



CDS (Clinical Decision Support) Connect Work Group
Meeting Summary
October 17, 2019
3:00-4:30 pm ET

Attendees 47 people including 13 phone dial-ins

Organization	Attendee Names
AHRQ Members	Ed Lomotan, Roland Gamache, Steve Bernstein
Work Group Members	Maria Michaels, Lisa Lang, Randy Thompson, Desai Apurva, Danny van Leeuwen, Edna Boone, Ruben Nazario, Ryan Mullins, Frank Sonnenberg, Dwayne Hoelscher, Ira Lubin, David Vaudo, Patrick O'Connor, Jeremy Michel, Joshua Richardson, Julian Brunner, Linda Wedemeyer, Majid Afshar, Noam Artz, Paul Seville, Preston Lee, Randy Thompson, Brian Bagdasian, Vojtech Huser, Marc Sainvil
MITRE CDS Connect Members	Bev Acree, John Boiney, Eileen Chang, Matt Coarr, Howard Gershen, Lacy Fabian, Susan Haas, Lisa Ide, Chris Moesel, David Winters

MEETING OBJECTIVES

- Welcome and brief review of meeting objectives and the agenda
- Share CDS Connect Accomplishments 2017, 2018, and 2019
- Share and discuss CDS Connect priorities for September 2019-2020
- Closing

ACTION ITEMS

- Work Group members may email the MITRE CDS Connect team with additional input for the CDS Connect priorities

MEETING SUMMARY

Announcement

Lacy Fabian noted that she will serve as the project lead on the MITRE side and primary point of contact in communicating with the Work Group.



CDS Connect Accomplishments

The slides recapped the highlights and set up the prioritization discussion for CDS Connect going into the next period of performance and build upon the CDS Connect accomplishments. The material is detailed in the final reports, which are referenced in the slides and available on the CDS Connect website.

Questions from Work Group (WG) Members

Question #1—Is there a sense if whether people are authoring with the Authoring Tool? There are some limitations to how detailed of a view the MITRE team can take with the use statistics. CDS Connect is hosted by AHRQ, so the MITRE team cannot access granular use information like you would with a private or industry site. This might be a priority to look at in the future along with the ways to promote the use of the authoring tool.

Question #2—Is there anything else to tell from questions people are asking? Is there any sense of what they are doing? There is a sense that people are working in the authoring tool. However, the MITRE team cannot view what the users are producing outside of it. There have been inquiries about how to leverage what is available and how to make use of the content. There are some anecdotal stories from those who have used it. A WG member had a good experience using the authoring tool—85% to 90% was done within the tool itself. There were enhancements based on his use. The tool has been the most useful of any GUI-based decision support development tool he has used.

Question #3—What are the four patient-facing modules with a pilot partner? Who is the pilot partner? *What would it take to implement it in the EPIC MyChart system? Should it then be five executable published artifacts?* The August lessons learned summary slides have a lot of the key details from the pilots posted on the website. This year b.well was the pilot for the four artifacts:

1. Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Part One, Screening
2. Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Part Two, Counseling
3. Healthful Diet and Physical Activity for CVD Prevention in Adults With Cardiovascular Risk Factors
4. Statin Use for the Primary Prevention of CVD in Adults: Patient-Facing CDS Intervention Statin Use for the Primary Prevention of CVD in Adults: Patient-Facing CDS Intervention

CDS Connect Priorities

High-level topics about developing, maintaining and updating CDS Connect to determine future priorities were discussed. Lisa Ide with MITRE introduced the proposed themes/priorities below and asked Work Group members to look at what resonates with them as most important to do. The discussion moved back and forth among the themes/priorities is documented below.

1. **Enforce Standards Compliance (Artifacts)**
2. **Enforce Standards Compliance (Repository)**
3. **Ensure Artifact Currency**
4. **Expand the Repository**
5. **Expand the Use of Existing Artifacts**
6. **Increase Trust**



Ed Lomotan set the context for the discussion: The prioritization is for next year. The first three years of CDS Connect are finished. Those years were about proof of concept, developing CDS and use cases. The current MITRE contract for CDS Connect is for one year and is focused on maintenance. There will not be new CDS development. The focus is to prioritize how to maintain and keep the system updated—how to keep the artifacts within the project current, and how to maintain standards compliance. This discussion is about prioritizing the immediate needs.

Feedback from the participants regarding which theme(s) is important to them

Theme #3

A WG member commented that maintenance of the current content of the guidelines is important. If it is not done, clinicians will not use it, and patients could be hurt. The WG member gave an example of the new blood pressure guidelines being rejected by 10 medical groups (with an impact on 3 million patients). They wanted to go back to old guidelines. The WG member said that they compromised for something in between. When guidelines have a heavy impact on workflow medical groups will not follow them.

Another WG member made a comment that artifact currency is at the top of the list because of the patient safety issue.

A WG member said there are several areas where there are competing guidelines, and it is important to have the most current guidelines available to maintain credibility. One feature could be that each institution implementing guidelines needs to have the ability to select the alternative guidelines they want to use.

A WG member said national leadership in each clinical domain should weigh in on who is responsible for authorizing, making, and approving the update.

A comment was made that a pilot test must occur each time there is an update to make sure it works before it is posted.

There was a concern about the theme that ensuring “value” was too lofty and impossible. Lisa commented that some of the language is aspirational and high-level goal setting to spark the conversation.

Theme #5

A WG member commented that if people use an artifact at a certain rate, then it is useful. If not, then it has no value.

Maria read the WG member’s comment from the group chat in the web conference platform: A dedicated curation network aspect is the number two recommendation of the AHRQ evidence-based Care Transformation Support (ACTS) Marketplace Work Group. Policy publication, application of endorsements and update authority would be maintained by this group separate from the technology tools. For example, the VA would still create their own artifacts based on standards and then submit them to the network via a next gen set of tools that implements a hybrid process of academy review and technology validation. Once published, the group would moderate feedback and improvements toward the vision of learning health systems, like stewardship.



Ed Lomotan commented: ACTS—The goal is to answer how do you get more people to use AHRQ resources and how to make those resources more effective; i.e. how do you make it more useful not only from a web perspective but also from a user interaction perspective? How are the resources useful to people who take care of patients?

A WG member commented that patients are an important stakeholder for the CDS repository. It is important to communities and advocacy groups. Trust is the most important thing to enhance stakeholder confidence. The patient and their direct care clinician are the ultimate user. What do we know about how they are using the material and how it is ultimately, supporting them?

Another WG member commented that presentation of information (e.g. how it is formatted, messaging, literacy, reading level, language etc.) is important when communicating with patients. Even when patients do not have access to a CDS tool, there should be a way for them to participate when the next gen capabilities become available.

Theme #5 and #6

A WG member asked how providers can use CDS artifacts in concert with informed consent statutes like there are in Massachusetts? The Massachusetts State Board of Registration requires physicians to obtain a patient's informed consent and it must be documented into the record that they have consented to whatever was suggested for procedures or medical intervention. How should this be captured since CDS Connect is based on some of the best evidence available? How does it get translated into the conversation with the patient to demonstrate that this it is a shared decision-making process? It will help build confidence and trust of the clinician and the patient.

Theme #3 and #6

A WG member commented that value sets were put in without guiderails (formatting, syntax, spell check, language, etc.). If someone external does a search, will it allow them to find a word that has been spelled incorrectly or will there be duplication? There needs to be a guide that has consistency for style so that CDS Connect remains current, accurate and trustful. This would be a preventative measure, as the artifacts start to grow and the chance for inconsistency increases. End-users will get confused.

Trust Attributes: How can trust within CDS Connect be increased? Which of the 9 attributes do you think we have to move on this year?

1. **Competency**
2. **Compliance**
3. **Consistency**
4. **Discoverability & Accessibility**
5. **Evidence-based**
6. **Feedback and Updating**
7. **Organizational Capacity**
8. **Patient-centeredness**
9. **Transparency**



CDS Connect

Attributes #6 and #7

A WG member commented that involving people in an on-going basis requires two-way interaction. The best way is to easily provide feedback based on clinician and patient experience using the artifacts. Organizations would need to support the use of this workflow, or it would not be effective.

Attributes #8 and #9

A WG member shared an example of a patient encounter. Patient said “no thank you” for everything the doctor presented regarding the preventative activities. It took 60 minutes to go through each of the activities outlined by the Annual Wellness guidelines, while the doctor typically only has 30 minutes. The patient understood what was being presented and made an informed decision to decline these options. This encounter illustrated the importance of these attributes.

Attributes #4 and #5

Chris Moesel brought the group’s attention to new FDA guidance: A big section of the Guidance hinges on whether the patient and/or the clinician can explore the evidence behind the recommendation themselves. A big concern for the FDA is regarding whether it is a device or not a device, whether it is low risk or high risk, whether it is evidence-based and whether that evidence is clearly indicated and explorable by the person using the CDS.

Attributes #2

A WG member commented that there are parts of this that must be done if there is copyright or intellectual property. There should be some flexibility around what someone defines as far as standards of what medication or what diagnosis. You cannot get around compliance. The artifacts cannot infringe on someone’s intellectual property.

Attributes #5

A WG member commented that there is a need to determine which artifacts have real impact on patient outcomes. Surveys or some other reporting mechanism may be needed.

Attributes #9 and #5

A WG member commented that we may say this is not the best artifact but being able to say exactly where your thoughts are and exactly where your benefits are might be enough to still disseminate the artifact. Very discreetly linking it to the evidence-based source and the process by which the recommendations were changed into the decision support.

There was a question from a WG Member about the meaning of Organizational Capacity

Lisa clarified that the definition comes from the Trust Whitepaper. She believes it means that the organization that sponsors development of an artifact within CDS Connect or outside of CDS Connect, it is important to know that the organization has the necessary staffing, funding, and resources to maintain that artifact and measure its effects. It should also reflect to the most recent clinical guidelines and if it does not reflect the most recent guidelines, it is made evident to potential users.

It was commented that the VA does not have the funding to maintain the artifacts it has developed and contributed. Since the funding isn’t there, a lot of artifacts could be eliminated.



The prioritization process is not seeking to create metrics but rather what activities should be pursued with respect to maintaining and updating CDS Connect that can foster trust. Is organizational capacity an important needle to move to help CDS Connect become more trustworthy? The requirement that whoever develops the artifacts must maintain and update for the long-term is a “no-go”. No medical group will agree to such a requirement. They do have to be maintained and updated but medical groups don’t have the capacity.

WG Member’s Comment

From a consumer perspective, no one will trust it when the authors are not committed to it.

WG Member’s Comment

It is already done on some level but will not be done long-term. Needs to be a team approach to doing it. Guideline developers should create the artifacts and then maintain them. The comment was made that something needs to realistically happen—specialty societies; they view it as a revenue source. There could be a disclaimer. The #7 requirement should be eliminated as it stands and revisited.

Closing

At the end of the meeting, it was announced that Lisa Ide, Howard Gershen, and Maria Michaels will be attending the Patient-Centered Clinical Decision Support- Learning Network (PCCDS-LN) Annual Conference on 10/21/2019. MITRE encouraged participants to send any follow up thoughts or questions about the Prioritization effort via email.