values.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

M

Some of those values are vital signs before 2013. Some of those values will include observations. When you get down to quality measures and secondary use of data, there are clear gaps here that we don't have standards. So where we say no standard adopted for 2011, that puts at risk the NPRM requirements. I know that's not....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. So maybe category three is a problem before 2013.

M

Right.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. And so we did hear some guidance yesterday in the standards committee on what kind of comments are most helpful, and so what we heard is that it has to be factual. It should have some either experience based or quantitative basis for the comment. We want to be as specific as possible. We heard from Dr. Blumenthal that it's especially helpful to consider things that have very broad applicability, especially to practices of five physicians and under. And that it really needs to be a logical outgrowth of what was already published, including what's in the preamble, as well as the rule. So we can change or remove, but can't add things.

Marc Overhage – Regenstrief – Director

Can I just – it's Marc adding a question or comment, I guess. As I read the NPRM, to Floyd's point, even the attestation in 2011 for ambulatory attestation, it says, will include the numerators, denominators, and exclusions for each clinical quality measure result reported, so it's not even a 2012 problem. It's a 2011 problem given that attestation actually has data. And I think there's some confusion about that. People think there's no data in, at least as the NPRM reads now.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And it's auditable, right.

Marc Overhage – Regenstrief – Director

Yes.

M

That kind of feedback, I think, is useful. I think the IFR for standards focused on those things that would be certification criteria and things that accepted interchange.

M

Does that...?

M

Well, I just, I'm telling you kind of ... we didn't get it right in everything.

M

No.

M

But the issue would be there, and what you have to do is calculate a numerator and denominator....

M

Right.

M

The sense was that, you know, and maybe we missed a few. Those did require ... standards because you would report a number that says here is our percentage or here's our whatever.

M

Rather than the numerator and denominator.

Rather than the numerator, but looking ahead to 2013 and 2015, if that information has to do ... electronically transmitted in some fashion, you know, we have to take a look at those quality metrics. I think this group can be very forward thinking in terms of where we're going. If we start thinking about secondary use, if we start thinking about other kinds of things, the recommendation could come out of this group that says we recognize all they need is a numerator and denominator that's a percentage. That happens internally.

M

Let me ... though and what I did hear from Karen Trudel on the NPRM was that there will – they are identifying ... for auditing to make sure that it was correct, so they're going to be auditing. It's much more complex ... any way you did it versus based on some standard.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, yes, but there isn't a standards basis obviously, right?

M

Okay. No, I understand.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And so, therefore, there can't really be any consistency in a measurement, at least for the next two years.

M

Right, well, except that you are supposed to do more than attestation for 2012, so it's not 2013. It's sooner.

M

But, I mean, we need to – this committee is ideally suited to kind of talk through some of those.... It may say ... identified standard ... your audit will be incredibly ... but that if we do have standards, we might be able ... that may be good motivation to think about what are we going to do with NPRM and what are the other....

M

I don't mean to interrupt you, but I am, Doug, wearing my provider hat, shamelessly. The consequence of saying, well, okay, if we're going to have standards for 2011 or 2012 that, oh, by the way, we haven't told anybody about yet, and that CMS would hold you in an audit to using those standards, that has implications as well for how we conduct business and how we adhere to....

M

And I think, in constructing the IFR, we tried to get the minimum set of things that we thought that would satisfy the requirements of meaningful use and things like that. We tried to focus on external exchange and the standards required do to that. And we tried to, for those things, for example, there was a numerator and denominator, and that's what was reported, we didn't specify what that numerator and denominator was ... metric, because we thought that may be an internal process. The NPRM says you have to have the functionality to generate that. But we're not concerned about your internal representation of that work. Now that was just the guidelines that we did, and the feedback from this group, I think, is going to be helpful to see whether we got that right.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

This is Floyd, and my concern is some of those measures are really benchmarks ... percentages, and I understand that, and that's fine ... necessarily meet the standard. Some of them are NQF endorsed measures, which we do call standards ... meaning for standards. And they actually get down to a level of which codes are used and how each thing is calculated. And if you are actually reporting on an endorsed measure, you are supposed to be handling all that discrete, defined data in your EHR. Whether it's in the rule or not, it's being requested in order to come up with the numbers to report for attestation. So in a sense, it ... reporting on an endorsed measure, so maybe it doesn't have to be stated....

M

You know I'm sympathetic to your career goals in this, Floyd. I'm a little disinhibited this morning. I had two hours of sleep. But I am concerned that, for example, if I were to take the perspective of my employer, I can almost promise you they are not going to read the NQF data elements with the same diligence and care that they would in IFR or, for that matter, in NPRM. So while what you're saying is true in an ideal world, I think we want to, and I share your goal of migrating that specificity into this kind of framework. We just have to be very thoughtful about what the timeframe for that actually is, because then people will actually be accountable for executing....

M

And allow me to say it's not only the providers that are going to be accountable, but it's part of the IFR for certain patient criteria, then ... accountable for coming up with certification mechanisms ... there's a whole cascade of things that occur. And there is....

W

I really think that what we're talking about relates to these quality measures versus what's over here for 2012 ... we're really talking about a very serious and well-formulated comment on the CMS NPRM. I mean, there isn't anyone who isn't writing that NRPM, I know, who wanted to have an implied requirement that you had to go somewhere else to figure it out. I mean, they would have wanted to actually have said, this means ABC for what you have to do. That would have been what their goal would have been in having a clear.... The fact that it didn't happen is unsurprising given ... timeframe in which they had to do it, but that's a very serious comment, and ... two things are supposed to be in synch. And it sounds to me like you're saying they're really not.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. This is Jamie. I think that the quality measures vocabulary discussion for the value sets in particular and the implications for comments on the NPRM, I think that's really going to come out during Floyd's section of this meeting where we got through that in more detail. What I'd like to do is ... Marc, do you have something on that...?

Marc Overhage – Regenstrief – Director

I guess I'm still struggling a little bit with process here and where we're trying to go, so maybe you can help me clarify that because....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

What I wanted to do is I think this has been a very good, general and broad discussion, but I did want to bring us back to wrap up just an initial overview of the particular standards that are adopted in this rule. We heard about some specific issues with vital signs, medication allergies at the ingredient level, and potentially HCPCS. What else is there in the table that are ... HCPCS ... so what else is there ... any particular...?

W

You know, I think that you could say ONC because it says i.e. If it had said e.g., it would have been okay because HCPCS is required by HIPAA.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

W

I don't think we can overrule HIPAA.

M

You've got to fix that.

M

Yes....

M

...in the long run because ... well, no, but I'm saying that HCPCS is a killer, right, because I can represent drugs in HCPCS, and now you're trying to pull together a quality measure, and you go look at their ... HCPCS codes, and it becomes very....

M

Least common denominator problem.

M

Yes, and they're not well – so while that is required by HIPAA, it's something that I think we've got to think hard about ... trajectory is because if we leave that secondary use, we're just dead. Just having gone through that with several organizations trying to map from their internal....

W

Yes, and so you could deal with it this way. You could say, all right, what this rule is saying is for procedure, you can use these. And then up here it says for medication lists, you have to use one of these. So what it may be that what this should say is the non-drug part of HCPCS and maybe some other exclusions because they're covered in the other thing, rather than just saying all of HCPCS because down here we're talking about procedures. We're not talking about drugs. Up here that's pretty clear that it has to....

M

So maybe that's a scoping question. That's a nice way to think about it ... for this domain.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That would be ... perhaps comments on constraints that are within the scope of the existing IFR.

M

Stan and I are lost. Where are the HCPCS...?

W

They're not there.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Well, that's the thing. HCPCS are adopted – because the adopted standards are HIPAA, and HCPCS is part of HIPAA, they're adopted, but they're not listed in the table.

W

On the other hand, we actually would like, from the point of view of the detailed of the medication ... so forth, we want to say no, there's a requirement for that is in fact ... RxNorm, which then gets you away from a piece of HCPCS, which is....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Now let me just ask. We haven't heard from folks on the phone, and let me just make sure, first of all, that you're still there, that you're with us, and see if there are any comments on the standards that are adopted in table 2A for part of this discussion.

M

Can you hear us on the phone?

Bob Davis

Yes. This is Bob David. I'm still here. Still listening.

Donna Pickett – NCHS – Medical Classification Administrator

Donna Pickett, still here.

W

...still here.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I want to give folks a change to air any particular comments on what has been adopted, but I also want to move our agenda along, and so unless there are other particular items, so again, we've heard some very

good discussion about vitals, UNI, and HCPCS in particular, so we will want to come back to those. We'll have plenty of opportunities to come back on all of these items, but I did want to move our agenda along and move to Betsy's presentation on the common definitions and processes for value sets and subsets.

Betsy Humphreys – National Library of Medicine – Deputy Director

This is one of the things, for the people on the phone, this is one of the things that was sent out just recently this morning, and I'm happy to go through it based on the handout ... one sheet....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think that they're Word documents.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. Essentially when we were on the call the last time, everyone was talking about value sets and subsets and whatever. And at least some of us on the phone got the impression that maybe when we were talking about these things, we each had something different in mind, so we thought that it was going to be hard to move forward with a logical agenda unless we all agreed to what it was we were talking about.

M

Spoken like a true....

Betsy Humphreys – National Library of Medicine – Deputy Director

No, I'm interested in concepts more than words. So the thing is that this really should have said discussion draft, but at any rate, the general definition of a subset is essentially a set whose members are members of another set. That is a set within a set. Okay. Fine. Then a value set, in general, is the list of possible values for a given purpose, and that may or may not be composed of one or more subsets of something, so that's how we're dealing with this, unless you want to have a different distinction.

M

I guess I would quibble with – are you prepared for quibbling?

Betsy Humphreys – National Library of Medicine – Deputy Director

Sure. I just think we need to come up with a definition, so whenever we say subset and whenever we say value set, we know what we mean. When you go down further, I'm then commenting on there are different types of value sets and....

M

It may or may not on value sets. The way I've always ... value sets in my career is that they're always a subset of terminology. That is finessed in a way that if you take HL-7, for example, something as trivial as administrative gender, which has three values – male, female, and unspecified – then you could say all right, that's a value set. But where's the source of vocabulary for that? The way it's managed and it seems like a copout, but you define the vocabulary space to be the administrative gender terminology space from which you take a proper subset or a complete subset of all of its values. I'm just pointing out that value sets, the way I've always conceptualized them, are always subsets of a larger set, even if you have to....

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, you know, I just sort of feel that in some cases, and I don't – we can define this any way you want, but from my point of view, if the value set ... codes, just the value set, it isn't a subset of anything else. It's the ... codes. There are only 50 of them. There they are. There's nothing bigger that comes from ... you know....

M

But then they'd be a terminology space of state codes that would be equal....

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. I'm happy to say that it's always the subset of something, no matter however is defined. But I think, in a lot of cases, we've got people constructing value sets. They're not using anything to construct them. They could, but they're not. Therefore....

M

I submit they're not making a value set, but they're making a terminology in that case.

Betsy Humphreys – National Library of Medicine – Deputy Director

I see. So you – okay. What you're saying is a larger terminology could be, by definition, the strange collection of things that are chosen to put into value sets for....

M

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay.

M

Just ... you would take the ... list as a terminology ... value set...?

M

Yes, and the reason why you bother with that, what might seem on the surface to be silly formality, is because it enormously simplifies the way you manage and orchestrate vocabulary.... If you always have this clear relationship that value sets always, in every case, derive from a terminology.

M

... resolved an issue for us because in administrative.... We say HL-7, but that's not the source we would ... as we're doing our quality measures. I'll show you later. It helps us ... that would make sense....

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay.

Bob Davis

This is Bob Davis. Could I ask Chris a question?

Chris Brancato – Deloitte – Manager, Health Information Technology

Sure.

Bob Davis

Chris, would you imagine that you would bring up the terminology to say healthcare terminology, and then within that have value sets for vital signs and procedures and medication lists and things like that? How high up would you create this "terminology" of which value sets sit within it?

Chris Brancato – Deloitte – Manager, Health Information Technology

Yes. That's a good question, and I think the answer is ultimately arbitrary and subjective, but my matter of taste here is that no, you would not declare the uber medicine source of all things possible in healthcare to be the vocabulary and have everything be a derivative. I've always believed in this notion of interlocking terminologies from which you draw the appropriate value sets. The other finesse that's relevant here is that at least in HL-7 notions of value sets. They can, and you more or less covered this, Betsy, derive from one or more sources.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. We can go down through this. So the issue is, I'm happy to strike the fact that they might be a subset. I'm happy to say they are a subset, or I'm happy to say ... just end it and say the set of possible

values for ... purpose. From my perspective, I know that we can define our vocabulary quotes ... integers, but I usually don't when I'm thinking of vocabulary, so maybe I shouldn't.... As long as we all know what we're talking about.

M

...talk, I've got to leave.

Betsy Humphreys – National Library of Medicine – Deputy Director

Exactly.

M

One is an object.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. Right.... Okay, so if we say that, in general, a subset is a set whose members are members of another set, and a value set is a set of possible ... values for a given purpose, and then we go down and say, in our context, which is sort of health IT vocabulary, I felt that a vocabulary subset was a terminology set that is a subset of a standard vocabulary, and I'm saying that because that's what I think we care about, and has been defined for one or more of the following purposes to produce the value set, to define the universe of relevant values and standards vocabulary for a specific purpose without constraining all possible valid values for that purpose. My view is that it is this second one that applies to something like a problem list because even if you had ... problem list, you have all of the SNOMED that could possibly be used as a problem.

The day somebody gets ... and it isn't in there, you're going to put ... in the record because I don't think you want to say we're never going to describe the problem the patient has because it isn't in the vocabulary. That's foolish. So I think you can say here's the constraint. This is where you can get your problem list from the standard vocabulary, but then you always have this open-ended option, you have to have it. I feel if you say you don't have it, then everybody thinks you're a fool, and there's no point going there.

Then for convenience, it seems to me, you have a subset. And that's to ease in implementation of the standard vocabulary. In my strong opinion, you can have multiple subsets of the same vocabulary for this convenience purpose because, A, if you ... subset of SNOMED for the problem list could be a lot smaller, and there could be a subset....

M

That's exactly how ... works, and it works extremely well because....

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. The thing is, it can be the two things. It's for the implementers, but it's for the users, and I believe strongly that it doesn't preclude the need to have access to or to use the rest of the vocabulary. It's to make life easy, but it is not to say, hey, this is the eye clinic, so we're going to standardize all the eye diseases for this thing. And low and behold, we have a need to also talk about stomach cancer of this patient and, for that, we can use whatever we want. This is silly. We'll never get to standardization that way. And it's also silly from the read point of view because if somebody legitimately sends you a problem list in SNOMED, and it happens that the people had problems that are not on the common problem list, so it's not the subset that you implemented, you still need to be able to read the problems of these patients.

M

It also needs to trigger decision support. It's not just read....

Betsy Humphreys – National Library of Medicine – Deputy Director

No, it's coming. Right. Exactly, so you need that for that. And I also feel that we should think about this convenience subset in terms of when we get to the questions of what do we do about these things. Who

produces them, and how are they distributed, and how are they updated because, in some sense, the convenience subset has a lesser requirement for updating, etc. I mean, it has one, and it has other requirements, but it has lesser than a true value set has because once somebody uses a convenience subset in their system, unless they have the most average practice in the world, they will eventually have to use terminology that didn't come from the subset, but came from the controlled vocabulary, so they're going to have to have some local modifications no matter what they do.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I'd like to put in a placeholder for future discussion and not have this discussion now.

M

Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

But I wanted to relate a couple of comments that I heard in the standards committee yesterday. One is that our highest priority should be convenient subsets that will be needed by implementers to have their – sorry.

M

Jamie ... are we in charge for this group or some ... ONC ... suggested subsets? How would you make those?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think that's something where we can rely on input from a lot of others, so where, for example, if somebody else, whether it's Regenstrief or HITSP or somebody has identified the 95% most frequently used ... test names in LOINC for routine tests reported in HETUS or some other particular subset, then what we can do in this taskforce is to say that is the convenient subset. We can make a recommendation that particular convenient subset should be made available to implementers related to meaningful use.

M

...have to be involved....

Bob Davis

This is Bob Davis again. I have another question from here. You're talking about convenient subsets, and I guess in the spirit of trying to harmonize our semantics, within the X12 world, all the time value sets are constrained for the purposes of that transactional use. That we would think of as just a constrained list. How is that different than a convenient subset?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think the definition that if I can just read back my own shorthand version is that that would be a value set, which is the universe of codes or concepts that can be used for that particular purpose, whereas the convenient subset is essentially an open-ended subset that says, all right, these are the 95% most frequently used lab test names, but you're going to have tests that aren't in that list, and you should still use LOINC for those.

Betsy Humphreys – National Library of Medicine – Deputy Director

Part of this is having convenient subsets for particular purposes has many values, but one of them is definitely on data entry because you can, as somebody starts to type in something ... assumption that there's a higher probability that they are trying to enter one of the most frequently occurring problems, then the least frequently, and you can in fact order – make it easier for them to find those and pick those without giving them thousands of things. That's just one little illustration. There are a variety of reasons to have them, even though obviously within the application, many others are used.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Can you hold for one second, Marc? I just want to go back to Andy's question about, so what does that mean for us, or why are we involved in that. I think that we have been asked to make recommendations about which subsets should be supported, published, etc., related to the interim final rule and meaningful use. I think that is something where we're going to want to consider input from the SDOs, from experts, and make recommendations.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

This is Andy. I might be the lone ranger.

M

No, you're not.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

I think that's a stupid idea because that's going to happen naturally. Do you think that urologists want to draw from the larger list of all terms? They want to see the ten things that they always diagnose and the five things they always order, and they're going to trade this stuff. They're going to go to their specialty society meetings. They're going to communicate with each other, and they're going to figure it out. As long as the universe is well defined, then they know where to go to get their subset. If we start trying, I mean, we'll just bog down. I can tell you that I thought that that was what I had to do seven years ago when I started on my little journey, and I didn't. Then they resisted it. They wanted to do it themselves after they gained experience with how their system was going to work. We don't help ... shouldn't. We don't have to. It will happen absolutely organically, and if we try to change that process, we're just going to get in the way.

M

Marc?

Marc Overhage – Regenstrief – Director

That's the two-hour sleep thing, Chris.

M

....

Marc Overhage – Regenstrief – Director

Exactly. At least that's my excuse today. I am with Andy that I'm not clear where the driver for this comes from. I can think of some cases where this might be helpful. For example, I'm going to use ... here's a list of 200 laboratory tests that if you generate them and send them ought to be coded because that brings a level of ... interoperability ... and lots of people need to use those. I think that's an example where I can see an argument for let's take data from national labs. Let's take ... data ... figure it out, and recommend a set of 200 things and say ... lab results, and it's one of these 200, it ought to be LOINC coded. And the other ones, do them when you can. I can see some value in that. I think the things, when you get into what are the diagnoses you're going to report from a high resolution MRI done on Thursday of the left right toe, that's not a business we ought to be in.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Let me just clarify.... I hope I didn't say, as I certainly didn't intend to say, that it's the work of this committee to develop any subsets. I don't think that's our job at all, but I do think that where there may be confusion about, well, what's the minimum that's expected and so forth, I think that we can provide recommendations about that. But I also think what I hope is the next part of Betsy's conversation is, I think that we can make recommendations about the process that, as Andy said, where do you go to get those things? How are they published and disseminated? Also, what are the processes for managing those? What are the rules of the road? I think we can make useful recommendations.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, and one of the reasons – this is Betsy again. One of the reasons ... out is because I believe that ... subsets, there are a variety of things that can and should be handled very differently from some of the other things, and that's one reason why we need to tease them out.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Help me ... understand.

M

To reinforce that, I think your distinction of a convenience subset, which in your urology example is something that we should stay well away from and, hence, it's useful to discriminate that use case from what I would characterize as its opposite, which is not a convenience value set, but actually a prescriptive value set that would have implications, say, for a quality metric or other....

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. I think that while I'll agree with you that we don't want to define the universe ... and we don't want to say you have to use this one, I do think that if there are some that can be produced centrally that have a broad value, they would be highly valued by implementers as a starting set, you know, as something that would help ... data entry. They would be highly valued, and so I think that since we're trying to move people toward meaningful use, the fact that we know of some where the issue might be, well, you know, what's the process. How can we build, for example ... terminology center ... NLM. I mean, if somebody had done something like this in the U.K. that is for the urologist, can we just make that available to people so they're not starting with a blank piece of paper when work had gone on in other clinicians somewhere in the world?

M

But it has no approval....

Betsy Humphreys – National Library of Medicine – Deputy Director

No, not an approval cycle, but just how do I find these things? Where do I get them? Are they being maintained in a way where it's my problem to determine whether in fact this thing is no longer in that vocabulary? It's been retired. It's now considered obsolete. Or is it being produced in a way where I don't have to worry about that because, you know, at least every six months, they'll report that out, and I'll find....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think, Stan, and then Marjorie, and then Marc.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. I guess I agree with the current characterization.

Betsy Humphreys – National Library of Medicine – Deputy Director

Speak up....

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

I just agree with the current characterization. There are two things going on. One would be, there seems to be consensus that we don't want to take on or shouldn't take on any responsibility for developing or editorializing on or, in any way, acting as an editorial board on the content of these convenience sets. That in fact it may be very useful for us to essentially set up a process that brokers, so that instead of everybody figuring out and doing e-mail or something to send these, there's a place they can go. They can say, if I've got one to share, I can post it here. If I want to pick one up, I know where to go, and there's a way to search and find them, know who made it so that there's something that we could do to facilitate, if you will, the trade and commerce in those things, but not to act in any way as an editorial board or as a restrictor of the content or a validator of the use or anything like that.

M

...commodity exchange....

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Marjorie?

Marjorie Greenberg – NCHS – Chief, C&PHDS

Two things. One is, it's my understanding that IHTSDO or some ... was in it developing some of these subsets. At least I know they are from the point of view of the mapping exercise with ICD-10.

M

For those of you who don't know, I'm the U.S. representative of the board.

Marjorie Greenberg – NCHS – Chief, C&PHDS

I know.

M

Betsy is on the GA, and I can tell you what the activity is. The activity is to try to focus on the most used codes as the first place to go to do the mapping. So it's not truly a subset for any particular convenient use. It's just a frequency distribution. And we, Kaiser, we gave them the first couple of years of our experience so that they could have a place to start, but again, that's exactly what Stan and others were talking about. We've had ... ambulatory....

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, it is true that the IHTSDO workbench is a good ... good environment for creating value sets, and it's also a fairly good environment, for example, for people who will work out the arrangements for it, but the potential is definitely there, and the reality too where somebody who has worked on a value set for X in the United States could work within an environment, a subset of SNOMED, within an environment where they could actually see that in fact the U.K. had a subset for something similar, and they could look at that and say, oh, well, I'll start with that and edit it or something rather than having a blank page. And I think that there probably will be an environment where folks in the U.S. can look over the shoulders ... doing something similar, and maybe even we could get them to the point of dividing up the work and start these, or something, depending on whether the collaboration ... you know, among the large ... countries, including the U.S., Canada....

Marjorie Greenberg – NCHS – Chief, C&PHDS

Actually, I had a second point ... quick, and although I'm a realist, I also, from an epidemiology point of view, I just get a little nervous about ... subsets becoming pick lists and particularly – I mean, it's one thing maybe for reimbursement, but in an electronic health record where, oh well, this is close enough type of thing. I know this is something in mortality coding that we really have argued against because we'll never advance knowledge if we reduce the causes of death to a pick list. So I think that's why ... I think when you're dealing, I mean, I like the fact that, as Betsy says that even if it's a constrained set for convenience, it doesn't mean the rest of vocabulary is out of bounds. But there are real costs. I think there are risks with pick lists.

M

That's great, but there's ... this is an aside because, in the death certificate stuff, that was taken to the extent that it said you have to type in diagnosis. And that's just so instead of doing something, which I think was really, really rational, which is to say either choose it from the list or type in what you need to say. They say you always have to type it in, which says I'm guaranteed now to have mistypes, misspellings that otherwise could have been. So I want to push back the other way. I mean, I hope that – anyway....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

This is fertile ground for.... Let's not....

Marjorie Greenberg – NCHS – Chief, C&PHDS

I won't go ... but I just, I felt I needed to put that on the table.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think Marc was next, and then Doug.

Marc Overhage – Regenstrief – Director

....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay, Doug.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

Let me just make sure that I'm kind of understanding what the discussion is because I want to make sure that we stay focused on what our goals are with regard to meaningful use, the IFR, things like that. We could, in this group, propose a universal solution to vocabularies, and I think that would be certainly something.... But I think, so what I'm hearing is that getting to meaningful use may be hard. One way that we could improve getting to meaningful use is to provide a clearinghouse of unapproved, not regulated in any fashion, but a way in which people who are out there trying to meaningful use can collaborate around value sets ... specific things that would aid them in getting....

W

Subsets.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Subsets.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

Subsets. I'm sorry.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

The second thing that I think we may also want to consider is that this notion of prescriptive value sets ... because, in some sense, we may, the group here may say prescriptive value sets will improve compatibility in comparison for quality metrics because everybody is using a prescriptive set.

Betsy Humphreys – National Library of Medicine – Deputy Director

We can get to value sets, but we're talking about subsets now.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

Subsets, so just....

Betsy Humphreys – National Library of Medicine – Deputy Director

See, and what we're saying is that a subset can be prescriptive if it is also defined as a value set. But many subsets are not defined as value sets, and we're not sort of saying that from my perspective, if you try to convert a convenient subset into a prescriptive set, then we are indeed in trouble.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

I'm not suggesting that.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay.

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

Please extract yourself from that. I'm trying to get clarification around this, and not sort of jump to conclusions, but I have this notion that there's this clearinghouse that falls outside of kind of regulations.

It falls outside of certification. It falls outside of the standards rule that this group may say, there's value, and ONC should think about that as something that would help get to meaningful use.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes. Floyd?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes. Can I add to your comment?

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

...then I'll finish.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I'm sorry. I thought you were done because Jamie said....

Doug Fridsma – Arizona State – Assoc. Prof. Dept. Biomedical Informatics

No, because Betsy got me off track. She got me all nervous about the work.... But there's this other thing that says it's about getting to meaningful use. It's about ease of interoperability, and it's about the importance of comparison. And so, in that sense, it's not about the clearinghouse that everybody kind of gets to, but this ... saying we want to identify ... whatever it is the right term ... that will help us get to those two things because the clearinghouse won't get us there, but that we need to be able to say, for us to be able to make relevant comparisons to quality measures, these are the code that you have to use, or for us to get the interoperability, everybody has to agree that these 200 are the ones that everybody understands that if it's outside of that, you'll have to serve ... exception.... But I just want to make sure that ... distinction to make.

Betsy Humphreys – National Library of Medicine – Deputy Director

You know, I feel myself that in the exchange of data that it could be an unnecessarily, if you were able to specify what the labs did, which you don't seem to be able to, but I think that should be on the list for the February request, the February request of things we need additional requirements, you know, things the ONC needs the authority to do. A notion that you would say to every lab, your first step is for 2011, you have to use the LOINC codes for these tests, and that meant that most if 95% would be standardized. I mean, I think that would be a very nice approach, but it seems to me that if I'm down here in the doctor's office of the hospital, and I'm exchanging, you know, I'm sending Stan's lab tests to somebody else, and they're all coded in LOINC, then I'm sorry. The other guy should be able to look them up and let you know what they are, even if they're not the 200 because LOINC is standard, and it arrives. And maybe you build certain things around the 200, and that's within a convenience. But when somebody sends you standard data from somebody else's record, and it is identified that this is a LOINC coded thing, then you should be able to read it. I mean, you should have access to read it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

The policy committee, I just want to interject a comment on what you're saying because I think the policy committee and the standards committee both said essentially to us that implementers need an easy and convenient starting point, which we've talked about as being these convenience subsets. And so I think what you're saying is that that's necessary, but not sufficient. And so I'm not disagreeing with that, but I'm just reflecting that one of the priorities, and back to Andy's original query about why are we in this at all. One of the priorities that we're intending to address here in this taskforce is the availability or lack of availability of that starting point for meaningful use....

Marc Overhage – Regenstrief – Director

Part of my disconnect may be, and I spoke with Andy, if we've got 200 problems to tackle, this feels like number 205 to me, and maybe it's not. We've had some feedback. It is an issue. It is a problem. It is a need, but how important is this? In other words, and sorry, I guess the question I would ask an

implementer, meaning I'm implementing Epic in my practice, or I'm Epic. I want to put a starter set in. How much of a problem is this keeping you from putting ... heck no.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I'll just ... my own personal....

M

I would have said the opposite.

W

Yes.

M

I have people who say it, you know, basically, I'm getting ready to map LOINC. Is there some way I can reduce my work instead of comparing my list of local codes to 40,000 LOINC codes? Can you give me a list that I ought to do first?

M

But that's a different thing.

M

That's exactly ... convenience subset is meant for.

M

Another distinction I was trying to make before, and maybe I didn't succeed at it, there's a set of things. I think that's an example of one that ... there's a commonality of purpose where that's very helpful. Picking which 20 codes that'll be on the urologist pick list.... That's a distinction....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right, so....

M

I think we agreed with you, Marc, but I think there's an interesting distinction here, and I'm starting to appreciate the subtlety of your subset versus value set. I like it very much, Betsy. But within subset, I think we can further divide it, and you have. Let's be explicit about it. To convenience sets, which is the urology thing, and I think we all agree that's not what we're supposed to do. But this LOINC subset, it's going to be, you know, you are required to report it in that if it's one of the 200 or so. That is not a convenience subset.

M

Right.

M

Right.

M

That becomes a difference. I don't know the name of it, but the kind of subset.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

This is Jamie again. So my way of thinking, that's a prioritization within the set of possible convenient subsets.

M

It isn't a convenient set.

W

If you're required to use....

W

But on...

M

...subset.

W

But the other thing, of course, is – but the thing is that if I use LOINC for everything, I've already done that. I do that.

M

True.

W

Then I don't care about this. This convenient subset, this requirement is not mine because I LOINC code everything. Therefore, it's irrelevant. It's irrelevant.

M

But you're....

W

But it might be somewhere else where it's a place to start for somebody else.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

I think you're absolutely right. This is Andy. We've already done all of this, and so what's happening, which is very interesting to me, is that I get requests from all over the world, but not from the U.S., for our subsets. And so the people are being smart in a lot of places. They're saying, gees, they've been implementing. They've got experience. It's all codified. Tell me what your frequency distribution is because I want to tackle that first. That's really what we're talking about here. For major segments of things that we know – and this is different from where I think Floyd is going to go. I think, in my mind ... it sounds like for you, Chris, it's starting to crystallize. We're not going to prescribe the 200 most commonly ordered laboratory tests, but we can sure tell people what they are.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And where to find them.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

Pardon me?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And where to find them.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

And who's mapped them, and said this is it, and it's not a prescription. You really don't have to do these 200, but you'd be well advised to because that will jumpstart your work, period, end of discussion. You don't have to do the 200 most commonly used diagnoses or procedures. It's really about taking frequency distributions with existing implementations, and sifting through it ... and saying, this is the stuff you really want to pay attention to. That's different from, what do you do for every specialty so that they can have ease of use, which they are also very interested in. But now we're going to talk about how do we measure good care, and NQF is going to say here are the sets for understanding who your population of blank is.

M

Yes, but now you're getting to value sets....

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

No, exactly, but....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, so let's get back, if we can, let's get back to Betsy's presentation.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. Right, so therefore, we say that in our context or this is what I came up with as a draft to discuss that a value set was two things. It was a list of valid values for specific segments of a standard message, which may or may not be or contain subsets of one or possibly more standard vocabularies. If I put standard in front of it, maybe that handles the issue.

M

My objection.

Betsy Humphreys – National Library of Medicine – Deputy Director

Your issue there. But clearly we are dealing with, in the message standards, a number of things. The valid values are one, two, three, four, which you don't find in standard vocabularies, or the thing really should be a subset of a standard vocabulary, but we just haven't gotten to that point yet. So that's one set of value sets.

And then we get to the list of specific values, which again it seems to me may or may not be or contain subsets of one or more, possibly more, standard vocabularies that define or identify a population that is nominated for a quality measure and the subset of that population that is the numerator, and there probably are some other things I should put there. One of the things to say is that I heard, within living memory, presentations of people who find that it is actually the combination of a set of values from a standard coding system currently in use like ICD-9 ... and an algorithm against the natural language occurring somewhere else with a high degree of accuracy, identifies the correct subset of patients, and that at least some of the work that I know that that network for which I believe ... coordinating data center. They've actually found....

M

Merge.

M

Merge.

Betsy Humphreys – National Library of Medicine – Deputy Director

That they could find it over here and move it over there, it may need to be tweaked, but in fact sometimes it actually works at more than one organization....

M

Yes. I'm the PI....

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. Right.

M

...and that is true.

Betsy Humphreys – National Library of Medicine – Deputy Director

So the thing is, I could imagine the scenario where I don't know if they're there, but I could imagine a scenario where the actual definitions of how we identify the population for these value sets is actually, you

know, this set of code and then this algorithm against this set of data. And, I mean, I don't know if we're going there.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

In some of our previous discussions would have defined that as multiple value sets within a quality measure rather than a value set.

Betsy Humphreys – National Library of Medicine – Deputy Director

And the only thing I'm saying is that means that we're going to end up with something that really isn't a subset of a standard vocabulary. It's a subset of the things we think we could imagine showing up in this part of the record.

M

I think we have to be very careful about distinguishing what we want to do in vocabularies versus what we want to do for standards, quality metrics, or other, what I call in generic terms, phenotyping, because I consider extraction of a particular combination of characteristics a clinical phenotype, in a sense. And, indeed, in the emerge network, we talk about high true put phenotyping, which shockingly corresponds with high true put genotyping, and it's all about ... at least ... consortium, and sort of getting the electronic medical record as quick as the genotyping these days. But, nevertheless, the notion that an algorithm is required to identify a complex phenotype, which involves rule logics, typically operating against medications, laboratories, diagnoses, some NLP frosting, that's our state of the art in emerge is hugely distinct from our task of defining vocabularies and value sets.

It's true that those algorithms ... use value sets, and I was puzzled. But now I think I understand why you did it. That you separated out the quality use cases in your specification here, because I didn't understand why you would bother to pick on ... and not....

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, it's because it's meaningful use, and we're focused on meaningful use. That's what we're supposed to deal with. I mean, if this was around our goal for this group, you know, I think that our vocabulary where we're sort of saying....

M

But I think this is a philosophical thing. I think or I would hope our goal around this table would be for the broad spectrum of potential secondary uses. And while, yes, we have a fiduciary obligation to look at meaningful use....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, and I would say, and my own guidance – this is Jamie again – on that is that, yes, but not necessarily for 2011. So that broader secondary use policy objective may be very well stated as a longer term objective of meaningful use for 2013 and 2015, and certainly could be used to inform recommendations that we make for 2011. But I do think that we do have a short-term focus initially.

M

Okay.

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, I agree with you. I guess my feeling is that if a value set or an identified set of controlled terminology, standard terminology of classification ... is part of what you use to identify ... then you just need to say it's part, and then you have to use this on top of it.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think Stan, and then Floyd, and then I'd like to see if we could wrap up this conversation ... description of the processes around these things and then move on to Floyd's section.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

Yes. This is Stan. The way we've thought about this, both at HL-7 and within Intermountain Healthcare, and discussions with Chris at Mayo that the second thing that you say, I'm a little nervous about calling that a value set. The reason is that the value set, the way we use it, is tightly tied to your first case where it's a field or a segment in the message, and we agree universally to that because that's what makes it possible for us to communicate unambiguously with somebody.

The second case, it may be a value set, but it's different. And the reason I say it's different is that this is now a collection of things that I want to use for a very specific purpose. It's not now general-purpose communication of data. It is this set of things is for meaningful use, or this other subset, they become very context specific. You know, it becomes, if you broaden it beyond meaningful use, and just talk about secondary use of data, these are now relationships where what I want to do basically is be able to use them for assumption logic and decision, whether it's logic for description of a phenotype or for quality assurance or for clinical investigation. It's now that subset is absolutely useful, but it's very context specific, and it's going to change day-to-day based on administrative or research purposes or other things. And so they're much more dynamic than—

Betsy Humphreys – National Library of Medicine – Deputy Director

I understand, but I think that the idea of ... NQF measures and whatever, I'll call these things whatever you want to call them. They have been calling them value sets for these measures that are written in here, so I think that they don't....

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

And we can go either way, but I think....

Betsy Humphreys – National Library of Medicine – Deputy Director

But they don't change all the time. At least, that's the idea of ... measures. I don't think....

M

Well, actually, I think what you're referring to is things change based on your need, and you develop a list of codes. Actually, I said we call them code lists just to confuse the issue, but I equate that with value sets.

M

Yes.

M

And that you presented, but that is....

Betsy Humphreys – National Library of Medicine – Deputy Director

So I don't mind calling them code lists.

M

I do.

M

...code lists, that's fine, but for this specific purpose, I need to know that this patient ... what patient I'm looking for, and it's all those that have these codes associated, and then what intervention I'm looking for ... codes. I think that....

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that's a value set.

M

...value set.

Marc Overhage – Regenstrief – Director

Chris, this is Marc. I'd love to hear your reaction to that, and the labels we're using are problematic. For example, when you described that, if I heard you say a set that describes a patient, this is Chris'....

M

A characteristic....

Marc Overhage – Regenstrief – Director

Well, a characteristic. Maybe you just need to repeat what you said because I struggle with this.

Betsy Humphreys – National Library of Medicine – Deputy Director

In my view, what I would have called this would be coming from a whole other place. The thing that they're defining looks to me like a retrieval strategy. You're just looking for patients that have A, B, C, D, E, F, or G.

M

No, well....

Betsy Humphreys – National Library of Medicine – Deputy Director

To make these....

M

Sorry to jump in, Marc.

Marc Overhage – Regenstrief – Director

No.

M

I mean, they're very close, and we just have to agree ... I'm not quibbling about the words, but I think they're mechanistically and procedurally different because they are a collection, but if say our purpose, I don't know what a good example is. I'm trying to think which major is a good example, but let's say we want it to do ... you know, we want it to determine whether people were receiving appropriate discharge medications after MI. And so you want to know, you know, are they on an anti-platelet aggregator. That list is going to change because, number one, it's very specific about being in that discharge, you know, in the discharge, so you wouldn't count every substance that actually did that as being a member of that set.

And so in the first use case, in the first use of value set, the tie is always to some structural element as part of a message or a model. And in this, it's a useful collection that is part of the logic that you're executing. I'm thinking of sort of the databases that support these two things, and in the first case you need a database that says what's the data element that this attaches to and it's an allowed value for. And in the second case, you don't need that context so much, or maybe you do, but it's actually a triplet of saying, you know, if I see a lab message with this code and this value of greater or less than this, then they're a part of the numerator or denominator.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay, so....

M

And I'm....

M

...phenotyping.

M

Yes. It's phenotyping.

M

...exactly what it is.

Betsy Humphreys – National Library of Medicine – Deputy Director

So if we want to come up with a name of this, I'm happy with it. Part of the reason of having a different name, one of the reasons why I said we had to do this or I felt we definitely had to do this because we were on the phone call before. People were talking about both things, and I didn't know which one they were talking about.

M

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

So if we want to make it easier for ourselves, then let's come up with another name that deals with what is the universe of vocabulary and code things that Floyd has to put together to define these measures.

M

...understand this is different. When you say the context, that's different than the specific values, and my slide is what we did in HITECH connecting the codes that represent concepts that measure ... and the context of its use and.... That's what we call a data element. In a sense, it's a phenotype, which a measure developer has to describe that up front. So does your researcher. This is the data I want and the context of use. When we talk about the list of codes, and I'll keep it to that and not give it a term, that's what we need to understand how to maintain that. We need governance, so if AMA is creating this, how do we know that they're updating the ... list?

M

I'm 100% in support of that, and part of my reason in distinguishing it is that in real practice, we typically need more than just a pure set theoretic. We need some assumption because what we want to say, you know, the rule says, if their white count was greater than something, and then what you're really saying is, oh, when I say white count, I mean a LOINC code that was an automated count or a LOINC code that was a manual count, or the LOINC code, and I'm really doing – now the element is that I'm using in logic is white count, but I need to know that any of these more specific subtypes of that count for that in the logic, and so it's more than just a pure set theoretic. There could be....

M

It's a class structure.

M

It's a class structure, and that's....

M

...referring to change ... different test, and it's subsumed under....

M

Then you want to put it there, and you don't want to change the upper logic.

M

The upper logic remains the same ... don't have to rewrite the rule.

W

...value set ... class.

M

Yes.

M

Whatever you decide ... happy to change the name of that...

M

I am too....

M

Just to help me ... I know you're going nuts here, Jamie, with your schedule.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

No.

M

...another way to help me sort these things out are, there are questions and answers, right? And so if you're defining a patient to include in something ... Stan's example, whether it's ... phenotyping or it's in a quality measure, the question is what are their discharge medications, and the answer is A, B, C, and D. And then there is a value set though that you're going to construct for a quality measure, which is what are the answers that I care about, right? Drug X, drug Y, drug Z that the patient is on that does distinct from what are the variables. What are the observations? What are the questions? And this is back to your point of the context of, is that in the discharge med segment of the message, or is it in ... those are two very separate things. When we talk about value sets or whatever, I never know if we're talking about that list of here are the three meds that I care about, or the three, and the FRT categories of meds we care about.

Betsy Humphreys – National Library of Medicine – Deputy Director

That is the ... and we'll just figure out a way to define this so we all know what we're talking about. That's what I was trying to get here was the specific value that you are looking for in order to identify your population, the denominator and the numerator.

M

Right. Here's the list of potential answers that I care about to a particular question.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. You could say it that way, or you could say here is the set of values that I'm looking for in this patient's record.

M

But to this point, I think, and I agree with it completely ... it's not just in the patient's record. So a great example is....

M

It's, where is it in the record...?

M

Exactly. It really matters where in the record it is, whether it's going to meet your need or not.

M

I think the scope of this....

M

What the question is that is in answer to....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

...context....

M

...whole thing, that's fine, but I would think ... is how do we manage that list of codes to identify the right meds for that moment in time.

M

So it's not the questions. It's the answers that we're talking about. A list....

M

The questions, we could certainly expand to say how do we deal with those, but out of the same vocabularies....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, so I think....

M

Well ... vocabulary too. The questions are a vocabulary....

M

Okay, so....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

We've gotten pretty far into Floyd's section. I do want to get back and finish Betsy's slides here.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

What I'd like to do is just put a pause ... not turn it off, but I want to put a pause on this section while we finish our discussion, a broader discussion about processes or subsets and value sets. Then we will dive back into this with Floyd going through some specific examples on measure development.

Betsy Humphreys – National Library of Medicine – Deputy Director

Okay. I do want to go through ... gross error on the next slide where it says priority ... address or available.... And, you know, based on ... will have to expand on this notion of ... obviously, but this second one should say value sets for meaningful use and quality measures, not subsets. Sorry. That's a gross mistake.

Then the third one is the other thing we're talking about, which is value sets for ... messages that are required for meaningful use. I'm asking this question. My view was that it was within the scope of this group ... value set does or could, I guess, draw some or all of its value....

M

I think you have to have those, or you're just going to end up with incomparable results.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. So my view is that we can just forget and say it's no priority for us to worry about value sets as part of the message that people want to persist in having these as not coming from any standard vocabulary or regard it as their problem if it's one, two, three, four, if it's the state codes ... something else.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I also want to just clarify on what's listed as priority one, convenience subsets. That is something we've been asked to deal with, but it's not what are the urology or the ophthalmology codes that are needed for that specialty implementation, but it's rather, it's what Andy was describing as, I think, the frequency, so not maybe the full frequency distribution, but making some recommendations as to what frequency based starter sets would be useful for implementers.

M

Just an additional comment, and maybe it's a segue into your next slide is, isn't it also the governance and infrastructure and education recommendations around all that?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

You're just the perfect straight man. Go for it, Betsy.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, for the next one, so I'm saying, and when I said what do we have to do, I was referring to the world or whatever, not necessarily that we're maintaining.... So it seems to me that you can look at each of these things and say what do you want to do about them. Do you want to describe them in a standard way? You may or may not want to create and maintain them over time, but you have to do that if it's a value set. There may be value to maintaining convenience sets too, depending on a specific, you know, particular one, particularly if they're identified based on ... chunks of time. You might want to come up with a new one ... current use.

You want to identify and establish a sustainable infrastructure that supports creation, maintenance, and dissemination. And, in each case, you're dealing with who decides what are needed, and we're going to have a different answer for this because we know what the answer is on the convenience subsets. Anyone can decide if they ... it's great, so let them do it. But for some of these other things, it is who decides who produces them, who reviews and approves them. Again, the answers to these questions are different because ... subsets. Nobody is reviewing....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right, so we may say that just having a clearinghouse is fine, but that some of them, particularly if they're going to be involved in the testing and certification of EHRs, may want to have more governance.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. So then there's then again, you're just answering these questions. I don't know ... how and how frequently are they updated. And then there also needs to be, at some level, some greater or lesser training or assistance ... in use of them, and also in use of the terminology as a whole so that people can do other meaningful use and other requirements, which includes things like decision support and pulling out patients and all of the ... how do we get all of the beta blockers ... enumerate them, and then other things like, for instance, patient education.... It seems to me that that's the universe of questions to be addressed, and depending on what we're talking about, answers can be more or less obvious, and these requirements for things like maintenance and version control, and so forth, vary pretty dramatically across these different....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes. There is, I think, a need for the same or similar set of processes for a different category of things, which is cross-maps that relate to the vocabularies that are now in the IFR. We had a discussion about this last year before we knew it was in the IFR, and so we talked about value sets, subsets, and cross-maps all needing some sort of management governance and dissemination communications. So even though our focus today is not really on the cross-maps, I don't want to lose sight of the fact that....

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, you can ask these questions about anything in this environment.... And one of the things that I had done for my own reference ... everyone at some point is from the point of view of some of these things. You can't ... the management of some of these things from the whole law and the legal framework of what the ONC has to do and what somebody has to adopt and whatever. On some of things, if it truly is the valid value list for something or it is the way we define the quality measure or whatever it is, then there has to be a process that is, you know can track back to who is making what decisions based on what's in the law. You can't....

Marc Overhage – Regenstrief – Director

This is Marc. What examples, besides the list of 200 LOINC codes, do we have of what these look like?

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, one of the ones that we also have that was produced at NLM, if we're talking about ... subsets, is the SNOMED CT problem list. And this was basically a two-step thing because we defined from ... gathered data from a variety of places on their most frequently occurring problems, and most of them or many of these places didn't actually have these problems in coding SNOMED. They had some local vocabulary.

So then the second set ... say here are the most frequently occurring conditions. Now can we create a SNOMED set that covers that? And it was not based on the fact that we've been using LOINC, and here are the 200 most frequent. It was, this is the problem that's coming out of all these sets. Now can we quickly tell people, well, here is the SNOMED equivalent of that.

M

Right, this is the core.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, the core subset. And the idea there was, well, if you wanted a convenient starter set or certain types of purposes, not all, hey, these were the 5,000 or 6,000 most frequently occurring things, and here they are on SNOMED. That was just to help people. Again ... producing something. Would that be the appropriate subset? That's why I feel ... immediately feels ... helpful. That wouldn't be appropriate for everybody, but it might help some people.

M

So we're talking about for, and I don't know what the categories are. Andy may have a list ... you know, ten or eight or something. I don't think there's 50 of these, if I'm understanding this right, that are essentially the distributions of use in the wild across most organizations. One of the limitations at Kaiser, as wonderful as it is, is that it's one organization.

Betsy Humphreys – National Library of Medicine – Deputy Director

Right.

M

So maybe it is different elsewhere.

Betsy Humphreys – National Library of Medicine – Deputy Director

And the core set is the one that we did it was use in the wild and six or seven or eight different organizations.

M

Right, so it's across organizations. And, frankly, I would argue you don't put any cutoff on. You don't really create. It's not really a subset that you're interested in. It's really, what's the distribution because some people may want the top five. Some may want the top 500. Some may want the top 100. It's sort of the distribution based on the terminology ... adopted.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Based on the list ... yes. That's it. That may be simple to knock off our list essentially....

Betsy Humphreys – National Library of Medicine – Deputy Director

The other thing is that there is, in some sense, a convenience data entry process, subset to RxNorm as well. It's called RxTerm because essentially if we're deciding ... meaningful use in the United States, it eliminates all ... that is not prescribable in the United States. You're not using it in the United States.

...the obsolete ones, which of course are still needed because ... etc., but it does that. So that's another one....

M

It's really the same thing. I mean, it feels like the same thing. What are the top 100 drugs prescribed, the top 1,000 drugs prescribed, whatever it is, so you've got another dimension ... geography. We're just talking about the U.S. We don't want to look at ... codes and figure out what the most common ... problem lists in Great Britain are.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right. So it might be something like top 100, top 1,000, you know....

M

Well, why not all of them? Who cares? Let somebody else pick.

M

Well, actually ... having not that long ago been working in a vendor situation where we would get requests all the time. Give me a subset of information that I can use with my problem list out of SNOMED, and so we could give our customer. We could do their frequency distribution. As the vendor, to be able to look at this convenience set and include it as part of ... deliver.

M

Sure.

M

Sure, they can use everything else.

M

Right.

M

...way to do that, but not every organization has ... in this room to be able to do that for them. The same with convenience sets for meds and connecting, especially if their ... connecting that to the ... codes where they actually have to bill for. It really helps a lot to have that at the front end....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Andy, just a second. To the extent, and reflecting back on Floyd's comment to some of the previous discussion, to the extent that these starter subsets, based on some frequency, become in effect the initial universe that may be implemented ... there are also, you know, we may also want to make recommendations here about the need for mechanisms to insure that implementers have the ability to query or look up the entire list....

M

...maybe it would be helpful for us to write rules of the road for this marketplace. So here ... American Society of Thoracic Surgeons, I'm already thinking about the convenient subset that's going to be useful for docs who operate ... and it's going to help guide them toward things that I'm trying to collect and measure because I'm asking all of them to participate. Every specialty society to one extent or another is going to be working ... can we provide them with guidance. It's not about what is your subset, but how do you set it up? Where do you go look for it? How do you make sure that your thoracic surgeons not only can see the subset, but can get out to the larger vocabulary when and if they need it, because not only do they have a patient who has to have their chest ... they're also psychotic and may need some medication. ...to me, that's a valuable way to ... time like this. We are going to have this marketplace. We are going to do these changes, and here's how we think it ought to work....

M

I made an assertion that this is tenish.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

That sounds right, approximate. I mean, order of magnitude, that's right.

M

Yes. I don't know if it's 5 or 12, but yes. Okay. And there's no cutoff. It serves the list, and....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I think ... one frequency distribution without cutoff or whether it's multiple lists at different cutoffs, I think that's something....

M

That's an implementation detail. But the point is....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. When you're producing the list, you have it. You have longer distribution.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

I mean, obviously you take what was done by ... and others ... job because we were taking ... didn't use a standard vocabulary.

M

Right.

Betsy Humphreys – National Library of Medicine – Deputy Director

Therefore, if you're going to figure out and do the correct mapping of ... to this, then you're obviously going to try ... top of the list, not the bottom, and you might never get to the bottom.

M

Right. Exactly.

Betsy Humphreys – National Library of Medicine – Deputy Director

... central activity ... creation....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

I have to say, I feel like we're coalescing on some common view of the work, you know, for this group going forward. And so what I'd like to do is see if we can wrap up Betsy's segment, take a break, and come back and dive into quality in more detail. Betsy, can you wrap this up?

Betsy Humphreys – National Library of Medicine – Deputy Director

I think that what I can do, based on our discussion and where I think we end up is I had a two-page document that dealt with this, and I think maybe what I'll do is do a little revision of it. And if anyone has, you know ... went through Floyd's presentation and discussion, then we'll figure out what, if anything, you want to do with this because we've got a whole lot of people in the world. We're talking about value sets, and some of them mean this, and some of them mean the other. So we just – the notion of coming up with a different name that captures this and imposing that going out, although I don't usually feel you can ever do that. In this case, we might be able to. I do think there's a problem because you have to ask the question about what people mean when they say value sets in this context.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

So we may want to think about our own names for these things. We talked about what I'm thinking of now as frequency subsets versus quality subsets versus other subsets and other value sets.

M

I'd be a little afraid ... quality....

M

I think we want to make a name that's good for kind of all secondary use.

Betsy Humphreys – National Library of Medicine – Deputy Director

Do we want to call it, so do we want to get it back to what ... and deal with it as unified definitions?

M

You know, that's actually maybe a good....

M

What do you want to name these?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Let's come back to that later. I'm going to say, let's take about a ten-minute break. Does a ten-minute break sound good? Is that enough?

W

Can you give us...?

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

All right. Do you want to say 15 and come back at half past the hour? Fine, so we'll come back at half past the hour. Thanks. What I'd like to do is call us back to order and turn it over to Floyd Eisenberg from the National Quality Forum to ... and we'll have an opportunity to get back to the placeholder we left earlier in our discussion about the – let's see – sets of codes for quality measurement purposes and other secondary uses.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Okay. So what I'll start with is this did come out. I finished this at 2:00 this morning, so I didn't get much sleep ... but it only was sent out by e-mail ... so everyone should have it ... on the screen, and all these pages are numbered ... going to the slide that looks like a document, this is all based on work done by the health IT expert panel ... funded by ARC that was given the task of creating a quality data set. And similar to what I had stated ... that meeting was there is no such thing as a set that's static that we could give you, and so we came up with the framework.

So far, we've had very good feedback on that, and the challenge though is getting it implemented. If you go to the third slide, the framework is really based on the fact that we're starting with a concept, and we called that standard elements. You can call it concepts, and we have a team. The team comes up with ... and it's a standard element. It's basically the concepts, so a condition and, in this case, the example on the slide here is diabetes. To represent diabetes, it has to have specific codes based on a taxonomy, which we ... HITEP ... code set, and this is the list out of that, so what would be what Betsy listed as the value set, which we call it a code list. And that then defines the element, diabetes, as a condition.

But the contracts ... we actually, in this particular example, we need to know it's an active diagnose, and that ... identify that on a problem list. And so the reason for the graphic is the concept itself is in the circle with its respective code out of the taxonomy, and the context is the square, if you will, that surrounds that that provides context ... we call that whole thing a quality data element, so constraining or binding the context with the value set or code list with the concept.

If you look at the next slide, what we did is there are a couple of examples here where I might need to know diabetic medication ... where the diabetic medication would be defined by a set of RxNorm codes as the code list, and the ... context, so it's not just that it's prescribed. That's a different context.

Dispensed is what we're looking for, and we, for a lab result, if a lab test is A1c, we want to know the result of it, so the third example. We also, in the context of a quality measure usually are looking for some PDF text that's telling us – not PDF ... giving instructions for where to find it in the record. This is more common with inpatient measures where there's a team of abstractors that reads the records and gets it all out, and ambulatory ... less of that, but we want to know the source of the data. And, in some cases, in one ambulatory measure, as an example, a blood pressure has to be performed by a clinician. Performed at home by the patient can't be used for that particular measure.

We can all agree or disagree on the value of it, but that's the measure, and that's how it's endorsed. If I wanted to know that I measure patient engagement in their own care, I might say it has to come from the patient or a device in the home, so that's where source comes in if they can define source. I'm not quite sure how to get all of that, all these data flow issues, source, recorder setting ... out of the record, but at least we can deal right now with the quality data elements in the top box.

What we did was identify about 35 data types, and what we call the data type is where it says diabetes active diagnosis, so an active condition, a history of conditions. I think ... history of conditions all are different data types around conditions. For medication, dispensed is one data type. Medication prescribed or ordered is another. Medication declined is another so that it's based on the concept medication. What other context are there? Each of them then ... will a pre-coordinated concept with its context, and that's how ... conditions, I mean, our data types.

Given the data type that provides the context balances this code list can help define what we're looking for. So if you go to slide five, our concept was having created this definition. If we could get those, in this case the example is a quality measure developer, and I keep looking at Marjorie because she's in the process with AMA and PCPI in the retooling....

Marjorie Greenberg – NCHS – Chief, C&PHDS

Right.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

She's very familiar with this is that if they can define their elements using the data types and identifying a list of codes, then if each data type had a mapping from each EHR, whether hospital, ambulatory or elsewhere, then it would be easier to put context in the EHR, knew where to put interoperable purposes to deal with the data type of the context. By providing you different lists of codes, they could find what's needed in the EHR. That's the context ... last.... So in other words, we're looking at that middle layer as a Rosetta stone, in a sense.

So if that Rosetta stone, that middle layer is the data types with HITEP, then ... now we keep hearing that EHRs want to innovate and change how they do things, but every time they send information for a certain context and use of data, if they do it, if they know what they called it, how they mapped it to that context and for use in data types in that way, then we can have measure developers or CDS rules developers saying I need to define the patient that has this context and these codes, and I could use the data types for that as well, or for researchers. Now maybe this is going too far, but....

M

No, to follow up on Chris' point, because ... struggle with it. Part of the reason I think I struggled, Chris, is that the quality data element is sort of ... patient has diabetes or not. It's sort of the abstract concept that you're trying to roll up. It's the phenotype in what you're doing. One of the things that I struggle with, at least the way it's usually presented, including this diagram ... successfully communicate ... is there's only one way to find out whether the patient is diabetic or not. That's to look at a list of codes, inactive diagnosis. As you've done in your ... work ... there are many ways to find out if the patient is active diabetic or not. And so one of the problems I have with the concept that's presented is that the quality data element is convoluted with the quality data type. In fact, you may have diagnoses ... medications ... lab test ... that define diabetes.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

If you give me a little leeway to explain how we get to that, and actually, if you look at slide four, the real reason for slide four was to answer your question, but some people ... third element. So if I wanted to define diabetes as a measure developer, I wanted all my patients with diabetes, I want to know all those with an active condition diabetes, and I can define that using a data type. I want all those with medications, perhaps you want to say ordered versus dispensed. That's up to the individual questioner how they define that. And I might want to define it by all those who have an A1c above a certain value. So the reason for that slide was to say they are using the data types three different ways, maybe four or five. But if I wanted to define my denominator of diabetics, I would basically say active diagnosis or med dispensed or lab result greater than or whatever.

M

Or I can say and if they were.... That's exactly the case. You get into these logics, and let me give you an example, if I might, with myocardial infarction where we encountered the notion that traditionally you've got ... that are elevated. You've got EKG findings, and ... fine. That works for some patients. But then, so that's flavor A.

M

Yes.

M

But you can have a silent MI, in which case your criteria for laboratory and EKG would be slightly elevated because we have notes supporting that. That's flavor B, and so on. You can have non-FT, all these permutations. At least in our way of thinking about this, it's not a single specification that defines the phenotype. It becomes then a family of possible permutations, each of varying strengths and certainty.

M

Yes, exactly. In fact, the answer is now zero, one.

M

Well, we force a zero, one answer.

M

Well, yes. It's probably not zero, one.

M

But if you're talking purely physiologically or, worse, philosophically, you're right....

M

But even for research, you pick a threshold for different purposes.

M

Can I make ... you know, we're in constant danger ... quality world, and I spent 20 years there having the perfect ... is good. The point here is not to make certain we have every single God damn diabetic in the denominator, but enough of them so that we can make sense of the clinical performance.

M

Yes.

M

Okay, and so, you know, what I'm struggling with here is, again, what I started with a couple hours ago. Tell me what your ideal future state is. What is it that you would like to be using as a set of tools that define denominators, that define numerators, and to extract measures? This isn't it. This is some step along the way because we're starting with ICD right now, but that's not where everybody....

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Well, actually, that's a good segue because the fact that we have ICD as an example is not the point. The point is that we can define each individual element to which you can apply logic, then you can define your phenotype any way you like depending on what evidence you have to define it. And the intent here is not to say it's ICD-9. It was to say you tell me the appropriate taxonomy, and in a tool to create this, which I'm about to show you, we would like to constrain the taxonomy to those identified by the IFR of the standards committee. So in effect, I would say SNOMED should be there, and not ICD-9, although the near term it's ICD-9 or either.

So the concept here is not constrained ... picture, I only showed one. So let me move then to slide six. One of the things we did is we want to identify these ... trying to figure out, now how – this is nice on paper, but how does this reach something coming out of the EHR? For good or bad outcomes, we decided that we needed to go to an organization that dealt with standards and said where would I find in a message, and this is a HITSP output, where ... in a message, which is supposed to be the HITSP opt 21 repeat. I don't know why it came out this way. The other, and the C83 mapping for CDA, where would I find this data type? Some data types you don't find in a CDA, and you can't find in a message like patient experience. We understood that's going to be a problem, but we have to figure out where we would get that.

To the extent we could, where would we find each data type with the definition of what we were talking about? That has been done. It is now published in this data dictionary from HITSP. The subsection of C154 data dictionary is the quality data dictionary. It maps all of these to some CDA concept, if there is one, and somewhat to a message. That was one of the efforts that we did.

Now the next step we did was say if we want to create a quality measure, and here's where you ... slide seven, we develop a prototype ... for measures, and we now have two measure developers actually using data ... to create the measures using the quality data sets. If you go to slide eight, the overview of this is, at the top, you are able to enter measures. We put the name of the measure. We were then able to say, for all of the elements within this measure, i.e. these concepts, and you enter the codes, the code lists ... measures, so I'll take you through that. But this is the overall screen. I'm not ... offline, I'd love comments on the screen, but we're putting out an RFP to have this more of a commercial grade ... based entry that will be part of our measure submission at NQF. This is an interim to do retooling because out of the NPRM, about 132-some measures in there, 112 of them we were asked to retool, so we needed a quick way to do that.

Looking at the HITSP process, doing 16 took a year. We have 112 that we have to do this year or quicker than this year. We needed a tool, so that's why we did develop this. But it uses the QDF, so I think it will help, and you walk through what some of your.... So look at slide nine, the first thing is you put a name in for the measure. Then you give it an ID, and identify this is what.... Next, you say, what are the elements? In this case, I want ... receptor blockers.... Actually, that's been done in the measure. ...more detail.... Yes, that's been done. You can talk about it.

It is a medication. The taxonomy is RxNorm, and the version is, and that's not a proper version. This is a sample data entry. The version of the taxonomy, rationale for creating the sets, so I created this set because this is what I want to do with it. So if anybody else would want to use this set, they would understand and could then decide if they reuse it or not. There's actually, if there are some constraints on this, and it's not just all ARBs, we asked them to, in the name of the set, include some indication of that constraint. A lot of the guidelines on use comes from the earlier vocabulary summit in 2007 that I think Chris and Stan and others worked hard at. So that's where a lot of the guideline for doing this, it's not quite to that level, but close.

And then answer to their list in a common delimited form, and also provide us an Excel spreadsheet that has the concept name and the code, but in here we have just the codes. So now that we've gotten the code list ... value set, we then go to slide 11, and we have a list of codes lists from which.... Now if there's an existing code list, the recommendation is not to add a new one if the one is already there that you can use.

M

That's a value set, right?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

That's the value set. If in fact you're reusing ARB, don't create it again. Use it again. Now I want to apply it to my measures. In this case, I might want to know ACE inhibitor or an ACE inhibitor or ARB dispensed. Now I have to apply it to my measure, and I also want to say the same thing, ACE inhibitor allergies, so I apply that to my measure separately, and so that's slide 11.

If I go to 12, you'll see once I start to add each one of these, I have to define its relationship to other elements. Here's where some of the logic comes in. Now move to 13 you'll see in this case the example that an active diagnosis has to have occurred during a measurement period. Measurement period is also defined as a separate element, so I'm able to know it's during the period. It could be prior to the period at any time in life, or a custom at any date to another date. So this provides the ability to provide logic how one attribute or one context applies to another or one data element applies to another.

And if they want to, they can also indicate specifically what the source it has to be from. It could be any. What recorder, if that matters who them, who had actually entered it. What's said ... and some of these are ambulatory measures, so they're ambulatory ... inpatient. Going forward, we're looking at making measures generic across settings, so setting will have less relevance as time goes on. But for the current measures you see in the NPRM, they all are setting....

And if you know the field ... although I'm not sure if that field.... So once you've done that, you go to slide 14. You now have all of, in the middle, all of the different code lists here ... this measure and any other. This is your local repository of all the different value sets that you may be using for all your measures, and then at the bottom left, the quality data set, the elements used in this measure that pull from using the value sets and applying the context, and then you can apply the algorithm to say how to add and subtract them.

In slide 15, you identify ... one box, denominator in the next, exclusions in another, numerator in another. We now have a box of – I want other data ... adjustment ... but you're not going to calculate on it, so put those data elements in here. But just send them, and I'm not going to calculate ... not my algorithm, on the registry end or the warehouse end. We're going to use those elements also to risk adjust and do some additional work.... So it provides both that ability as well.

And just, I know it's not the perfect way to do this, but the next slide actually shows how we did it. So each data element is given a number, as you've entered it, and so its population is element 42 and 43 using.... The denominator is 44 or 56 or 54, and it does take a visual to go back and see which one it is. But for now, this seems to be working. At least I've been hearing good reports, and so they're able to provide the logic to say how to actually calculate this based on the elements. So your phenotype may well be your denominator, which includes all of those codes or some.... But what we're looking at is specifically how do we deal with the lists of codes so they can be reusable, so they can be updated.

The other thing ... slide 17 is allow you to export it, the whole quality data set to that measure, export the logic. What we'd like to do, which is currently a manual step, is export it in an electronic measure format that's slide 18, which is the healthcare quality or health quality measure format HQMF, e-measure representation ... standard ... just validating HL-7 based on the HL-7 ... and so putting it in that, which has a human readable form ... and also an XML from which you could use logic to extract or you could just read it and understand it much more clearly than text based measures. So the real early form is you could certainly understand it more clearly because it's more clearly defined.

We found that HITSP sometimes you had to look through a lot of probes to actually find the data element that was there.... This requires that it's very clearly specified, so that's the first step. The second step is how would we go from this direction.... So our retooling effort right now, slide 19, is we have 112 measures to have retooled by the end.... Some of them will be challenging.... Some of them include

inclusions, exclusions that are really hard to find, and so one of the pieces ... need to validate the format when it comes out ... really looks like the same metric and say it is....

We also need to create a standard tool that is not just ... to create measures going forward, and we need evaluation criteria for – can I just take this measure and run it against some test ... locations? That's a very high level, simplistic comment, and from this audience, I'm at risk for saying that, but what is it that we mean ... and I know it really works because, at NQF, we need that.

M

It's a workbench.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Yes, so we need something like that. But right now, one of our concerns is how do I deal with the value set, and here are the things that I was concerned about. How do we maintain and that the value set has the appropriate metadata associated with it that anybody who wants to use it knows what it is, knows where it came from, understands its meaning, so they don't misuse it. That's the first piece, and there's HL-7 rules around that. HITSP adopted many of those in technical ... 903. I don't know the numbers of every HITSP document.... There are only a few of them....

Also, are these all extensional or intentional, or how do we manage the difference? They happen to be only these codes, and I have to update them for ... RxNorm list of ARB increases, it automatically changes.

Betsy Humphreys – National Library of Medicine – Deputy Director

And what you're saying is you have some that are the ones ... the others.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Right. We do, but then measure developers question that should we do that or should we actually specify and update it. And only when we have the new version of our measure do we go from the new list. There's some tension there on what I'm asking for.

Betsy Humphreys – National Library of Medicine – Deputy Director

Well, I understand that because depending on what happened in X, Y, Z in the system, you might in fact be measuring different things.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

That is true. Some measure developers do not want them to just change until they're ready to, and in other cases, yes. And there is the data element they're looking at.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes, true.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

So we need some rules around that so they can understand what that means, so that's one of the things we're looking for is what recommendations we give to measure developers. I have folks now in the structured recommendations. It used to be called the hardened rules project that are looking at the e-measure and the QDFs as a way to define what they need to ... phenotype, and then make recommendations, so they have similar issues. Their first question was, can you hand me the value set that came out of the measure so that I don't have to recreate them? My answer is, I don't have them yet. And I couldn't if I wanted to because they're owned by someone else ... measure developer. So ownership becomes an issue, and I that gets to my next level.

If we want to reuse these granular, atomic level value sets for creation of measures, research queries ... reporting and measurement, decision support, we have IP concerns that we need recommendations around. Should these actually have IPs? The fact that AMA created this set, do they own it, or is this something--?

M

No. I'd just make a rule that if you participate, you're donating.

M

Well, that's a governance rule that if this committee comes out with would be perfect, and I have also others saying, some saying we employ terminologists, and we know how to do this, and we want to do it ourselves, and others say I hate this. If I could pick ... the right RxNorm list or from the right value set, our job as a measure developer is the evidence and creating the queries. We don't want to be in the code set business or code list business. And NQF really doesn't have the expertise right now to compare your code list and yours and say they're different, and go back to you and say, harmonize. That's a very complicated process, so how can we facilitate sharing? Is it centralized? Is it, they created one, and they meet all the criteria, and Betsy created some. Stan created some. And there's a federated way to share it that everybody adds to the group and agrees that you're the owner ... but they won't create their own. I mean, what are the rules of the road to try to make this enterprise work so we can get these measures done? Maybe we can't see that.

M

So many fun questions....

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

What's that?

M

There are so many fun questions here.

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I'm sure. Anyway, this is where we are is we need to understand now how do we move the enterprise forward in order to create these measures, queries, etc.

Chris Brancato – Deloitte – Manager, Health Information Technology

This is Chris. Can I just ask a couple of questions?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

Sure.

Chris Brancato – Deloitte – Manager, Health Information Technology

The NPRM describes here are the quality measures. From that quality measures, then with this whole notion of not managing the internal representations, but in fact creating standards around interoperability and those sorts of things, we've identified a series of standards that we want to be used for certification criteria and adopt.... When I take a look at some of the things that you've got here, you've got some things that are on the list that are not on the IFR and that are not identified as standards from HHS.

One thing that would be really helpful is to do the analysis and sort of see how many of the quality measures that you have here are based on other kinds of things not about.... And the reason that that's relevant is that the NPRM and the IFR.... If what we do is we say NPRM has been supporting ... oh, and by the way, to report on that, we are going to require you to use the standard that the Secretary has not adopted. We actually are, in effect, adopting a standard without following the federal....

M

That's where we were this morning.

Chris Brancato – Deloitte – Manager, Health Information Technology

Yes. So that analysis becomes, I think, really, really critical. That becomes a critical thing that needs to be put into the IFR or feedback to the IFR saying these are some of the issues....

Betsy Humphreys – National Library of Medicine – Deputy Director

And obviously based on what the law says about how you adopt the standards, those need to be identified. And if they truly need ... and there isn't something else that could be used instead, then I think they have to come forward from the standards committee, the policy committee ... and then the Secretary accepts David's recommendation, or they don't....

M

And, frankly, one of my challenges in responding to your request is when NQF reviews these measures and has some ... steering committee, and they're endorsed, over a number of years ... modifications ... send back to us until they go to "maintenance" and then we look at all the detail again. And none of these have been through maintenance yet, so just so you're aware, there are things I don't know about those measures, and our database doesn't have all the detail. So until they're all retooled, and I have my ... element list, I can't really answer that question with confidence ... at all. What I can say is, unfortunately, there are a lot of observations and findings, especially on the exclusion list, because that is dealing with a number of inpatient ones.

I could tell you from the 16 retooled by HITSP, there are a lot of things that some ... standards for whether you want to adopt them or not. But there are some issues there, definitely lab, definitely findings that are not addressed. Med allergies is highly significant, and there's nothing in 2011 or 2012 to cover that. UNI, at that level, they're not specified. They're specified at the meds level.

M

I guess we just have to have a certain, we have to have a significant ... to that because we cannot, through a secondary process, impose an additional regulatory requirement that hasn't gone through the process that we have to follow....

M

I have a question specifically about that because I'm aware of one model in the quality world, the regulatory model that's little bit different, but it's at the state level, so maybe it can't work at the federal level. The state of Maine, a number of years ago, stipulated in regulations that a specialty society or a series of specialty societies would be the maintainers of quality definitions and measures. It isn't specified in measures. They just said it will be them, and that's the rule. So is that a kind of delegation that can't be ... in federal regulation?

M

No.

M

Because you could say the NQF will maintain this ... after that, the regulation doesn't speak to....

M

Can someone clarify for me though because I'm a little confused? What is the piece that you feel like is new here?

M

Well, there are things that....

W

The only way to use this measure is to have at least some translation in your thing to a standard, which is not specified.

M

But what standard is not specified? That's where I'm losing....

M

Are you calling the ... standard?

M

No, what I'm saying is that the NPRM says the quality metrics, this is a quality metric, and that's going to be, you know, we have to define that.

M

And there's a bunch of language that talks around the designated entity for, whatever the words are, standards, which is NQF.

M

Right, and so they say when NQF is going to create the quality measures....

M

Right.

M

Endorse.

M

...or endorse the quality metrics, but they define those quality metrics in terms of standards that haven't been adopted by the Secretary.

M

That's where I'm losing it because I didn't hear any standards Floyd talked about that are not.

M

Well, I think you're talking about my HITSP mapping.

M

Yes, I'm taking a look at....

M

Doesn't have any standards.

M

No, I think what he's talking about is these ... what do you call them, quality....

M

The data types?

M

Data types, yes.

M

But the data types are not, I mean, you know, you could think about this different ways, but the quality data types are not, I mean, they're conceptual things, right? It's active medications or something, right?

M

No. Hang on. No. Quality data types are not executable.

M
Right, unless they're ... to standards, then they're not....

M
But active medications you might find in LOINC code that describes a section of a report that was active medications or whatever.

M
...talking about this guy, right?

M
Yes.

M
Okay....

M
Essentially.

M
So—

M
But that's okay. I still don't understand.... We're not specifying whether you can use Java or JavaScripts....

M
No, and it's high level ... but it's essentially a logical rule.

M
Yes, but that's okay.

M
So it's executable.

M
Right, so I still don't see the conflict.

M
But what he's saying is this is a de facto standard that has no federal standing.

M
Right. That's okay. Why is that a problem?

M
...because if to satisfy meaningful use under the CMS NPRM, we've got use these guys.

M
You don't have to use these. You have to use the measures that these describe.

M
Tell me the difference.

M
You don't have to. You could implement this in Java.

M

No, no. Let me....

M

But the logic has to be the same.

M

...doing a good job trying to explain what I was thinking, but let me ... if I could explain what I was thinking.

M

What did you say?

M

The issue is, I'm taking a look at the slide before this, 17, and it says here that ... it's got a bunch of code sets on there, and so one of the code sets is ARB, which has RxNorm as a code set.

M

Right.

M

But if you define your quality measure saying the quality measure is defined by this list of RxNorm codes, the risk you have, and I'm just ... we have to go through this. What I'm raising is a potential problem, which is, if NPRM says here's a quality metric, and we're going to give it to NQF to define or endorse those quality metrics, and then those quality metrics in turn are defined in terms of standards that haven't been adopted--

M

Right.

M

--like RxNorm.

M

I agree. RxNorm....

M

Yes.

M

But this is ... you've gotten exactly to the crux of what we were talking about before in the standards committee yesterday is where we've got the cart and the horse.

M

Right.

M

Absolutely.

M

...near term solution ... and the solution is, first of all, if you talk to the AMA and ... some of the early work on this, they're the first ones to start. When they create their list of codes for a procedure, they're creating it in CPT ... and in HCPCS and in SNOMED, so they're providing multiple options, which means whatever you have, you can produce. If we're talking meds, and they say RxNorm, all you say in your IFR is you need something that's mappable to RxNorm. As long as you have something mappable, no one is using RxNorm directly in their system, they're okay. There is a challenge with some like LOINC for vital signs

because we would say that. So if you wanted vital signs, you're going to find a LOINC code for systolic blood pressure.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

And LOINC is not adopted for that purpose.

M

And that is not adopted, so you have nothing there, so there, there is a problem. But for some of them, as long as you say RxNorm mappable, then this works.

M

Right.

M

I guess what I'm saying is that analysis ... helpful to come from this committee because if it identifies things that says we can't describe the quality measure from the NPRM in a way that we can ... because the standard doesn't ... for us to do that.

M

So that's....

M

...in the rule.

M

Isn't it in the rule?

M

Isn't in the rule, yes.

M

Also ... for 2011 ... attestation, some of that doesn't matter, but for 2012, well, actually, they have to report the data, so it does matter.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Now let me just ask, I guess, a regulatory process question.

M

...guide....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

If LOINC isn't an adopted standard, but it's specified in the IFR as being just for lab test names, which is more than that, but let's just say it's that, so it is adopted, but not for the purpose of vitals, so are we saying – so if we say it would be a useful recommendation from this committee to say the IFR, the final rule should be adjusted in terms of the use of LOINC.

Betsy Humphreys – National Library of Medicine – Deputy Director

Yes. I think that the one thing we know about the rulemaking, or at least that I believe I know about it is that if in fact the IFR governs what the products have to do, what they have to be able to do, and it says there's no standard for vital signs, then those products don't have to have implemented LOINC for the use of vital signs. Then if the people who are using the products are supposed to report this, then you have a big disconnect. And the only way to fix it is to change the reg or, alternatively, to change the NPRM because the IFR is set for something. And they say there it is, so another approach to this, and not advocate anything would be to say, well, we've gone through the 100 and however many measures you tell us we're going to have to use, and there are these dozen or every single one of them or 50 or

them or half of them where actually the use of the measure requires the use of the standard, which is not required over here. So we consider that to be a very good reason why you have to change ... final rule ... CMS.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

What I'm saying is that I think the vocabularies that are needed for ... some case in which I'm wrong. But I think that, in general, the vocabularies that are needed for all parts of all these measures are in the final rule, just not for these purposes.

M

They're mentioned somewhere, but not....

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

They're mentioned somewhere....

M

...LOINC....

M

No ... purpose. If we do it by purpose, we're going to ... HITSP morass, and we're dead.

M

But what I can tell you though is....

M

...be by data concepts.

M

...question rather than look at all of these measures ... in an overview of 524 measures, without all the data, went through and mapped every data element we had at NQF to the PDFs, quality data sets, and we might have found one or two elements that we tweaked in our final report because of it. But I believe our quality data set will handle every element needed for all of the measures in the NPRM. So if we take the quality data types, it's the data types and the standards and the vocabularies that will give us what we need rather than each measure, so we have 35 data types. That's a doable and not complicated process, especially since I have the HITSP table, and you don't have to agree with that table, but we at least have something to work from....

Betsy Humphreys – National Library of Medicine – Deputy Director

...that seems like ... used to happen, and then that definitely ... you know ... a formal comment that has to be made, and probably actually ... respond to both in the NPRM and....

M

There's a lot of interaction.

M

...far enough to change the NRPM....

M

The solution is that they have to become ... if you will, and right now they're not.

M

Just for the record, and I actually sent David a note yesterday after the meeting to say, I actually think that they are phenomenally well synchronized given the time that was available to write this stuff.

Betsy Humphreys – National Library of Medicine – Deputy Director

I do too.

M

I think it's incredibly good, how good it is. And it's just really peeling the onion, the next layer.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes. We, of course, go to the....

M

...phenomenal, well aligned in many ways, philosophically ... incredible, the work that the federal government accomplished....

M

The other thing....

M

...really true.

M

...another IFR ... certification. Something that might be worth looking at is not certifying the measures in the NPRM or in the EHR, but the capability of handling all data types to be able to handle any measure is more reasonable, in my standpoint....

M

...certification has to go into the IFR.

M

Yes, but those criteria, rather than say you can handle these 122 measures, and then they might not be able to handle anything else. It makes more sense ... that you're certified to be able to output any of these 35 data types in this format because that way you can deal with any metric to an extent.

Betsy Humphreys – National Library of Medicine – Deputy Director

... been endorsed by the national committee....

M

Right.

M

But we don't care about that.

Betsy Humphreys – National Library of Medicine – Deputy Director

But that's....

M

Again, it's the issue of ... regulations. The issue is that it's not part of the IFR right now, and because of the nature of an interim final rule, we can't add something ... like that.

M

Right.

M

...IFR.

M

The other IFR is where the certification....

M

Certification is going to be.... That's an NPRM that's going to come out to describe the process of certification, but the criteria are in the IFR.

Betsy Humphreys – National Library of Medicine – Deputy Director

So the issue would then be whether ... is probably not a place to hang your hat on, but you probably can make a comment because it mentioned anything to do with the quality measures....

M

I think the comment goes back to the NPRM, which says the NPRM has made all of these kinds of quality measures known, but the IFR doesn't address how those are structured. You know, I think, again, you're going to have to ... comments at both places.... I think they're all really valid points, but it's one of those things that I'm realizing that you have to be very, very careful that as we sort of further refine the definition of things, we have to make sure that we're not introducing regulatory requirements outside of the normal process....

Marjorie Greenberg – NCHS – Chief, C&PHDS

Yes, because you aren't.

M

Right.

Marjorie Greenberg – NCHS – Chief, C&PHDS

I mean, you might think you were, but you're not.

M

Right.

M

I encourage you to say that even though ... IFR, there's a lot that can be done, expanding on that, without having said it in the IFR, but if the IFR didn't mention something like ... you couldn't do that at all.

M

Right.

M

So that would have to wait another year for another IFR.

M

And it has to be explicit down to that granular level, not nested in a HITSP document somewhere.

M

No, I understand, but I just think if we want to move forward ... these capabilities, I think it makes a lot more sense....

M

That's an interesting point. So you can't assert by reference. I mean, forgive me, but when you say you're going to use ICD, you don't list every possible ICD code. You reference the code system because it's a standard.

M

The HITSP things are standards too.

M

No, they're not.

M

No ... specifications.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Yes, they're....

M

They may be implementation guides.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

...implementation guides, right, exactly.

M

But to put a finer point on what Chris is saying here, there are a variety of things that have been incorporated by.... When you incorporate something by reference, it says if you put it into a document....

M

Right.

M

So anything that is in the IFR that has been incorporated by reference can be commented on because it's considered part of that. Can I just tell you that I'm trying to print LOINC for the federal register?

Betsy Humphreys – National Library of Medicine – Deputy Director

Oh, God, it was so funny.

M

It was....

Betsy Humphreys – National Library of Medicine – Deputy Director

SNOMED.

M

We broke a printer....

M

...or something like that.

Betsy Humphreys – National Library of Medicine – Deputy Director

I was at the meeting, and I'm getting an e-mail from you ... sat there saying ... the office of federal regulations require ... printed copy down here, a hard copy of every standard, so could you help us figure out how to print out SNOMED CT?

M

...we've got to deal with that too.

M

Very small.

Betsy Humphreys – National Library of Medicine – Deputy Director

And LOINC, in comparison, we thought to ourselves, in my office is this wonderful document, LOINC had been translated to Chinese. We thought, well, there's a hard copy. Let's just....

M

We broke the printer....

Betsy Humphreys – National Library of Medicine – Deputy Director

For SNOMED CT, I mean, it was ridiculous, and so I actually, this is actually something that I haven't approached yet, but I actually think we ought to do it because, I mean, President Obama and the Administration, they say they're up on technology and whatever, and I guess my view is we ought to at least.... You know, it was so ridiculous, and then somebody is saying, well, there was some poor soul having to say, well, why do you have to do this.... But anyway, they came back and they said, we have to do this because it has to be there for.... Of course, the only response to this is, hey. If anyone wants to come down and inspect this thing, then ... this is the person who will never implement a system....

M

Which kind of goes back to where we started. I'm wondering about, you know ... how sophisticated of logic can you do or did you anticipate? Rather than saying this thing existed in this interval, could you say that a value of this had to exist two days prior to the existence of this?

M

Yes. Actually, I have the database, but it has a run timer, so I can't show it to you here, but yes. I'm not ... but it does. It lets you say within two days of this or prior to two days of this. It does let you do that.

M

...in a related question, then that gets into, there's been a lot of work on expression grammars, not the least of it done by SNOMED, ABNF grammars and the like. Are you inventing yet another idiosyncratic grammar?

M

...would not....

M

Actually, our intent for this was to provide something to get into the electronic measure and to express ... our main intent was to assign it to ... and create a measure. We are very open to not modifying.... This was, in a sense, a quick fix to be able to get something that they could enter. How it's represented clearly we'd prefer it as basement standard ... work with you on making sure.... This was not intended as a final product. This is an interim.

M

And then the other one was just my ... the interaction of this with more detail ... clinical models. So one system could have blood pressures that say essentially systolic blood pressure standing, systolic blood pressure sitting, systolic blood pressure right arm sitting, you know, all pre-coordinated in a single code, or the more rational thing that you would normally see in most EHRs is you would see a single code for blood pressure, and then the separate parameters to that, you know, what their sitting position was, a compositional grammar to that item, and so if you're actually trying to state a rule against that more compositional thing, you actually have to have some shared model so that you can reference the right points, so that you've got a name to say, and if their position was sitting, or if you think about orders, or even the problem lists. Active orders, you know, we sort of skimmed over, you know, it's an active problem because it's, quote, on the active problem list. Well, in database speak, there isn't an active list per se. What there is, it's a list who has a status field that says this is an active item in that field.

M

That's one way to represent it.

M

Yes, that's one way to do it.

M

I understand that.

M

There's a dependency on my favorite things, which are these detailed clinical models.

M

Where have you ever heard that before?

M

...I fully agree. In this particular tool, there is a box to say where it gets ... we call them attributes of this are you interested in. On the HITSP work ... understand whether HITSP is the right organization to define the model. Having used the CDA model and the attributes within it that is defined, and what we've done is provided that list of all available attributes to the measure developers to be able to select from those to say I want systolic standing and sitting and....

M

And actually, that's really, Floyd, I hadn't brought this up on our call, but that's been a difficulty for me is how much pre-coordination and detail do you provide given the level of expertise for those who will actually implement this. I understand pre-coordination, and I really appreciate post-coordination and clinical models because of my history. But what's thought of as an issue is, what I'm hearing is for the novice user, give me every permutation of ... blood pressure, and SNOMED sometimes ... have codes with context built into it.

M

Right.

W

So I kind of shudder to do this, but I actually give them the pre-coordinated, and then I give them the flavors of ... that's what....

M

That's really why that next level of detail, we did some work, but we'd love to get deeper to define it more clearly. Right now ... but they can, if they want, say any blood pressure or only standing....

M

And, I mean, to be clear, what you've done is wonderful. I think this is so nice.

M

And I do understand the need for....

M

Yes. I mean, in the context of where is this on the list, I mean you can do so much with what you've got. Don't start worrying yet about the additional part of that. But eventually we'll get there.

M

But we did build into it that that they will need to be able to incorporate that into their model of those. We'll see whether ...

M

Yes. I mean let's see. I mean it's okay to say CDA, but what you really want is a set of these models because, people, there will be, for good reason, different versions of pre-coordination of these things as people implement them in their system and so what you want is a library of these things that are logically described, independent of CDA or independent of SNOMED or of anybody's – I don't mean independent of SNOMED codes, but where the information model is described independently of any particular syntax, message syntax or ...

M

So let me ask you a question on that because I didn't put it on my list of things that maybe you should consider ... with it because we have some terminology ... who gave us all of these post coordinated

concepts and you can ... so where is the context that I could tell an EHR to do this? And I was told in this setting I was able to do that because I was able to work with the EHR. So is there a standard way; and this is a very naïve comment, so I apologize for it; that I could tell all EHRs here is a way to use those coordinated terms? If there is nothing like that how can I recommend that they use those coordinated concepts that are out of context ... use? So we, in HITSP, moved forward for pre-coordination, but understanding this need, so that's something maybe this group could look at is how you deal with terminology that way. Maybe there isn't an answer, you know ...

M

No, there is an answer.

M

Okay. Well that's great. I mean ... you probably know it ...

M

Well, I mean ...

M

... issues ...

M

... you've got to ... there's more than one answer probably and so what we would end up doing is – I don't know what we want to do. I should have said there are answers, because you can do it more than one way.

M

So I'd have to agree with you ...

M

You know, open EHRs describe these kinds of models. We're doing it with what we call clinical ... models. The U.K. is doing it with what they call the ... architecture. The VA is doing it with their version of UML models for these things, so there are too many ways.

M

Yes. It's going to be a broken record of yesterday, but there's a logical ... that we would like everybody to get to and there is a whole ... or a variety of places that people are starting to ... and what they need is a set of acceptable steps along the way and a timeline.

M

Yes.

M

So what can you do today and what can you do two years from today? What do we expect? That's two years; not four years; not one year; two years ... what you've got and then the ... is four years or six years or whatever it is. That's when we get to a small cluster of models that are acceptable that are ... and that help us to accomplish this sort of thing.

M

Yes.

M

If we don't do that here nobody is going to do it and we can talk about a lot of other things

M

I ... actually ... if I were ... HITSP because ... meaningful or not I would say this is going to fill a gap that we have identified in a technical ... so I think it needs to be done regardless of HITSP. It was a gap that we found and we had to deal with it, so ...

M

All right. I mean I can give a short presentation some time to just sort of introduce people to what's being done and if that's useful.

M

... frustrating ...

(Overlapping voices.)

W

And when you're the lone voice ...

M

... issues ...

W

You're not typically ...

M

There'd be two of those voices ... matter of ...

M

... recognized ...

M

... I don't know exactly ... the end result we're looking for ... presentation, but I think ... my last slides ...

M

Thank you. So I think we've certainly discussed a couple of key comments. We would want to recommend ... this group ... to CMS and to the ONC about the need for consistency, coordination and, as Mark put it, describing the cart before the horse issue in detail with illustrations from some of the measures we're, for example, as we talked about ... is not adopted for a purpose, but is needed for that purpose and the measures, so that's one thing I think came out of this.

There is also, obviously, a much broader discussion and so I'm not sure and it's not clear to me what next steps you might want to ... to, either in the very short-term in terms of comments or in terms of our next set of priorities for the next few meetings that come out of this ... related discussion. So I'm looking for ideas of proposals of what are our next steps related to this other than those comments that we discussed.

M

Well, so you're saying based on our discussion we would have some specific things that would have to go into ... there's a problem here that –

M
Right.

M
... here's his issue ...

M
Right. We've identified some of those, right?

M
And so we would have to have that. I think from the point of view of what ... engaged in doing ... whatever it is they're doing now we will be further ahead than we are now in terms of having some level of ... I am in agreement with ... about the ... issue and that strikes me as a ... activity, which I do think – I mean it's not that it couldn't get started going on now, but I mean it is as ... out ... there are these things and we're going to ... continue to beat our heads against this problem in terms of having anything with ... and expandable or scalable ... come up with a set of these things So I actually feel that from my perspective it's a reasonable recommendation that ... forward, not because it necessarily solves a problem in the next six months, because it won't, but because if we really want to ... scale over time ... get there.

M
How would you describe that recommendation?

M
Well, I think that I'll tell you what I'll do a little – rather than wordsmithing around the table here I'll think of how I would say that –

M
As I think about it I have trouble driving ... the same, so having a strong answer to look at would be –

M
Yes. Okay.

M
This is I think I'm ... this is too big and so having it written out ...

M
Well, what you want to do is think about this as something that you build them as you need them – not that it's something you build before you can do the next step, because you can do so much with just the simple assumption that blood pressure is a simple field and that people could supply that or a list of things that you can roll up into that field. That will get you a long, long way –

M
And that's where we're –

M

And don't invoke the bigger stuff until you really need it and then only build the models that you need at the time you need them. Don't assume that you're going to boil the ocean.

M
... question whether we ... detailed clinical models.

M
Sure.

M
Are these represented as ... HL-7 ...?

M
Say that again.

M
What is the representation of the ...

M
Within Intermountain they're XML, yes. Detailed clinical models are XML and –

M
They're in XML. So they're –

M
We've actually done a fair amount of work trying to ... and we've had discussions about adopting UML between our two organizations ... the basis for Stan tries to ignore those discussions.

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

That's not true.

M
But at present there's an Intermountain ... for ...

M
I mean at some point ... we don't have time ... at some point we just need to – I just need to sort of describe some of the things we've kind of been ... to help provide the framework for ...

M
I think –

M
That would be great.

M
The notion of figuring out what's the next logical step in this area and if it really is valuable to ... has ... at least get things in line to do it ... this strikes me as something that – that's what I mean about draining the swamp when a swamp ... over –

M

Oh, yes. That's very true.

M

It would be very valuable and then it would provide a level of guidance to also ...

M

Still, when I think about what we're trying to do with all of this stuff in the IFR and interoperability ... is we're trying to create interoperability all of the way from actually ... all of the way from sort of the transport layer resting ... on how you're going to do that to the packages to the content to the application. There's a whole series of ... trust relationships that we have. There's this entire stack of things we need to be able to support interoperability. At the end of the day in some fashion all of those things have to fit together, so for example, you may say I want to be able to do a universal lookup so that I can ... the query and say I've got a person who is unconscious. I know what their name is. Does anybody on the network know who this person is ... use case that they describe around ... and the DURSA. Well, that DURSA, the data use agreement, has to match the technology that you have and has to match with the security ... implement, so it has to match the whole set. Now, if you're just sending an electronic description without a trust relationship with different technology, with different standards and that's why I'm interested in learning a little bit more about a deep dive into this detailed, clinical model, because that's one of those intermediary connections between kind of the vocabulary package ... for a particular use.

What I'm working on, the thing that keeps me up at night is trying to figure out what that framework looks like and how can we create something that essentially can take raw materials in on one end and on the other end produces those things you need to support the

M

It was the darkest day of my life when I realized that vocabulary was necessary but not sufficient.

(Overlapping voices.)

M

And just one aside: The really important sharable part of this is the expression of the structure in a sharable way and we've done it one way. I could care less. If we could do it in UML I'll support that 100%. We'll pour our content into that. If we all decide to open EHR is the way to do this or if the U.K.'s
—

M

I think at this point we are trying to leverage some of the several best practices that other groups have used. We're trying to extend some of those to support not only kind of exchange between different organizations and ... we're pushing the vocabulary and terminology in a way that

M

Well, what kinds of conversations have you guys had with ...? Because they've done a lot of sophisticated work here.

M

Oh, sure. Yes.

M

I'm not saying they've solved the problem. In fact, as you know, in their semantic framework they're doing it over again, but seeing that they're doing it over again and you're thinking about doing it –

M

No. I'm not trying to do it over again.

M

I understand, but they are. But the question stands what kind of communication are you having with the

M

We have on our ... talk about

M

Well, no. That makes it – there's cross over there because Charlie ... and Charlie has introduced; and NCIS now adopted ... methodology for ...

M

Well, see, that's the thing. What I'd like to do at some point is kind of ... your presentation of what we've been discussing ... and ...

W

Great idea. Let's do it at the next meeting.

M

Yes. You tell your stuff. He'll tell his stuff.

W

Yes.

M

Yes. I think that would be great. I think that's a good idea, actually, for a good section of the next meeting.

M

Yes. Yes.

M

I'd like to sort of pull us back to a different part of the conversation that we were just having, Floyd's presentation, and that is that it seems that there are at least two, but perhaps two essentially extreme categories of EHR implementers who will be seeking meaningful use. One category is the folks who just say essentially they want the super set of all of the lists of codes in all of the standards and just tell us what it is so that we can make sure that we have all of those in our pick lists and something to that effect.

Then the other, and perhaps extreme, would be users who actually would internally use the tool that Floyd had on his slides and develop their own version of the measures and really engage in the process. And so I'm wondering if we can make recommendations out of this group that would meet the needs of, if I've described those two extremes adequately, if we can make recommendations out of this group of things that would meet sort of both sets of needs that could be made available and what ONC should do to make those tools available.

M

Can I just ... a little bit ...

M

Yes. Then there are the ones in the middle.

M

Yes. There are those –

M

They're sophisticated, but they don't want to develop a measure – but then who would want to? I mean gosh –

M

I ... been thinking about ... well, a little bit, but that was beyond the standard There is that group that wants – give me all of the codes and I want that as my starter set that I implement because if you're going to be measuring ... I want to make sure at least for all of the measures I'm going to take all of the conditions and have those as my starter set problem list. So yes, we would expect that there will be something like that. Maybe vendors will want to implement that.

The second is those who want to be able to output just for all of my patients here are all of the data and send it over to Stan's registry or data warehouse. You calculate it for me because you're also certified, and I'm certified and now I can be meaningfully using because he gives me the results that I don't actually do the logic; I just send him this one set of data on my patient and the other is I want to calculate it myself –

M

So what would you call that second on that intermediate level? What do you ... short end –

M

It actually ends up one is that it's a little separate. I want to incorporate all of these lists of codes combined as my – what did you call that in your upper level, my subset, so that's my convenience set so that I know that everything is captured, but on the measurement side it's I want to be able to use the value sets to provide one generic set of patients for someone else to calculate it.

The other is I want to apply the logic myself. Now, I didn't go as far as I want to create my own measures –

M

Yes.

M

Because that's a little –

M

Yes. So it's the issue of I just want to apply; I want to extract the denominator and then I want to send it over to somebody else to apply the logic and come up with the ... –

(Overlapping voices.)

M

The numerator and then give me back my number ...

M

I'll give you all of the data on the patients and you calculate whether I've succeeded or not.

M

Good.

M

And there were good examples of that in some sample testing that occurred ... last week ... all of my patients ... laid out ... they did all of the analysis and sent it back and the other one did the calculating themselves, which

M

I think you're exactly right. There has been a lot of different

M

Yes. ... would be an example of a registry that wants all of my data in standard format –

M

So then the issue would be what are we defining and should we be defining ... done already. I mean, okay, I'm taking models; I'm taking this model ... export it, so what am I exporting? I mean I know I have to apply the criteria to find the patient and that's described over here. I'm finding the denominator, but now what do I have to send?

M

So I think what I'm going to send is a set of patient data and now I'm talking interoperability, so what standard do I use to send that? Is it in ...? Well, not yet. I mean ... so where do I put that in? It doesn't have to be CDA. That's just an option.

M

Well, you know, the thing is that it seems to me that since in that case you are providing an option you're not requiring people to do this, but you're sending a signal. You could conceivably be sending a signal to service providers and it would seem to me that it would be possible to say here's the standard format for the export of this data and it's conceivable that the fact that that standard wasn't described in here really doesn't matter because no one is required to use it. They can use your measure and they can calculate it themselves.

M

And in some respects they're calling their enterprise the rampant use or service from this third party.

M

That's right. So this is a very good point. It seems to me if you want to get out of the ... you don't necessarily want outcomes ... and the other ... do this ... to each of their customers, "Okay, here's what we want to depend on." It sounds to me like what you need is actually more than any of the ... that are already compliant in 2011 ... standards ... more than what ... detailed data. So then the issue would be it would ... another ... issue is defined; get to the point of saying well, here is the standard way of exporting all of the data you would have to export once you ... universe so that a third party could in fact calculate

the measures and doing that sooner rather than later is good because you would know that ... all of the efforts, all of the people who were ... service just have to be ... data is going to come in this format.

M

But then that's ... issue that is not in the ...

W

I don't think there is a requirement ... transmit; it already requires transmitting any of the things that I I'm not ... –

M

I'm not sure it is.

W

Patient summary and so forth, but I would think that some of the things you need to do this are not necessarily in the summary as defined.

M

Yes. They are definitely not in the summary as defined. They're not in the CCD or CDR or in any standard summary.

W

So somewhat thinking about what are the things that you can support or do to ... down the road like this ... data model. It would seem to me that coming up with some proposal for ... export much more than what's listed here so that ... so it becomes a usable market and you're not being told by outcoming research from this group and this group that this is the way you have to send the data – (Overlapping voices.)

W

... program for that and then you end up in the same old business about how do I switch to the other guy ... cheaper ... have to ... data

M

There I agree, but let me give you a slightly altered use state ... currently what I'm sending from hospital to another setting there is OASIS; there is MDS; there are other sets of data that I send and they're basically questions that a nurse filled out or maybe the doctor ... and sent them up and they CMS has been putting together the care tool that is in the larger data set that encompasses it all, so we've had a request because we were asked originally when we created CDS to look at the GDS. Does it encompass all of the information sought by the ...? At that point they said, "It's not ready yet, so don't do any mapping."

So now I get the call, "So where is the data set for care? Because you said you were doing it for us." Well, no I didn't ... problem that's a separate issue and I'll deal with it, but what they really want is can I get the care requirements out of one thing to send to another, which is instead of saying for quality measures sending it to CMS or ... I want all of the data elements at transition and care to send to another set, another site. Isn't it the same container that I want to put that in that I want to send to the following ...? So it's for care, as well as for measurement. That's what I've been trying to ...

W

Well, yes. I mean I would assume that maybe we've got other use cases with this thing, but ... not been fun, which I gather it hasn't ... required here –

M

... the IFR they deal with sending the care information and, in fact, is that not required? CMS is going to be requiring it and I don't know that there's a standard for that, so that's a concern ... comment to ... but I don't know what could you change, because there needs to be a way to do that.

M

Well, is there a logical way to do this? If this is a plan doctor just say you

M

Well, could I use CDA if I map all of their needs to; I know I have CDS on the brain; but if I mapped all of their answers and what they needed to create and the logic to create their answers out of the ... data ... coming out of the records that I created ...? That's one answer. Maybe there are other factors.

M

Yes. I think we're past the detail that I know of current CDA capabilities, so you're past ... but I think it's true, but I think we want to go past that in the sense of saying what we want to do in fact is create a mechanism so that it's very lightweight to basically say these are the clinical models that I'm doing and any clinical model you want to send, here's an algorithmic way to transform it into the ... of

M

Correct.

M

That is sort of ... in terms of so that we're not maintaining the same information in two different places, but the other one just becomes the source of the structure, the payload within the CDA document.

M

And if the payload is standard then at each hand they can create it or unwrap it the same way –

M

Right.

M

Without having to worry about it being different –

M

Right.

M

Whichever type of data ... and that's where I see a standard making sense, of how I send the set of data for different purposes.

Bob Davis

Jamie, excuse me. This is Bob Davis. I need to go catch an airplane, so I just wanted to let you know that I'm going to be signing off right now.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Thank you, Bob.

Bob Davis

Okay. I'll be in touch with the next set of meetings and calls. Thank you a lot.

Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy

Okay. Well, thank you very much. I guess for everybody else, we are approaching another break time to perhaps grab a bit to eat, but I do want to wrap up this conversation and try to understand if there are any other next steps, so what I've ... thus far are now a longer series of potential comments, both to CMS and to ONC about the need for really coordination of these two rules and primarily around the existence and specification standards in the EHRs that are needed for the quality reporting that's required in the I mean the issues are broader than that, but I think in terms of what we can comment on on the IFR or the NPRM that's potentially, I think, the series of different kinds of comments and some of those may go to this care tool and others to ... essentially measure specific comments –

W

Yes. I do think that even though you anchored your comments ... the IFR ... justify the reason why ... needs to be made, whether the recommendation is ... the line in terms of the Standards and Policy Committee or whether it is national comment you certainly can justify it based on the fact that it's easy for this and it also ... all of these other problems –

M

Right.

W

You're making it seem more compelling.

M

Right. I think separately we've also agreed that in the long-term, but probably not in the short-term, we want to keep detailed clinical models on our agenda for this group and I think we also then are talking about making some specific recommendations around essentially starter sets for quality and potentially other secondary use purposes around potentially all codes that are in the measures for potentially, I guess, folks who want to calculate and report things and do it all internally versus those who want to use external services and other capabilities –

M

Well, I think I wouldn't want to leave out to manage the enterprise of a myriad of ... developers just creating their own lists of codes or value sets and having an exponential explosion of value sets –

M

I'm sorry. Isn't that the NQF contract?

M

What?

M

Isn't that what the NQF contract is for?

M

Unfortunately, unless we get funding to manage that ... there's not ...

(Overlapping voices.)

M

But actually, the question is is NQF the right place for that. These are value sets being used for clinical purposes, not just quality. This is really a higher level than just quality ... certainly, NQF would be happy to do that given the right funding and the right staff, but there needs to be some governance around that. At one point if you mentioned that we had that ... proposal to convene a group to determine what the governance is to do that, but I saw this group as ... the appropriate to report.

M

Well, I do think that recommendations on broad governance ... developments is outside of the scope of this task force.

M

Yes. As I always say –

M

But I do think that we may want to make a recommendation, for example, to the Policy Committee that that's an area where we have some concerns.

M

Well, I'm not sure I agree that governance and management of value sets is out of scope. I'm not –

M

Okay. All right. I thought you were talking about measures –

W

... value sets ...

M

Okay. Yes. But I think the process, okay – I wasn't thinking about it in terms of, I guess, the governance of the major developers in that regard. ...

M

I'm talking about ...

M

That's what I thought I heard you say.

M

...

M

Okay. Is there anything else that came out of this discussion that will constitute next steps ...?

M

I just want to pick up on ... if we don't provide some sort of ... standard infrastructure and ... different ... self measures, which are, you know, what these clinical specialists consider ... then we will be creating ... I think that you would be apt to get to a place where ... qualified groups, professional ... whoever they are and if physicians develop measures and certain types ... but on the other hand they can't do it on the back of an envelope or ship it around in a non-standard format or have it in a place where people who are

developing other measures which might overlap with it can't see it, so that they'll come up with something that's slightly different.

M

And I would just say guideline developers ... support folks are doing ... developers are using the same –

W

Let me couch, let me put a limit around what I just said: It seems to me that I can't, that ONC can't care about what everybody is doing, but if it's something that's on a trajectory and ends up being in a requirement for meaningful use it has to be done in this way; otherwise you're causing all kinds of problems with people who have –

M

I mean I think that point is very well taken. Recommendations that come in; it could be backed up with data and it could be sort of focused on meaningful use and then also, meaningful use not only for 2011, but 2013 ..., so –

W

And my feeling is if we do something about ... then we can offer the infrastructure for use by anyone who has a legitimate reason to do such a thing or whatever. Then what we can, in fact, be saying to them is if you get to the point of being able to produce the data that shows that this is a ... valuable measure, guess what? It's already in the format that's acceptable for being incorporated into some sort of a plan for one or more

M

What you want to make clear ... if you have a good comment in there, but it's not tied to those things people are going to say, "Yes, it's a good idea, but it's not really under the purview of what the legislation"

W

I don't know that I was even describing the comment on I was describing something that we all need to figure out how to get done

M

No. No. No. I get it. I think we're on the same page with that. I just want to make sure that we've got a very good, robust discussion here and we'll have to

W

Yes. I mean I think we've talked about a number of things, some of which to my way of thinking, need to be turned into specific comments ... document and some of which need to be ... in terms of It's not all

M

Yes.

M

Okay. Thank you very much. I think we're at another break point, so I think this will be our lunch break. I will come back, so is 20 minutes enough?

W

Can you get a sandwich anywhere in 20 minutes?

M

Yes. A block away there is –

W

I know the place around here. I just wondered whether ... local here too –

(Overlapping voices.)

W

Can we bring food into this room?

M

Yes. Can we come back in here?

(Overlapping voices.)

M

Okay. So, folks on the phone, we're going to start up again at half past the hour.

(Break being taken.)

M

Is there anybody back on the phone?

Donna Pickett – NCHS – Medical Classification Administrator

Hello. This is Donna Pickett.

M

Hello, Donna. So, we are going to start up again a little later than originally thought, but in just another minute or so.

M

How late do we go?

M

Well, we have scheduled until 3:00.

M

Okay.

M

Based on what we want to do next I think that we're in the home stretch. I think we've identified a number of different priority areas. You know, it's ironic; I always hear other committee people saying what an incredibly rich discussion that was and how important and so forth, but I really feel that, you know, that this was a really meaningful and rich discussion truly. But I think also we've identified a number of different areas where we do have particular action items and steps to take in terms of both, developing comments on the ... and the IFR and also developing other directions and recommendations for infrastructure, for management processes, for things that need to be ... and potentially for marketplace, clearinghouse kinds of activities. So I think we've identified a number of different areas and so I think that

the next, the rest of this meeting is really to the point of planning, is to see specifically what's next and actually end up with, I think ideally, a schedule of calls for developing our comments and input on the IFR, the Those are areas where we've decided what we want ... particular comments ... but I also think we have a schedule of monthly meetings coming up.

We talked about some things related to quality that we may want to have as part of our next meeting, but we may also want to have either in the form of testimony or panel discussions or just by inviting other subject matter experts to the party we may want to have extended discussions with people who are not task force members on the particular frequency, high frequency subsets, on the potential for what I think we've described as probably lower priority, but convenient subsets for specialties and things like that. I think there are a whole set of issues around process management, particularly for the value sets using that term in the context of the required quality measures and other secondary use purposes.

So, for today, I'd like us to have a discussion and figure out if there's a particular sequence of events that we want to walk through and particularly what's our agenda for the next two or three meetings. How many calls should we try to schedule ... comments and what process folks feel is appropriate? Are there things that we really want to get testimony on? I know that, as an example, I've been approached by AHIMA and HL-7 members, who want to come and give us input on their feelings about how we ought to propose or recommend management of, in AHIMA's case, code sets related to, actually value sets related to diabetes management and so to what extent do we want to have processes that include getting input and testimony on things other than what we've talked about and how do we want to include others in our deliberations for the things that we have talked about.

Marc Overhage – Regenstrief – Director

This is Marc. So listening to what you just said, if our primary goal is to generate this task force's or working group's or whatever we are feedback –

M

I think we have a few things.

W

...

M

There's an immediate term, which is comments on the IFR and the NPRM.

Marc Overhage – Regenstrief – Director

Yes.

M

I sort of think of that as a separate spread of activity that perhaps we could handle in phone calls –

Marc Overhage – Regenstrief – Director

...

M

That's separate from sort of what I would consider our regular business, which is enabling meaningful use through other recommendations.

Marc Overhage – Regenstrief – Director

... people ... clarifying ... may know or may not. At the IFR we have like 15 days left for feedback –

W

No. March.

W

March.

Marc Overhage – Regenstrief – Director

I thought it was 30 days for an IFR.

W

No.

M

It's really –

Marc Overhage – Regenstrief – Director

Sixty days.

M

It's really the –

M

The same timeline as the ... ordinance.

M

...

Marc Overhage – Regenstrief – Director

Okay. That's what I was confused on.

M

Yes. So its effective date is February 13th. Comments are due March 15th, but the next Standards Committee is February 24th and so I think we should try to have our at least draft comments baked before February 24th.

M

Yes.

M

So a month.

Marc Overhage – Regenstrief – Director

Okay. I'm sorry to take ...

M

No. That's okay.

Marc Overhage – Regenstrief – Director

So that's one thread –

M

Right.

Marc Overhage – Regenstrief – Director

Inside this group feedback, that doesn't require external –

M

Right.

Marc Overhage – Regenstrief – Director

...

W

No. I mean I don't think it really does because anybody who has external ...

Marc Overhage – Regenstrief – Director

Can do it.

(Overlapping voices.)

W

Right.

M

Right.

Marc Overhage – Regenstrief – Director

So then the second set of work is?

M

So then the second set of work has to do with recommendations that we would have on making available how to determine, how to manage, how to disseminate and how to make available the starter subsets based on frequencies, whichever ones those are, other convenient subsets, but also starter sets of value sets that are going to be required for quality reporting and potentially other purposes in the NPRM.

M

... starter sets or governance around management and means are a subset of that value

M

Well, I think it's probably both.

M

Can I suggest that a general rule of thumb for me, developing the governance and the ground rules, the good thing to do first, before you get ... people start battling about the ... you may need a use case if something ... what the ground rules are going to be, but once you start discussing what the standard is then all discussion ... nobody wants to be governing

M

Yes.

M

There's a man of experience.

M

Okay. So I like that suggestion, but that would imply that at least part, if not most of our next regular monthly in-person meeting, which I think is February 23rd, should be we've already talked about having part of that devoted to measures – are we calling these quality measure value sets or what? Do we have a term ...? Anyway, the management of Floyd's stuff –

M

Well, I mean you don't call them quality because they are not unique to quality.

M

Right.

M

We should call them value sets or

M

Let's call them value sets.

M

That's just that they're being used; I mean they're using it, so we'll just have to describe ... and we'll just have to say that we have a focus coming from meaningful use for these things that have to be used ... measures and just be sure we describe them in such a way that everyone understands that that's not the only thing that they're ... for.

M

Value sets used in auditing.

M

I hope you ..., Jamie, because if I heard that externally my pushback would be, "Wait a minute. Those are just the hierarchies that terminology developers already ... the FRTs," and if it needs to be similar, let's force it into Likewise, it's in SNOMED. SNOMED has got a hierarchy that we shouldn't have a separate set of lists. Those should be nodes in the SNOMED hierarchy, shouldn't they?

W

Well, I mean you could say that, but I guess the question is what you need to do is determine whether the person is on a beta blocker or an X or a Y or a Z –

M

Yes.

W

Which means that somebody has to say that's the logic of it, because –

M

Right.

W

The vocabulary has only got so many organizations.

M

So they don't need a list of beta blockers?

M

Well, I'll give you a better example –

M

...

M

If you use the ... that would be fine and I don't know that ... specifically to these measures, but all of the beta blockers are ... that this subset –

(Overlapping voices.)

M

That's okay. You can –

M

You're being the devil's advocate here, right?

M

... accommodate that so that you could add to or –

M

... the FRT as one ...

W

Yes. So we're talking about what do we call this thing when you're defining the universal vocabulary that you're going to use ... and if you don't want to call it a value set we won't, but just what do we want to call it? In some cases it's defining something and you're using IP-9 because that's what –

M

Yes.

W

In certain cases. I'm afraid it would be an enumerated ... and in some other cases it would not be. So the issue is what do we describe as this thing and then we can say that there ... of it and obviously, if there is a way to fix the vocabulary so that you can pull it out at a higher level then we ought to feed that back into the vocabulary developers. I'm just saying there are cases where it won't work that way.

M

Right. Of course.

W

Some enumerations have the same –

M

Of course. Of course.

W

So what do we want to call it?

M

... we really don't want; I'm making a statement you guys may not agree with; we really don't want people choosing out of the source terminology unless they have to. In other words, I want them to pick something out of the FRT and only if, only if they can consistently make their case because what will happen is it will be wrong.

(Overlapping voices.)

M

Here's an example: What we tried to do is really take a brand ... we would say take that brand as one value set and all ... of it –

M

Right.

M

And then take that sub brand in there that they want, take that as another and ... say this might do that.

M

Right.

M

That way you're not creating one value set without the brand and one with, but so I mean you could do the same with any of

W

So what we really want, we want to have something and I mean this is the wonderful ... value set where I don't want to document ... if we have to go there. I think the issue, is you just want to be able to describe this thing that we're concerned about, which is how we are stating the vocabulary coverage of a piece of something that is required for one of these measures ... so we're just coming up with how do we use vocabulary to define this universe and we presumably do it in the most efficient way, not the stupidest way.

M

Yes. With that principle I agree.

M

Let me just ask a couple of kind of process questions. If it isn't the vocabulary –

(Overlapping voices.)

M

Well, I just want to make sure –

M

You talked a lot about certain quality metrics, right?

M

Yes.

M

And the thing is that that certainly is a part of the vocabulary problem, so I guess the question I have is the committee has now decided that the key, most important thing we have got to do is quality metrics. That's the next thing that we've got to work on.

M

No, I don't think –

M

What I'm thinking though is that if we're talking about getting this IFR out and kind of trying to establish some priorities we've not really talked about what are the other things that are on our list. We've sort of begun to develop a plan based on the last items that we just talked about. I'm not sure that we've done –

M

No. I think basically we had a broader discussion today and we've enumerated a number of different areas where we want to develop recommendations for infrastructure, communications, management processes, dissemination of vocabularies and so what we're saying is that the first priority is to establish sort of rules of the road. One area for doing that is what's the road for development and management and dissemination of the value sets ... that are required for quality that also have other important uses, but that there are other rules of the road, so we're talking about basically what are we going to do – what's our February meeting about. So that determining, I think, rules of the road primarily around development and management processes for both subsets and value sets and in terms of the sub sets that would be included would be primarily those things that are based on the most frequently used codes or concepts to assist implementers of meaningful use.

M

So the other question – I'm just going to throw it out there: Do we clearly understand what the problem is? We have our perspective in here, but do we understand representatively whether or not we understand the problem and then we arrive at the best solution ...?

W

I think that in terms of part of the job here was to retool these things in some format and then you have 100 of them or whatever you have and then we talk about is this the right format. I'm afraid that we probably ... come in and provide additional opinions about that format, but it seems to me that we don't know ... represent any of this stuff ... so you've got this deadline and then the issue is he's going to put these things out in XML and wherever they're going and then it seems to me we can get rational influence as opposed to before that because otherwise we could have five guys developing different ones simultaneously –

M

When you're saying represent this stuff though you're talking about representing measures?

W

Yes.

M

Because representing the list I don't think is hard.

W

No.

M

It's representing the measures that you're talking about.

W

That's right. Of course, the thing is that representing the list it seems to me that the issue is how do we represent and manage the list in conjunction with at least because it's required by meaningful use and this is a ... use case from the point of you're managing and updating a list of vocabularies because you do want this to be all of the X, Y, Z except you've excluded these, so hey, when we add ten more it's a human review thing as to whether this thing is still correct, because maybe we've added another one of the exceptions –

M

Right.

W

So SNOMED has moved on or ... or whatever and the FRT and there are exclusions. So I mean if you're sitting over there saying there are no exclusions then maybe we don't have to worry so much when it's updated, but if you have exclusions then the new things that happen in the updates could be

M

The ... challenging ... is I have to go back to ... measure ... of each of those measures to have them retooled, because they understand the meaning of their elements, someone else's ... and they have their expert panel based on their meaning, so they may create ... – actually, they're creating them for ... measures is one set of ... it, but the same concept is coming out of a new patient measure or they're going to get new code lists or a new value set ... someone else subcontracting to another group and they're not going to be identical. That ... so that's the first challenge. These will all come out based on the NPRM ... and they'll be inconsistent on the value set level. So that's the near-term –

M

I want to take Doug's question to us and sort of back it up to a higher level: Are we focusing on the right things still fundamentally? Let me give an answer to that, because I think we have gotten a lot of input from the Policy Committee and the Standards Committee and their workgroups on the things that we ought to cover and my view is that that's what we're covering. So there may be other views from within ONC, the department or the public, about what we ought to be covering in those task forces, but I think we're covering what the Standards Committee and the Policy Committee said were priorities, which were basically very simply to make sure that vocabularies are available to implementers for purposes of becoming meaningful users to make it easy for them to understand and implement cross maps ... as well as subsets and value sets, particularly those that are required for their quality reporting purposes. So

that's what we've heard. I think Doug is raising, in my mind, a question of do we need to have other input on what we ought to do.

M

Well, I think one of the things that we're commenting on right now is that there's a problem in the ... and we're saying that we think that the quality metrics are ... they're not ... in a computable way. Now ... might come back and say, "You know what? We understand that, but we're just going to give you a ... document that has all of the measures ... map it into your thing and extract it and that's what we're going to do to describe We want you to kind of work this out as we go forward, but we're not going to change NPRM. We're going to clarify it, but we're not going to change it and we're not going to require people to have computational methods to be able to extract it. We're not going to require them to use RxNORM codes. We're going to say ... and we're going to have to ... a patient." We can raise all sorts of questions about that, but ultimately that could be a ... that it comes down to.

The issue is I think we have to be careful as we're framing this that we've identified the problem and we've jumped to a solution, but there may be, in fact, an entirely different solution that they come up with that we don't want to do a computational one. I sort of ... because I'm a proponent of making sure that ...

M

There's no need for comparability of reported measures across institutions is what you're saying?

M

Well, no.

W

...

M

I think –

M

But you can define it in a different way. You can define this by –

W

Yes. Well, so I guess the issue is that again if you're saying what is the first thing that needs to be worked on and what's the next thing or whatever, this is something that needs to be worked on because no matter what we do in 2011, if we don't have a way of managing this we'll never get where we want to go. So that needs to be done so the issue then is is there something that needs to be done before that. I suppose that right now, unless it happens next week, that if people say what I've been calling convenient where we're talking about starter sets or frequency distribution sets or whatever, then an issue in my mind, which I'll try to get set with ... where in the process are we of getting whatever level of ... we want to get in terms of the ... subset, but what I think is better is if you say here is the core subset, here is ... here is the thing. This is a first draft of these things or a second draft or a third draft. Now the people like to come in and comment on whether this is helpful or not because it is something specific as opposed to having another group of people wander in without something particular to say, to look at so they could say if you look at something in particular and it's the wrong piece of the element you can say you started at the wrong end. What would really be helpful is if something ..., but then you can actually have a concrete discussion.

M

Andy.

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

I mean ... support ... just said, because of something that you mentioned before: Did I understand you correctly that a team that wants to come here and testify about a diabetes value set –

M

Yes, about –

M

...

M

I know. So we said the rule is that we don't want you to talk about that. We want you to talk about how it is that health information management is going to use vocabulary or what problems you're going to have. I don't want to hear about

M

They say what they've developed for diabetes is a good way of establishing value sets that establishes a pattern for reuse –

M

So what they're really going to talk about is we have a way of building value sets and would like to suggest to you here is an example. That's great.

M

That is what they want to do, so ...

M

I'm trying to figure out what problems we're trying to solve for the community in the United States. It's not very grandiose, but the fact is that the whole deal is it was intended to encourage implementation and meaningful use of electronic health records. So to digress from what section; I got a call last week from a set of researchers, who liked to interview our end users about SNOMED CT and ... if you want to do that you're going to get a whole bunch of people staring at you blankly because they ...

M

... SNOMED CT. They ... medical references. So the uncertainty in the world of ours is what is this. What are you talking about when you're talking about vocabularies and what does it really mean to me? The answer is almost nothing if we do it right. So the first order of business is what Marc talked about. You have to make it possible so that under the covers the vocabularies ... ease of use with a clinical ... you can actually deploy electronic medical records. So that's the frequency distribution.

M

Right.

M

Then they're going to say, "No, I want my money. There's \$44,000. I want my money." If I spent all of this money it gets ..., so I have to do this stuff to get my money, so how do I make the stuff easy? I talked to them about vocabulary. We're going to make ... for them, reporting ease. What do we have to do at

this committee to ... those ... you have not yet specified a standard vocabulary that is actually necessary to produce a measure then they can't do it. That's a problem. We have to solve that problem, okay?

The second is we have a bunch of vendors, people with existing systems or people who are about to lie; they were going to have to be able to say if by buying ... I use you I'm going to get my money, so ... what is a simple thing that I can do in the next 18 months if I've got very limited time to make modifications ...? I'm trying to tick off three or four things that we have to accomplish within that I don't know if this is helpful to everybody, but I'm a very simple minded person sometimes. I just can't – we're not going to settle some of the more granular issues about vocabularies. We have to settle some big issues so that people can put stuff in and get their money.

M

So I think that what we were talking about developing rules of the road for in our next meeting, which are the frequency distribution subsets and the value sets that are required for meaningful use ... I think is a good starting point towards the broader goal that Andy pointed out. I think that's a good first or next step for this group in our next meeting; to focus on those rules of the road, what those rules of the road are. I'd love to hear what's needed in terms of how are these subsets and value sets or how can we be helpful making recommendations about how these subsets and value sets are developed, managed, modified, communicated, disseminated, made available, etc., even licensed.

M

The only thing I'll add to that is just to say no. It's very likely that hypothetical ... I'm sure it's a scenario in discussion right now –

M

... I have no knowledge of ...

M

But I'm sure it is because what I'm hearing is they could say we gave ... to go ... we're just not going to worry about that and we're just going to ... version I've got today, but if they don't do that I already have ... creating these values that now the sooner we get

M

But it's an important ..., but I guess ... the point here is this committee is charged with sort of helping the larger Standards Committee and interacting with Policy ... piece of the puzzle. I think about when we start talking about quality metrics, start talking about comparative ..., start talking about clinical research, all of those pieces are tied together and so we have to be very clear. I want ... to ... his comments on the solution set ... manage data at his level. So there's a lot of people who are doing it and it's perfectly fine if this committee kind of comes back to the Standards Committee and says, "We believe that the only way to do this is ... with the quality methods."

The problem is ... that's out there, they're going to look at that and say, "Gee, I didn't have a chance to ... and I didn't get to try all of the different settings." That feedback will come in, but it won't come through

W

Okay. The issue is if things ... and there are a lot of people who have done various things, some in this room, about how you manage value sets and subsets and what have you. There are multiple systems. I started to say the function for many of them have been ... considerable ... from the federal government and there are multiple of them. So one thing that seems to me if we wanted to look at this issue and we

wanted to look at investments made and whether any of these are the basis for moving forward and in which scenario, that we could actually have something where we actually looked at the existing partial solutions then we might just start with the ones or just limit ourselves to ones that have already received considerable funding from the federal government.

M

I'm going to suggest that that's really getting into the infrastructure question and infrastructure and requirements to use it for the development and management of the code sets, right? But I think the infrastructure, because we talked about that going beyond meaningful use as it is for 2011 and going into quality, as well as ... guidelines and other secondary uses. So it seems to me that that discussion, I'm going to propose, should come after establishing some principles or rules of the road in our next meeting, so maybe that's the meeting after next.

M

Well, I'm a great fan of infrastructure, but I agree with you. I want to go back to Andy's point about getting governance straight before we have all of these other discussions and this little rich discussion reminds me of innumerable rich discussions we've had on the U.S. realm, as it's fondly called, in HL-7.

W

Right. Just so ... I thought it would come up in the first hour.

M

... it's always ... I'm a little slow on the mark here. For those of you that aren't imbued in HL-7e, it's the notion that countries or realms have a governance mechanism to do terminology selection and value set creation. Many of us have commented for a long time that the United States has no such infrastructure organization. Many of us thought that HITSP would be that; indeed, at one point, Betsy, you declared that HITSP is that –

Betsy Humphreys – National Library of Medicine – Deputy Director

No. I'm just saying if there's any kind of ... if there is any kind of executive order or now law that says that this is part of the governance structure we cannot set something up that doesn't fit under that, so it may have to be not that, but you have to take that into consideration; otherwise we just can't say we really need this so we're going to set this up over here and somebody else is going to read the law and say ONC wants to do this ... or whatever, so what have you done over here. That's all I meant about HITSP. It has to be done in the context of HITSP ... done it then. It couldn't be done as an extra somewhere else. That's all I meant by that.

M

Well, you know, we all thought NLN should be the place where it happens, but I understand it's not in your legislative mandate or, for that matter, your budget. That being said, I wonder if one of our early action activities could be to, again, raise the flag on this particular issue since we are an advisory committee. If we say, "Look, if you want to have meaningful use, if you want to have people do shared value sets, if you want quality metrics based on consistent granular data and incidentally, you don't want it to be a cottage industry, everybody goes out and makes their own value sets, you want some cohesion, then the solution is obvious. You need something like what they used to formerly know as the U.S. realm." I don't care what we call it. I don't think any of us care, but the mechanism and infrastructure has to be there or the advice. You can even put that into the response ... again, you can back that up with existing countries. You can back that up with what other people are doing and provide clear exemplars and alternatives –

M

Can I use 20-year-old PowerPoint decks?

M

What I guess I'm saying is that I think that becomes a very useful

W

Yes. I think that essentially that the fact is that you can pass parallel processing and allow a lot of people to do good things that they want to do if there is a mechanism for them to be told how to do it or what they need to get it to the point where, yes, it can be sort of designated as a U.S. wide standard If that doesn't exist then you can't get to where you're going. It's not necessarily that you have to designate three people and then ... people in this world to do it, but somebody has to be sort of overlooking the process. The one that can say, "I'm sorry, somebody already did that and we like theirs better and you'll have to use this one ...," –

M

I think Marc was next

Marc Overhage – Regenstrief – Director

Just a clarification: If there were a U.S. realm and then a lot of them were doing it with Betsy between the realm –

(Overlapping voices.)

M

She would be the ... lady.

M

She would own the ring that ruled them all.

M

There you go.

W

The problem is that ... too old and ... lot of déjà vu all over again ... younger than I am he's probably having the same feeling, but it seems to me that I remember that other advisory committee; I won't mention the name; having a recommendation about this and ... about the National Library of Medicine maybe ten years ago. So there also were recommendations under the ... informatics about bringing together we called them value sets, but I know in the function ... group that I was in ... whatever. So they may have fallen on deaf ears because we weren't then where we are now. Certainly, there wasn't real money in this.

M

Well, yes, it helps that there's money attached to this, right?

W

It does. It gets people's attention, but I think it wouldn't hurt to go back and bring in some of those.

W

I mean we're so clear where we were Wednesday One of the things is that HHS has the legislative authority to do this. They have the legislative authority to select this, to anoint them, to adopt them. You

can debate whether the legislation gives them the authority to provide some level of ... and ... and that's an issue, but I think that life is different now, but the issue is whether there is going to be decisions that this activity is going to be under taken by somebody and then there's going to be ... coordination of the ... of it.

M

So let me ask you, I think as we ... the context of this has been recognized ... has been a gap, this has been ... recommendations in the past. Now ... is the time to act on

M

So I think one of the questions that came up, and I think this was on our last call for this group when we were getting organized and scoping, was about the relationship of this group to both NCVHS and also HITSP and other sources of recommendations around these issues. I think the general answer is that for purposes of the HITECH Act the Standards Committee has the statutory authority to recommend these things to the secretary and so ... authority basically and so our input from those other sources, including the previous recommendations, are just that, they're sources of input for us and so we can second them and recommend them and forward them on.

W

So clearly, in terms of providing the authority track in priority policy, the Standards Committee will ... the recommendation up through all of the inspectors. So the thing is, obviously, you can define this and say one of the things we have to standardize is the value sets and messages and all of the ... other purposes that we're going to where we want to go, but then it seems to me there could be recommendations in this group, which the Standards Committee could deal with, which is how does that get operational ... sit here and say themselves or even a working group of them are not going ... are not going to be able to manage this process all of the time.

Pete said there are many people ... issues and one that is a very interesting R&D issue is how do you minimize the work on anyone's part of dealing with the updates in the vocabulary ... and after you have all of your decision molds that are looking for certain adverse events and so forth, whatever you're based on and ... I mean we're saying what do you do with all of that installed basis and all of the ... using ... measures that ... use them and clearly, we want to end up in a position where the least amount necessary of human subject clinical expertise is ... I don't think it will ever go away, but the least amount as opposed to ... and obviously, if you don't have to you don't want to do it in every healthcare place ... and that's an important part

M

... that was the reason HITECH used the value sets to represent these things, because they ... can change the measure without having to do any other interventions

M

Okay. So getting back to sort of our sequence of upcoming meetings, what I'm going to propose is that we schedule two or three closed, not open to the public, group calls for task force comments on those things that we've talked about here today, comments on the IFR and the NPRM where we would then finalize and propose those comments to the Standards Committee on February 24th. So I think that's going to take at least, I'm going to say, two one-hour calls with some drafting in between that we need to schedule.

Then for our February meeting on February 23rd I think essentially at that point we shouldn't be working on these comments any more. We might have an agenda item to approve them, but I don't think we should really be working on those any more. For that meeting we've discussed really focusing in on governance, getting governance straight, establishing rules of the road for all of the processes related to subsets and value sets so we can develop an agenda.

W
Right.

M
Does that sound right?

W
Good. And that will be open to the public, right?

M
That will be open to the public. Right.

W
Okay. That was my issue. I wanted to be sure it was an open ... –

M
Yes.

W
Whatever happens ... meeting with ... not involved saying ... –

M
So that –

M
... that's the reason they can't be there; it's because you've got that stuff to do to them.

W
Right. But what I see and what I can see as a meeting where it would be interesting to get input and maybe it's a little further along the agenda, but not go forward as far along is essentially to say okay, gang, here are three frequency based upsets. We've got one; here is one over here with these problems and here's one that's over here or here are a couple that related to ... and here is another one over here where you .. identified, prescribable drugs and based ... why don't you go look at those things and then why don't we have a meeting where people, who've actually looked at them can come in and tell us what's ... and can run with everything or why they really should be available in a totally different format or what, something. I mean maybe that's not an interesting issue, but I think probably what seems to me to be useful is if we have something which is an artifact, maybe it's the first 25 of the measures that have been retooled. Put it out there and we say, "Okay, gang, now come here. Could you use this? What do you think?" Just give them something that's real coming in ... on that ... this is what we ... the vocabulary ... time frame to just listen to everybody's problems.

M
Right. One other thing I'm thinking about for our February, either for the second ... public meeting, or maybe this is another call to be scheduled as a closed phone call, is, Doug, you talked about helping us to get on the same page that ONC is on in terms of a broader, interoperability strategy going forward.

That's something that we can start doing essentially now. Would it be helpful in terms of our development of governance and rules of the road, but with that knowledge and framework in mind?

M

Yes, I think. I mean I think there are two purposes. I think one purpose is that I think ... a good group of very smart people can ... something ... regardless of how ... better and then the other thing is with them being formed kind of ... but it's one of those things when you think about the semantic steps you can slice it and dice it and So there may be different governance mechanisms as one layer

W

I would just make the comment that I mean I don't know how you want to ..., whether you want to have some sort of a phone call and ... but that's the kind of thing that if you have some thinking or things you wanted to put up that's the kind of thing ... that's the kind of thing that blows everybody out of the water. There were ten people ... with The rest of us don't know it. So I mean you just have to set that up. If you want input at an early stage then get it, but be sure that you have phone time on the agenda. That isn't too far where you make that public, because that's the kind of thing that people really get excited about is they feel they heard it six months after the other guys heard it.

M

Yes.

M

Yes. I think that's marvelous. I think there are two things. One is that if we're going to do this in a public forum then we have to finish these things internally, so I wouldn't give our – then the other thing is you have an idea that you're not all of the time thinking about X, Y and Z and doing it in a public forum. Suddenly that becomes ... when you did join, when, in fact, where you put the discussions on that.

So we need to time. Now, granted we have a bunch of S&Ws and other stuff that's coming up that's sort of a bundle out of the work that we were contemplating. You still have the ability to jiggle things around a little bit, but before those RFPs

M

Sweet. We'd like to be able to get some

M

Well, is there something that you would like this group's input on before it's ...?

M

I think that's helpful, but we can do it in a public forum as well. It's up to you.

W

... saying that this all happens quickly in terms of being around and dragging people ... comments from the committee that have ... something comes out on the street ... you're saying that there's a long ... –

M

Is there anything that we do in this office that has a long ...?

W

No there hasn't. Well –

M

Not recently.

M

Okay. So perhaps you will want to circulate something to the group for a draft for comments or something?

W

So, Floyd, in terms of when ... planning ... exchange when would there be a number of these things that you were just willing to have people look at?

Floyd Eisenberg – Siemens Medical Solutions – Physician Consultant

I would have hoped to have ... I could have handed to you today. I have two, so this is an appreciation issue It was ... because IP is kind of ..., so I think we'll have them by the first of the month.

M

I still don't understand the question that we would do with the – I'm sorry I'm not following his thoughts.

M

I think what he's saying is I have the code lists that they've developed –

M

But to what end? I'm confused again, because I thought we were talking about statistical lists of likely uses and distributions and stuff, but then we came back. I'm confused again.

M

Well, see, I thought we were talking about both, the ... and the value set.

M

Well, if the value sets have ... –

M

But they're –

(Overlapping voices.)

M

But I thought we agreed we were going to talk about governance for that, not about ... so I'm not sure what's sharing the sets.

W

All I'm just saying is that as I think we've said here, that they've gone ahead and built these things ... find these things a certain way –

M

Yes.

W

And they've retooled these measures in a certain way.

M

So we see the way you're talking about the actual details. I mean they've got some access database because they had to create something.

M

Well, actually, there's already a list of values it created for the 16th.

M

That's content. We're not talking about content here. That's why I'm confused.

M

I thought you were asking for content –

M

Which he was.

(Overlapping voices.)

W

No. What I'm going to say is that it seemed to me that the idea is you could have told us these measures, this whole ... here, which includes the vocabulary. And then people are theoretically going to apply these things in order to meet the measures, so my view is, and maybe it's not my issue; maybe it's Paul or the committee's or somebody else at Standards Committee, not ... vocabulary, but I think as soon as possible we put out 25 of these things or however many you have and you start saying then it is going to be an interim process. I think people are going to come in and say or maybe they're going to say, "Boy, you're brilliant." It's perfect. Or they're going to come in and say, "Here are the issues and problems then. Quick, let's get a different version of this before ..." –

M

I have a suggestion to the group that I'd like to make in terms of our sequencing and how these things fit into our meeting schedule. So the February meeting is primarily on governance, rules of the road, primarily about infrastructure for vocabulary, talking about vocabularies, subsets, value sets and cross maps for focus, as we talked about, for multiple secondary uses and for critical guidelines, meaningful use.

Then in April and May we can go back to essentially the content, so those are sort of rules of the road and infrastructure that potentially goes across different content sets. Then in April and May, come back and between now and then determine our exact priorities, but in April and May, talk about specific needs in meaningful use for frequency subsets and for value sets. Make whatever recommendations we're going to make and add to it ...

M

... started talking about content and I think there are only two reasons that I can think of ... our content. One, as an example, try to test ...

M

Yes.

M

And the other is to check whether there are any things ... the NPRM can't ... content gap and then have to somehow adjudicate that, but I don't want to spend a lot of time talking about value sets here, the specifics of whether a value set is good or bad and whether it ... things or not ... –

M

What I meant was this is not the specifics of choosing the values in a value set or things like that, but rather –

M

What if we have public meetings?

W

That is a process we should ... we need to address because the fact is if you don't want to talk about it and you shouldn't but somebody is in charge of it and so people need to know what's their ... because somebody publishes this thing and the X, Y, Z academy of whatever starts working with it and says, "You guys are nuts." They have to have a process –

M

Absolutely ... we need to talk –

M

But the process for ads or the process for problems or the process for ... may be different, depending on the requirements and the ... and so forth –

M

Well, we'll talk about that when we talk about governance.

M

Yes. What I'm hearing and this is convenience ..., so we're going to develop our own governance rules until we get rules out of this group, but that said, somebody is going to say how did you figure that out and that's going to happen, but that's what we're going to have to do in the meantime, because it's ... and that's

W

Yes and I think that the other issue is defining ... and some of the background documents I think ... background ... identification of what they ... and what isn't ... argue about what it is or something ... so then the issue is this is what this is and ... how ... and then there are things that don't need to have anything. I mean they do and they don't.

M

So it sounds like there's more to discuss in the ... essentially what we're going to do after March and the contents of those meetings, but I think we've got a list of things for our next monthly meeting and a general subject of infrastructure for after that we can flesh out.

The other thing I'd like to do while we're all here, hopefully with our calendars, is to set the time of at least two phone calls as a group between now and sort of mid-February.

W

... calendar ...?

M

Sure.

W

You're dates here are February 1st, 4th or 5th; that's Monday, Thursday, Friday or Monday, February 8th or Wednesday, February 10th. Maybe pick one in one week and one in the second week.

M

Yes. Okay.

W

One, four, five, eight and ten.

M

Is this for a call?

M

For a call.

W

Yes, a one-hour call you said, didn't you?

M

Yes. Four and ten are really good for me. I don't know about others.

M

Four and ten are the best for me.

M

February 4th and February 10th.

M

Four is good for me.

M

What time? Because if it's early in the morning I can do it on the 4th.

W

Your time?

M

Yes, early my time.

M

So 10:00 a.m. eastern.

W

Ten o'clock to eleven o'clock. Okay.

M

The 4th at 11:00. What on the 10th?

W

The 4th and the 10th we can do 11:00 eastern time.

M

I can't do it 11:00 to 12:00.

M

You can't do it then?

M

How about the 5th and the 10th?

M

Let's try and get the same time frame.

M

The 5th I can't do.

M

The 5th I can't do.

M

That's

M

Okay. So it sounds like we may go ahead without you on the 4th, Marc, but we'll try to get everybody on the 10th.

M

Yes. I'm going to be in Geneva on the 10th. I might –

(Overlapping voices.)

M

I can have wine and cheese –

M

... on the 10th?

W

What time are you going to be able to get on –

(Overlapping voices.)

M

Ten o'clock to eleven o'clock eastern.

W

Okay. I can't do it from 10:00 to 11:00. I can do it from 11:00 to 12:00.

M

On the 4th or the 10th?

W

On the 4th.

M

On the 10th don't we have ...?

M

We do.

M

Okay.

W

Well, the afternoon of the 9th, 10th and 11th is the National Committee.

(Overlapping voices.)

M

Yes. Yes. Okay.

M

Now, on the 4th, Andy, can you do 8:00 Pacific?

Andy Wiesenthal – Kaiser Permanente – Exec. Dir. CIS

Hang on a second. Well, later would be better for me ... –

M

Eight o'clock a.m. Pacific I could do. I have a firm cutoff at 9:00.

W

Okay. So we're talking 11:00 eastern time?

M

Eleven o'clock to twelve o'clock eastern on the 4th and ten o'clock to eleven o'clock eastern on the 10th.

W

Correct. I'll send out invites.

W

Great.

M

What time on the 10th?

M

On the 10th it's 10:00 to 11:00 eastern.

M

I can do later on the 10th.

M

Yes? Would later on the 10th be better for those ...?

W

The 10th is really completely out for me because of the National Committee.

M

Well, how about 5:00 on the 10th eastern?

W

This probably would go until 6:00 ... committee meeting.

M

You can't please all of the people.

M

All right, 6:00 eastern on the 10th.

(Overlapping voices.)

M

All right. Let me take a strong hold and in terms of times on the 10th we're talking about either 10:00 to 11:00 a.m. eastern or 5:00 to 6:00 p.m. eastern. Preferences between those two? I can do either one.

M

I can do either one.

M

I can't do 5:00.

M

I prefer 10:00 a.m. because that way it won't

M

Okay, but if we do these two times then we won't have Marc for either of the calls and ...

M

... really good date.

M

These are very good dates.

M

Yes. Well, written comments.

(Overlapping voices.)

M

... is also having a call this week about comments on the ... you might be ... the Standards Committee that way too, but –

M

Yes, but I'm just saying that we have a particular viewpoint in this ... but we'll write a draft, circulate it. If that changes –

W

... participate on the 10th ... if we get ... in advance ...

M

Okay, so these are two calls that we've established then on February 4th at 11:00 eastern, February 10th at 10:00 eastern. These are just task force members only and the purpose of these calls is to develop our comments on the IFR and the NPRM. Betsy and I will draft up something before these calls.

W

Another thing that I thought might be helpful would be that I would modify this ... document about the ... definitions and then we could actually, if the task force has a place to post things, we could actually post it, because I do think that out in the community we have all of these ... about what are we talking about ... and so at least you could see what it is that we've decided to call ... I mean I'll circulate it before, but I think it would be helpful to say we've been talking about

M

If there is no other business I think that's a wrap.

M

Do you want to do the later calls when our calendars are more open?

M

No.

M

That's probably a real good idea. Now, these would not be calls for purposes of comments on the rules, but what we had previously talked about was having one conference call per month in between each of these in-person meetings. I mean it's better to reserve the time and then let it go later if we don't need it, but I imagine that we've got plenty of work to do and that we'll actually have these calls.

W

You're in March now, right?

M

Right.

W

How about March 8th or 10th?

M

Looks good.

M

So basically what we would be saying is it would be nice to have a pattern, so I'm going to suggest that we say maybe the second Wednesday of every month at 10:00 a.m. eastern. Do you like that?

M

Might as well. Modifications

M

Yes. So because the Standards Committee meetings are generally the third or fourth week of the month this would be between them in all cases.

W

Yes.

M

One-hour calls?

M

One-hour calls.

W

Yes.

(Overlapping voices.)

M

All right. The second Wednesday of every month starting on March –

W

On February, March, April, May, okay?

M

Starting March 10th. Yes.

W

I don't need ... I'm available on March 10th, but

M

... date?

W

That's what I was trying to figure out.

M

It has a familiar ring to it, but I think it's that week – I mean that month, in March, but ... actually not –

Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer

In the afternoon on Wednesday would be better.

M

Okay. So Stan is suggesting that Wednesday afternoons would be better.

M

That's fine.

M

Late afternoon makes it a little bit easier for me, so 4:00 or 5:00.

M

The afternoon is really not good because of ... data council.

M

Okay. Judy, if we're not going to do the second Wednesday of each month what's the next best ...?

Judy Sparrow – Office of the National Coordinator – Executive Director

How about Thursday, say March 11th, which is the second Thursday? That would be April 8th and that would be May 13th.

M

So how about the second Thursday of every month starting March 11th at 10:00 a.m. eastern?

W

Let's go back to the second Wednesday in the morning.

M

Okay. And you'll have an alternate for March?

W

Maybe not, but maybe it's possible. What day is that? That's the 10th?

W

Yes. That's March 10th, April 14th and May 12th.

W

At 10:00?

M

Yes.

W

I can. I mean I'll be in the country. I can try to call in.

M

Okay.

M

All right.

W

The regular time the second Thursday is definitely better.

M

Would you not make the March meeting then?

M

Yes. I would be there. This is up against a weekly standing meeting that I have with my direct reports.

M

Oh.

M

But I can reschedule that or delegate it. I mean this is once a month, so if that's the best time, just do it and I'll –

(Overlapping voices.)

M

I would try to shift that by just one hour, but then I couldn't do it, so –

W

No. I'll get my ... I have no ... but I will tell them that I have to present my part of the agenda at 11:00.

M

All right. Acceptable. Okay. We've got our schedule. We've got our agendas going forward. We've got a bunch of stuff to do. Now if there's no other business I think that's a wrap.

M

You will be sending out a summary of this, of what our plan comments will be for us to then ...?

M

Yes. So I think I've got a page of notes. I'm going to go back and forth, I think, with Betsy and we'll draft up some very drafty comments and circulate those for markup by the task force. We'll do that in order to have basically a round of markup for our phone call on the 4th.

W

On the 4th. Then we have a call on the 10th of March.

M

Right.

W

Then we have a call on April 14th.

M

Right. We have a call on February 4th and February 10th. Both of those are for comments on the proposals.

W

Right. Then we have a call on March 10th.

M

Then we have a standing monthly call starting in March.

W

The second Wednesday 10:00 to 11:00 eastern, even when we go on ...?

M

Yes, I think.

M

I've got a quick question for you. Since some of us are on multiple committees that will be commenting ... on the IFR how problematic is it if they ...?

M

My guess is we'll have many

M

I'll breathe a sigh of relief. We've done this one.

(Overlapping voices.)

W

Is time limited ... through June or like go on ...?

M

This task force is not time limited. It depends on serving at the pleasure of the Standards Committee, so

–

W

Potentially this could be through the rest of the year ... –

M

We think it's going to be that ... that will help me –

M

Okay. Thank you very much, everybody. My previous comments about the usual ... about this being an incredibly meaningful and rich discussion; this was truly a rich discussion and I appreciate that.

(Overlapping voices.)

M

Thank you, all of you on the phone that we forgot.