

**Meaningful Use Workgroup
Subgroup #4 – Population Health
Draft Transcript
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Presentation

Operator

All lines are bridged, Ms. Robertson.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning, everybody. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #4: Improving Population and Public Health. This is a public call and there will be time for public comment at the end. The call is also being transcribed, so make sure you identify yourself before speaking. I'll now take roll. Art Davidson?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Art. Charlene Underwood will be joining a little bit later in the call. Amy Zimmerman?

Amy Zimmerman – Rhode Island Department of Health and Human Services

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Amy. Marty Fattig?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Marty. Yael Harris? George Hripcsak?

George Hripcsak – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. Are there any other full workgroup members on the line? Okay, is there any staff on the line?

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle. Okay, Art, I'll turn it over to you.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay. After the marathon last week that we had in Washington, there was some discussion about ways to proceed with the subgroup 4 recommendations. I think at first, and George correct me if I'm wrong, I think at first we thought there would be a presentation on July 10th of preliminary findings from the Meaningful Use Workgroup, but I believe that's been postponed to, I think it's August 1st or something like that is our next meeting in August.

George Hripcsak – Columbia University

Correct, August 1st is when we first present.

Michelle Nelson – Office of the National Coordinator

Yes. We were originally hoping to accelerate the timeline but it didn't seem feasible, so we just need to be prepared by August 1st to present to the Policy Committee meeting. I'm trying to see when the Meaningful Use Workgroup meeting is before that, because that's really when we'll need to be ready. Actually, we're trying to plan one for the week of July 23rd, so that is most likely when you'll have to have your final analysis ready.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, and I think we have one scheduled for the 13th.

Michelle Nelson – Office of the National Coordinator

We do, but we're hoping to have one in between the 13th and before the August 1st Policy Committee meeting.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay. And the one on the 13th of July is just our subgroup, or the full working group?

Michelle Nelson – Office of the National Coordinator

The one on the 13th is the subgroup.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Michelle Nelson – Office of the National Coordinator

So if you think you might need another subgroup call we should probably plan to schedule that. Maybe we can see how far we get during today's call, and that will give us a good idea if we might need one more meeting.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Good, good. Okay, so to get this conversation going, Michelle put together this matrix, she sent that a little earlier and then I just sent out a second version of that with some scribbled notes that I quickly put in late last night. It's not to say that this is in any way final or suggesting that these are the items that we should only discuss, we could discuss others as well today, but to start the discussion I thought we would maybe look at some comments I had put in. The way that these matrices are set up is the third line for each of these, where it says "Meaningful Use Workgroup, Subgroup 4, Stage 3 Comments," so in an earlier call this week the Meaningful Use Workgroup went over items for efficiency, quality, and safety, and Paul used this format, so we thought we would just follow this pattern here, and you can see what we have is Stage 1 Final Rules, Stage 2 Proposed, Stage 2 NPRM, and then some comments from the Meaningful Use Workgroup that I think were just quickly gathered at some earlier point in the last several months before we sent back our comments. Is that right, George?

George Hripcsak – Columbia University

Say it again, Art.

Art Davidson – Denver Public Health – Director of Public Health Informatics

The middle line of this matrix, where it says “Meaningful Use Workgroup,” these were the comments that the Meaningful Use Workgroup sent back to ONC.

Michelle Nelson – Office of the National Coordinator

Those were the comments on the Stage 2 NPRM, so they were really sent to CMS for their rule.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay.

Michelle Nelson – Office of the National Coordinator

So once the Stage 2 Final Rule is finalized, we’ll update this document with the final Stage 2 rule, because we might have to make some changes, and have a call on Stage 3 then.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay.

George Hripcsak – Columbia University

Michelle, are the Stage 3 suggestions in here? I’m just looking now.

Michelle Nelson – Office of the National Coordinator

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

They were in there, and I’ve overwritten them a little bit.

George Hripcsak – Columbia University

Okay, that’s fine. I was just curious. Thank you.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And we’ll get to that as we go through. I did overwrite some of that stuff, so we may want to preserve that somewhere in this document.

George Hripcsak – Columbia University

Okay.

Michelle Nelson – Office of the National Coordinator

There were only a few, though, Art, anyway, right?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Michelle Nelson – Office of the National Coordinator

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, the main one was the patient reported data on some sort of public health button. That was one, George.

George Hripcsak – Columbia University

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And we'll get to that as we go through the conversation, I think. Maybe we can just dive in, the three items that we all know so well from Stage 1 and proposed in Stage 2, and then there are a couple more that were added in Stage 2, the cancer registry, the specialized registry, and then I added another one at the bottom, the patient generated data, which was one of the items we had on there, George, and then I added yet another piece of this matrix, where I just lumped a bunch of other items at the very bottom. But maybe we can start at the top.

George Hripcsak – Columbia University

Okay.

Art Davidson – Denver Public Health – Director of Public Health Informatics

The first one is around immunization registries and information systems. I think that the public health community that we've been hearing from is now suggesting that we really push this one to be, as was suggested, we be able to see cumulative immunization records and the recommendations for vaccinations. This is now saying that not only will you push data to the IIS, but you'll receive data back from the IIS, and I don't know whether this fits under this category or if we're doing the recommendation piece, it might fit under clinical decision support, which might be a clinical quality measure that we were thinking CDS would be part of that effort. George, do you know whether there's a need to segregate CDS activities from these Meaningful Use measures?

George Hripcsak – Columbia University

First of all, the CDS objective is generic. It's like here are the criteria to decide if it counts, so we don't want to go there. But you make a good point about this has become a quality measure rather than an objective, so as an objective I'd probably leave it here. But when does it transition to a quality metric is a good question.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Art, this is Amy. Forgive me, because I know I've been on some calls and not others, but the question I would have on the clinical decision support side is from the provider perspective I'm assuming we're talking about they're using the immunization recommendations in some way that would make sense to the clinical quality measurement. The question I have is, are we talking about, and this I think is important, and maybe you already discussed it and I wasn't on the call at that point, are you talking about feedback from the registry, having the clinical decision support built into the registry and using it? Or, are you talking about importing the immunizations into the EHR and the EHR doing its own algorithms?

Art Davidson – Denver Public Health – Director of Public Health Informatics

I don't know where the recommendation will come from. It could come from the IIS. It could come from within the EHR. I think in this example that I've written here clinical decision support should permit the electronic health record to access and use a knowledge base, and that could be that the IIS is accessing that and then giving information back to the provider, or that the EHR is accessing that knowledge base and then providing that directly to the provider without going through the IIS.

Amy Zimmerman – Rhode Island Department of Health and Human Services

So you're leaving flexibility.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

So here's the thing that I think we just need to think about, and flexibility may be the way to go, and I can verify this, but in states that are still universal purchase states, like depending on the product that's being used there may be nuances on, at least there used to be nuances on schedules, so for instance, in Rhode Island I think there was always a preference from the immunization program in KIDSNET to have providers use the algorithm built into the state registry than having every EHR have their own algorithm. And I need to verify where we are with that now because I haven't had this conversation in a while, but depending on product and what certain states allow or don't allow, there may be nuances and differences there. And I'm not sure we want to get into dictating that, but it does have an impact on the EHRs and how they do this, so that's why I'm raising it. If we haven't considered it, I think we just need to be cognizant of that.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I think that's an excellent point. And you'll see, this is a repeating theme, we're going to see this again done in eligible providers doing case reporting. There are variances between states and jurisdictions and the suggestion is that those states and jurisdictions post what is their preference to this knowledge base, so that if Rhode Island had some slight variant on the ACIP recommendations, that it would post it. And the EHR is looking for a Rhode Island specific, if there is one, and if there's not then it goes to some national guideline, or whatever. The knowledge base is not unique, it needs to be maintained by Rhode Island, that it would say these are the specs for immunizations and recommendations for immunizations in this jurisdiction, Rhode Island, or in New York City it may have a slight variance on that. But I don't believe it's going to be valuable for each provider to have to maintain his or her own immunization schedule. That should be something the EHR just consumes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Yes, I agree with that. I absolutely agree with that. I don't know how many EHRs now have built-in algorithms, and that's been something that early on was a discussion here about if providers are using that versus the state ones, particularly because in our case, and I think there are only still a handful of states that are universal purchase states, so it is important to know what the state is funding and isn't funding and those products and those schedules associated with those products.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And there's nothing to say that the EHR has to consume the knowledge and then do all the algorithms internally. They just attach to the IIS –

Amy Zimmerman – Rhode Island Department of Health and Human Services

The recommendation, right.

Art Davidson – Denver Public Health – Director of Public Health Informatics

The recommendation comes back in an HL7 message and it's done.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right. I'm actually saying to me it's more logical to do that than to have vendors have to build in algorithms on their own, or have a default on where to go to get it.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I don't know that every state is ready to say, "Come to my site, I can provide you this service." And it may be that some EHRs already have this built in. I don't know. I don't know that we want to say this one way. All we're saying is you need to be able to receive a recommendation somehow, or generate a recommendation somehow.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I'm comfortable with that. I don't know whether, from a vendor point of view, and we don't have Charlene on the phone to know how challenging or not challenging that is based on some place that's having, like a national EHR company knowing in Rhode Island they need to be able to pull it in from our registry. But in some other states they don't have it and they have to build it, or whatever the case may be. I don't know how that works from the vendor perspective, I'm just raising it because I just wanted to make everyone cognizant of there's a difference there in where that information and the recommendations are going to get pulled from. And I'm agreeing with you, Art, we need the flexibility, how to word it in a way and then how to be practical from both the state perspective and the vendor perspective I think is what's important.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Art?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, Marty.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

This is Marty. In an ideal world, it would seem to me that the best way to pull this data would be to have this data available in some sort of an HIE. Now that being said, that would maintain the flexibility. How we do that and how we promote and move the HIE platform forward is the big issue, I know.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I'm just thinking about this from my state, I'm hoping that my HIE will be the intermediary to the IIS and I'll make a call through the HIE from whatever site I'm working on in immunizations and the immunization registry, or the IIS, that the state would respond to that call, feed up what they know about this patient I'm about to give a shot to, and make a recommendation, and the HIE is the method by which that message is returned to me. You're saying the HIE would have the knowledge. It could be in some states that's true; in my state the knowledge lives over in the IIS and they are partnering with the HIE.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

And then the beauty of it is it can work both ways.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, it's not to say whether that knowledge needs to – there needs to be knowledge somewhere and the EHR needs to figure out a workflow that allows it to benefit from that knowledge.

George Hripcsak – Columbia University

This is George. So what we want to say as far as the data, we want to make sure that the data are gotten from outside the organization, including any state, or city, or local immunization registry, and that the knowledge is centralized at the discretion of, really it's going to be of the state, whether the knowledge is centralized and the EHR calculates based on that knowledge, or whether the recommendations come and whether they come through the HIE ... calculates for you. It's not that we don't want to decide now, but we want the knowledge to be centralized that it's not resident in the EHR itself. And then we need some mechanism where a state or local public health authority can decide for that region really how it gets done, at least that's what we're envisioning.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. Yes, and it would be the local public health department and the HIE and the consumers of the data.

George Hripcsak – Columbia University

But someone has to decide – yes, I agree with that, but how is a doctor right here going to know what am I supposed to do.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

George Hripcsak – Columbia University

I think that I'd have to go the state or the relevant health department, be it my city or local or state health departments, to find out – no, I have to think about how you execute this. How do you hook it up? I have my EHR, what does it hook to? We don't want 50 different things to hook up to for 50 different states.

Amy Zimmerman – Rhode Island Department of Health and Human Services

And that was kind of my point. I'm sorry I threw a red herring in, but I think it's an important distinction.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I don't know that it's really a red herring. I think it's just something that we need to figure out, how can the knowledge base accommodate these slight variations? Ninety percent of the schedule, or even more than that, is going to be the same. There's going to be these very slight variations that we need to account for and allow a way for that knowledge to be exposed.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Yes, and it may be more even in the catch-up schedule. Sometimes I think where the differences were, where the algorithm got tricky, at least it used to be the case when I was more involved in it, and maybe the schedule standard is the same but depending on which product you use if you're catching your kid up, there were a little bit more nuances. I'll check with the folks here. I actually don't even know what we're doing. I know right now if you log into KIDSNET, because right now we're not bidirectional, so if a provider goes and pulls up a kid's record in KIDSNET, they're going to get the algorithm that we've programmed in the state that matches what we cover as a universal vaccine state based on the products and the schedules, etc. I don't know whether, I'll ask the immunization folks, I don't know whether they're running into any issues where providers have algorithms that are coming up in their own EHRs or whatever. So, again, I don't want to make more of it than not. I just think it is important because I think there are, at least there were, some nuances in the past.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay. I'm going to drop a note to the CDC as well, so that's helpful, Amy, if you could do that.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And then I'll canvass a little bit around the CDC and find out how many different schedules – are there 50, are there 56? Is it really there's one basic one and a few minor variations. So let's do a little searching about this.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Okay.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I think we have general agreement here that this is maybe an area that we want to push forward too. I want to go back to the point that George was making about as an objective and then transitioning to a quality metric. So you're saying that the objective would be something along the lines of EHR is able to benefit from this knowledge base in supporting the provider to give the right shots, is that right? Is that the quality metric?

George Hripcsak – Columbia University

Well, I'm not sure that we're ready to go to a quality metric, now that I think of it. The quality metric would be the outcome of the immunization, and I think that may be too distal, because we really want the process to work, so I think that probably for Stage 3 we're still going to be doing whatever we call them, functional metrics, yes, functional objectives. So I think how we do it is still relevant, and it would be what portion of the patients you care for are properly immunized, would be the outcome measure, right?

Amy Zimmerman – Rhode Island Department of Health and Human Services

So even if you were to try to measure, let's say we decide on Stage 3 is really to be able to use the algorithm, the immunization algorithm recommendations, and I'm thinking this through out loud, so forgive me here if I'm way off base, but if we're saying in such and such a percentage of cases you should be able to document that you've used the algorithm, is that what we want to go to? And then how easy or not easy is it to document for the provider to say, yes, 50% of the time I immunized an individual I had the algorithm, I saw the recommendations?

George Hripcsak – Columbia University

Well, that's good. That would be the functional metric. I would say that's not the quality metric.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right, I agree, absolutely. I agree with you. The quality metric is on the outcome stuff.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. So we're saying along the lines of some measure of retrieving that information?

Amy Zimmerman – Rhode Island Department of Health and Human Services

That's what I'm struggling with, because we want people to use it and they can only use it if they pull it up from wherever it's coming from. How you document that you've actually used it, I don't know how they capture that and then measure that.

George Hripcsak – Columbia University

So we would have to say that they – I don't know how to phrase it. Really, they're in some area where some algorithm is deemed to be the right algorithm, so we've got to figure out how we figure out which algorithm is deemed, and we want that algorithm to be maintained essentially so we just want to see how often they use that, either by having their EHR calculated according to the central algorithm, or by just getting the recommendation straight from the state or city immunization registry. And we want to know, as you said, for how many – actually it's not so much how many immunizations they give, but how many children or how many candidates who maybe would have needed an immunization did I check the algorithm for.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right, that's what I was trying to say. You said it much better. Thank you. And it may not just be children. There's a whole issue around whether, if we're talking immunizations here we're talking adults too.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

And that's where algorithms get even trickier, because that's where combining what's in a registry with what's in an EHR, you know, adult registries, I don't think, are as far along in as many states, but I could be very wrong on that comment, as childhood, or it didn't at least start on that. So if you're just thinking about a tetanus, the recommendation may be able to give one because you don't know that the patient had it. If you didn't know that the patient had it, then my guess is you should give it, in certain instances.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. We'll have to get to the issue about adults versus kids at some point, but –

Amy Zimmerman – Rhode Island Department of Health and Human Services

That may be another way to phase this, or you give the out. Like, for instance, in Rhode Island we're moving towards an adult immunization registry, but we don't have it now. So for all those adult providers ... the current meaningful use, they're just exempt on immunization because unless they're a pediatrician or a family practitioner immunizing kids we don't have an adult registry yet.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

And I don't know what the percentage is across the board of adult versus childhood. You may want to ask CDC, Art, if you're going to talk to them, so we can think about the impact of that and if we want to qualify as a phase in or not.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. Okay, so we're going to keep this at a functional metric and it's really about whether they were able to access and/or consult an algorithm that's appropriate to their jurisdiction and that they were able to receive a summary record also.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Well, I think the two go hand-in-hand.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I think they do too. I just want to be sure that we didn't drop that off.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I think the summary record comes first, because if they don't get back the summary record their record will always be incomplete.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, so it's the summary record and then whether they're accessed and consulted the correct algorithm for their jurisdiction.

Amy Zimmerman – Rhode Island Department of Health and Human Services

And all of this then becomes contingent on the fact that the local registry, whether it's state or regional or whatever, can support this.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I mean, obviously, like in our case we're not bidirectional yet, by then hopefully we will be, but if Rhode Island isn't then obviously those providers can't do it if the public health agencies can't support it.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

And from an EHR vendor perspective it means they have to be able to consume the summary record back in whatever recommendations or algorithm were generated, however we work that part out. But I agree, I don't think they should all be generating them.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Well, but the EHR as part of its certification criteria would have to be able to consume data from some knowledge base.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And that would be hopefully something pretty standard that the Standards Committee would recommend a method by which that could happen, right? This gets to certification criteria.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Yes, I think so. So if you and I do a little more research maybe we can come back on that part of it, on the recommendation part of it.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, good. Okay, any more comments about this area? I think we have some stuff to work on and we're developing the thought; it's nowhere near finished. So maybe we can move on to the next one, which was on our list to test the capabilities, submit electronic data on reportable lab results. This is where, I alluded to this a little bit earlier, a similar sort of knowledge base is being proposed here and now, and again, I wrote this late last night, so the wording may not be precise yet, but the concept that was being proposed at the Council of State and Territorial Epidemiologists that I was at early last week with meetings with the CDC, with all these epidemiologists from around the country, we met with Seth and Jim Buehler, both of whom testified to our subgroup, and the idea is that eligible providers have an obligation as to mandatory reporting for about 60, more or less, conditions and diseases in just about every jurisdiction in the country. There may be some slight variations there. In one place there may be reporting of a disease like toxic shock and maybe another place it may not be reportable, or mumps, or varicella is another one, so there are these variations.

And the CDC was saying well, and the CSTE has been saying, we have been working on creating these tables for reportable diseases by lab for a long time, those are called the Dwyer tables, and they've maintained these reportable case tables and they were now saying that they'd like to do the same with reportable diseases by jurisdiction, by eligible providers, compared to before it was maintain these tables for the labs. There was an idea, again, that there would be a knowledge base and that each jurisdiction would post to this knowledge base its rules and then that would be exposed to an EHR that could say, I'm in this jurisdiction, tell me what I'm supposed to do. And then the EHR could consume that and then generate a message that would go to the state or local health department based on the case.

One of the things that came up was there are 60 different cases, or 60 different diseases or conditions to be reported, and each of them is slightly different. They have different needs. You may have more respiratory questions for respiratory disease, and food-borne exposure questions for food-borne diseases that aren't pertinent to the respiratory ones. There was a lot of discussion around this, and the CDC has been trying to figure out how to get the comprehensive data list for each disease prepared, and this has been a monumental task that's taken years to produce only a few diseases, because I think they've done measles, tuberculosis, pertussis, and anthrax. There were four diseases that the CDC has worked on, and it's been very slow.

One of the discussion points at the CSTE meeting last week, in this small session, was let's not try to do everything. Let's just try to do the base case report, which is not saying I've completed the case report, I'm just starting the case report. And that there would be an opportunity here hopefully to leverage the consolidated CDA, which the EHR is supposed to be able to produce, for transitions of care to make that a method of transmitting a case report to the state or local health department. And you can see there on this list that there are only a few elements, maybe it's a dozen if we could flesh this out a little more, but it's not going to be everything that you would want to know about pertussis, about was your sibling immunized, when was your last immunization, how many people in the household, how many of those people need to be treated prophylactically, all this other stuff that would go on as a consequence of a case report, but it's not the initial case report. So there was a decision made in this group that we push for a common method for all 60 and then slowly work on adding templates for additional data that would be added to the CDA over time that would then fill in the gaps of data for other needed variables as part of the case investigation and treatment. Does everybody understand? Are there any questions about what I just described?

George Hripcsak – Columbia University

Is this related to the query health stuff, are they kind of doing the same thing, where they're going into your EHR and running a query? I guess that's on the EHR as opposed to focusing on the CDA.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay. The query health is really at population level.

George Hripcsak – Columbia University

Yes, they're avoiding, they're trying to be anonymous.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, and this is at an identifiable level based on statutes.

George Hripcsak – Columbia University

Is this query health with identifiers?

Amy Zimmerman – Rhode Island Department of Health and Human Services

I thought it was the opposite. This to me, Art, the way you ... sounds like the EHR has the knowledge to know when to push data to the state when it's a reportable disease, so that there's some sort of coding or knowledge in each EHR to know what these 60 conditions are and then know that they have to create and send a core set of data for each of these 60 conditions, versus query health, which I thought was coming into your EHR and pulling it out.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, so the EHR – exactly, Amy, you've got it – is there's a knowledge base out there, CDC may maintain that, your EHR vendor hooks up to it and figures out which EHR you are, what jurisdiction you're in, either pushes or pulls the data down, and then your EHR is now using that knowledge base to determine which reportable diseases, here's an ICD-9 code, here's a SNOMED code, and based on that I'm going to prepare a case report to go to the state health department, which is also the URL for that, or the method of reporting is stored in the knowledge base.

George Hripcsak – Columbia University

So the knowledge is centralized just like query health. The question is the implementation may be where the application that actually goes in and queries the data, and this is very much like the first one, which is immunization directions, so I don't know that we want to go into too much detail about – the Standards Committee should be figuring out more details about the CDA or the implementation. But we have to figure out how to phrase this, but our requirement, like the previous one, is that the knowledge is centralized and the outcome is, instead of a reminder going to the doctor about the immunization in this one, it's that data are transmitted to the health department, including identifiers.

Amy Zimmerman – Rhode Island Department of Health and Human Services

This is Amy. The challenge here I think, and it's a little bit with the immunization one, as I see it, is we're trying to make the requirement on the provider, so what's the requirement on the providers, because we can only make the recommendations for meaningful use. So the part that I worry about a little bit is we put a requirement on physicians to report all reportable diseases in their jurisdiction and a case report using CDA standards, and how they then implement that and the centralization part of a knowledge base, if it's not built yet and it's not maintained, I don't see that as within our authority or control to be able to – we can drive it, we can recommend, but it's not really a meaningful use objective because whether it's CDC or state level or whatever, they're not getting incentive funds. Do you know what I'm trying to say? We can say what's required of the provider and how they use their EHR and we can make recommendations that we think the best way to implement this for all EHRs in a practical, reasonable way is that CDC maintain a knowledge base, but if the knowledge base isn't ready yet or done and the providers still have the requirement, they're still going to have to figure out a way to do it. So how to reconcile those is what I'm wrestling with in my mind.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Jim Buehler offered to do that knowledge base management. So I think the CDC recognizes it can play a major role here.

Amy Zimmerman – Rhode Island Department of Health and Human Services

So they think they can have it done and ready in time?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Then the only thing is you have to caveat at saying "contingent upon" or something, right? That's fine if CDC is going to create this and maintain this knowledge database on reportable diseases for each jurisdiction, etc., etc., and be able to maintain it and keep it up with laws changing –

Art Davidson – Denver Public Health – Director of Public Health Informatics

Let me just clarify. The CDC will maintain a site where each jurisdiction can post its requirements. It's not like the CDC is going to go out and canvass. This is self-service. The CDC is setting up the environment for each jurisdiction to say, here are my 60 diseases and here are the other 2 that I do special.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right. Whoever maintains it, I'm just saying it has to be ready and maintained and then what we're saying is the providers have to send the data and the logical way to do it would be to use that.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I'm just concerned about the timing of the readiness. You just said four diseases took years, right?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Amy, this is the point, is that we're only talking about the few items I have listed at the very bottom of this page where it says EG. That's all that has to come in the CDA. Almost all of that is already in the CDA.

Amy Zimmerman – Rhode Island Department of Health and Human Services

So I'm going to play devil's advocate here, so I'm a physician and I have an EHR, do I have to have a dual system, my EHR is capable now of doing these four conditions, but I've got 50 other conditions that have to get reported?

Art Davidson – Denver Public Health – Director of Public Health Informatics

No, no, no. Amy, forget about 4 conditions. We're doing this list of items for 60 diseases.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Ah, okay.

Art Davidson – Denver Public Health – Director of Public Health Informatics

It's just a case report. It's that first card. You know, when I was in practice I'd fill out these little yellow cards and I'd send it to the state and the next thing you'd know someone from the state would call me.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Okay.

Art Davidson – Denver Public Health – Director of Public Health Informatics

"You had a gonorrhea case. Did you treat the gonorrhea case?"

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right, it's the initial case report for all 60 conditions.

Art Davidson – Denver Public Health – Director of Public Health Informatics

That's right. That's all we're trying to do. We're not trying to achieve what those four comprehensive use cases were for anthrax, pertussis, measles, and tuberculosis.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right, that's why you can use the CDA.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Okay.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. Now, on top of that over time the CDA would develop templates for each of these other diseases, but at this point the only thing we were saying at this level was we're going to do the initial case report directly from the EHR because the EHR knows the reportable diseases in that jurisdiction and it is able to generate the CDA and send it to that public health department.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right, and I guess all I was trying to say was I think in terms of the actual Meaningful Use objective, I think it's about having to report using a CDA for 60 conditions or all reportable diseases in your state. The method in the Standards Committee in terms of using some centralized thing, that's a way to do it, but that's not the objective. Do you know what I'm trying to say?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I'm trying to be clear about, when we go to word these, what falls within our recommendation versus what is outside the scope of what we can recommend. We can recommend beyond it, but I don't think that CDC maintaining a centralized database gets put into the Meaningful Use recommendation.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. So the recommendation is that EPs do initial case reports. That's what we would be measuring.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And then, as I think George was saying, the Standards Committee is going to decide will a consolidated CDA work for this, and we also need to have a place where the knowledge base could be maintained, just like you were saying CDC needs to step up and if that doesn't happen this cannot happen. We can't expect an EHR to know all of this reportable disease stuff on its own. It needs to consume this information from elsewhere.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right, so it's a readiness and timing issue, that's all.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I'm just trying to chunk out what we can, through this process, recommend and then we can try to drive and recommend the only way to implement it is to do this other stuff, but there's no money attached to that right now and we don't have control over that.

Art Davidson – Denver Public Health – Director of Public Health Informatics

But I think there's commitment from CDC to do this work.

Amy Zimmerman – Rhode Island Department of Health and Human Services

That's great.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes. Any other comments about this one? Okay, so I think there are some good thoughts here.

George Hripcsak – Columbia University

I think the action item, Art, is you should try to rephrase them now into objectives.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, right.

George Hripcsak – Columbia University

... being as terse and concise as possible --

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, I'm --

George Hripcsak – Columbia University

... offline, I mean.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, I'm realizing that, George. Yes, we need to get more precise here. So the third one, if we can move to the next one, was the syndromic surveillance. And I don't know that there's any change here. I think that this may remain as an EP menu measure. I don't think there's any encouragement to really make this core for EPs. I don't know that there was that much discussion about this for us to really focus on it at this point. So if there's no objection, then maybe we can move on to the fourth item, which was the cancer registry.

I spent a little more time at this point reviewing the middle comment here about Meaningful Use Workgroup, and I can't remember why we tried to consolidate these two registry objectives. George, maybe you can remind me of that.

Michelle Nelson – Office of the National Coordinator

Art, this is Michelle. I think it came out of the Health IT Policy Committee meeting, because at that meeting, I forget when it was, probably the April 4th meeting, I think it was, they were wondering why we chose cancer at the time, and they wanted us to think a little bit more thoughtfully about that. I think part of the reason why cancer was chosen is because there's more work being done in that area, but they question why cancer. So I think coming out of that meeting that's why we said maybe it's too much to have both registries and so people should be able to choose, although cancer is further along. It was at a high level around in circles kind of conversation, to some extent. Does any of that ring –

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, yes.

George Hripcsak – Columbia University

It was somewhat arbitrary. We still wanted cancer highlighted at the end of it, so even if it was one objective with cancer plus other, even though it was one objective. And it does make sense to make it one objective because they were somewhat similar, other than substituting the word "cancer" for now something else. Yes, I think it was a somewhat arbitrary decision to try to accommodate all the comments.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. So indeed the cancer registry specification is probably the most developed.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Thank you. And I'll mute it.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Is that Charlene?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, this is me, Art, I'm on.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Welcome. So we're on the document, the revised one that I sent out, so if you open that –

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

I'll get on that. Yes. I'm going to mute too. I'm in a little noisy place.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, thank you. So we're just talking about the cancer registry and why that was suggested to merge into one menu objective with the specialty registry. And the people at the cancer program at CDC have done the most work in this HL7 specification, so I don't know that the specialty registries have even a spec yet, so that's what was a little bit confusing to me is how we can combine these two things when the methods for one were much more developed than the methods for the other. But that may have been because the Policy Committee wasn't really focused on the method, it was just focused on a higher level approach. But I don't really know what the specialized registry spec would be, and we'll need to talk that through with the Standards Committee.

George Hripcsak – Columbia University

Well, in a sense we're going to find out, because CMS is going to publish a final Stage 2 rule, so we'll see what CMS comes up with in that regard. In other words, and we're deciding Stage 3, so it would be good to see what they end up doing with registries in the final rule for Stage 2. But what you're introducing here is a new concept that it's not just for specialty registries, it's also, as you say here, for – what did you call it – ... based information.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. First of all, I thought it was interesting that we started with the term “a specialty registry” which came out of all that testimony we had from the American Heart Association, the American Thoracic Society, do you remember all those testimonies we had, George?

George Hripcsak – Columbia University

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Those specialists, and they were the ones who were talking about creating these registries for internal defibrillators and cardiac arrhythmias, and congestive heart failure, and then the word got changed from “specialty” to “specialized.”

Amy Zimmerman – Rhode Island Department of Health and Human Services

That could be because there are other registries in place, like some states have birth defects registries and traumatic brain injury registries.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

So I think it was trying to be more inclusive to other registries that do exist.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, right. So I think that's good. It happened and I think we're taking advantage of that, as a public health agency we're trying to figure out what that would allow us to do. So I am talking about some of the things that we heard in testimony both recently and back in July of 2010 when people were talking about some of this ... based analysis and allowing us to really look at information that query health might be able to do. I'm not sure. I don't know enough about what query health can do. But some communities may say this is a way for us to move forward with these more specialized registries that we're trying to do in Denver for BMI and cardiovascular disease risk. And I know New York City's done stuff like this and obviously these have also been very effective in using EHR data to look at more population perspectives. I don't know that this is ready for primetime yet, but the fact that these children's special needs registries, I know that those exist, there are, as Amy said, the traumatic brain injury, there are other registries at the state that we contribute to, and I just wonder if we should be making participation in these registries something of a criteria for meaningful use.

George Hripcsak – Columbia University

Art, there's a different character then. Remember, the specialist registries, it's kind of a voluntary field. It was like, well, do the one that's relevant to you, as opposed to the public health objective, say syndromic surveillance, so ideally you want to try and get information from everybody across the state, and so the ones you're describing to be useful, you really need to push everyone to connect to all the registries we're talking about.

Art Davidson – Denver Public Health – Director of Public Health Informatics

You could say that, but I don't think I'm pushing that far. I think what we're trying to do is transform the healthcare system to be able to at least say I'm getting information from EHRs and it won't be to every registry by 2017, but the EHRs are capable of speaking with some registries by 2017, that the ability, just like the same thing we were talking about, the ability to consume knowledge based information about immunizations or about reportable diseases is the functionality that we want the EHR to have and then incrementally you'll be able to do more with that. You'll be able to move to giving immunizations to older people instead of just kids, or able to provide data for more registries instead of just one around hypertension or around children with special needs.

George Hripcsak – Columbia University

Okay.

Art Davidson – Denver Public Health – Director of Public Health Informatics

It would say, oh, you only need to do one. I don't think we're trying to get people to do all of them. Any comments on that?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is Charlene. One comment, George, and this is one of those cross-cutting ones, when we were working on the quality requirements the first segment, the piece that we were doing with Paul on Monday, when we looked at creating patient lists we started to talk about the use of registries for that mechanism instead, so this one kind of correlates with that mechanism in terms of a means to start to manage, and I don't know if we can elevate the thought managing certainly patients in the context of a population, managing your panel, those kinds of things, I don't know if we can bring it into that context and if the registry's a source of that, I think that's great, but I think we're trying to elevate Stage 3 to population health. So that would be my comment as we're trying to look at addressing this issue. I know we've had issues in registries, to be able to report to registries there's cost considerations and those types of things, so I think that's where we've hesitated, to some extent, kind of making that a mandatory requirement.

George Hripcsak – Columbia University

Okay. Well, again we need a concrete, concise description of what we're suggesting.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, that's my job. There was this idea I think about managing a panel. So we're not going to try to get to the point of taking data back from a registry and somehow meaningfully using it in this, we're just trying to get them to report, right?

George Hripcsak – Columbia University

I guess. The goal is that, but we're moving forward on immunization in that regard.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. We shouldn't try to do too many bidirectional pieces at this point.

Amy Zimmerman – Rhode Island Department of Health and Human Services

This is Amy. I think for these other registries, since, again, there's a lot of different kinds and we're going on the philosophy of if you're participating send for whichever one electronically, I think the bidirectional, I don't even think we have this figured out. This is really going beyond the immunization, which is probably the most established in terms of registries. So I agree, I think that we need to try to chunk this out in smaller steps and get the data flowing in to the registry.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. Okay.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Ultimately that registry then, the ability for that registry to do things on a population health basis, whether it's epidemiological, surveillance, or something else, or at least be able then to know, I need to call these docs because these individuals have this defibrillator which has just been recalled, or whatever the case may be, at least then the information can be used from the registry level if it's not at the individual level. But we have to be able to figure out how to get the information there electronically first and get that flow going consistently and in a really institutionalized infrastructure manner before we start going the other way, I think.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. Other comments? So we'll move on to the next section. In the version of the document that Michelle sent out earlier, in this section it said "patient generated data submitted to public health agencies." As I sat down to think about this last evening, I think it's impossible for public health agencies to consume patient generated data directly. I don't know how that would work. We can't even get patient generated data easily into EHRs yet, and they actually know who the person is, they have a therapeutic relationship with them; whereas, the public health department has a resident citizen relationship and has no one enumerated. So it seems a bit far-fetched for me to believe that a public health department, other than some sort of social media thing, would be able to consume patient generated data.

So then I was thinking, well, what would we do, what could we do with patient generated data? And then I said maybe we could do this by patient generated data submitted to an EHR that is then made available to a public health agency. And here's where we had testimony back in July of 2010 and again earlier last month with a suggestion about occupation and industry code could be something that is collected by an EHR, but we also heard from Eileen that the physicians and registration personnel aren't necessarily that good at doing this, and I was wondering whether this might be, as we had this discussion last week about patient generated data, is this a safe place for us to start with patient generated data, where they could contribute their information to an EHR. Yesterday on the Meaningful Use call I asked that Paul add occupation and industry to the demographic variables that are collected under that first category of quality, efficiency, and safety. So that has been introduced, but now here, getting back to this idea that patient generated data is of value to public health, is this something that we might consider?

Amy Zimmerman – Rhode Island Department of Health and Human Services

Art, again, maybe I lost you a little bit. I'm not sure I recall, and again, I know I've been on some calls and not on others, but discussion around public health and patient generated data. And it's not that it's not useful, but I think we have to think about how public health would use it. If it's occupation and industry type of data, then I think your approach of including it in demographics, and to the extent the demographics get incorporated into a particular cancer registry or something, or asthma registry or something else, then it potentially makes sense. I don't know under the population health if we can't clearly articulate what we want with patient generated data, maybe it's population health but not public health, so it's, again, focusing on incorporating it into the EHR, and I think that's very different than thinking about having it go directly to a public health entity.

Art Davidson – Denver Public Health – Director of Public Health Informatics

No, it's incorporating it in the EHR, and then whether it's query health that does this or registry message that adds data to a registry, those are secondary uses of the data, occupation and industry codes. But it is not about trying to push data to public health at this point.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Okay, good. I just wanted to make sure. That's what I thought you were saying. I wanted to make sure.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, maybe I haven't stated it clearly. It's about collecting a key piece of demographic information in the EHR that's available for population analysis at some point down the road. And my point was that when you ask people to code industry and occupation in an EHR, they don't necessarily know much about this occupation, this person knows about much more. And there may be ways to have people use a kiosk, use a Web program, use an app, and collect their occupational industry history and current occupation as well. So those are things that if we made it mandatory to collect occupation and industry codes for patients in an EHR, we'd like them to be using a variety of methods to collect that. It could be the patient gives the information. It could be the doctor collects it. It could be an industrial ... collects it. I don't know. It could be a variety of people.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Again, Art, I'm going to go back to being really focused and practical, so if I sound like a broken record, tell me to be quiet. But in the Meaningful Use recommendations this is about what the providers need to do with their EHR.

Art Davidson – Denver Public Health – Director of Public Health Informatics

They need to collect occupation and industry –

Amy Zimmerman – Rhode Island Department of Health and Human Services

Collecting occupation I think is fine, whether it comes in a separate recommendation from us, whether it's included in the demographics that were discussed yesterday, I think that makes a lot of sense. Beyond that, how much beyond that we can go at this point, you have to accept it from a patient kiosk into your EHRs, I think we're getting a little far ahead of ourselves, but that's just my personal opinion.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Well, it's just that the EHR needs to have a way to collect that, and then the providers would be judged on a criteria of have they been collecting it.

George Hripcsak – Columbia University

Art, I think it might be useful to link this, so patient generated data for one of our objectives, one of our public health objectives so is there patient generated data for immunization, is their patient generated data for, I guess you're doing it for the registry in effect. I think it probably can't stand on its own. What we do is we actually have patient generated data for immunizations. We let patients enter immunizations into the PHR, which is then linked to our EHR and the city, CIR, but they're marked as patient generated, so I don't think they actually go to the ... health department, they just go locally to our thing. For example, do you want patient entered immunizations to go to the city immunization registry?

Art Davidson – Denver Public Health – Director of Public Health Informatics

I think that would be something we would want in the immunization registry, why wouldn't we?

George Hripcsak – Columbia University

Yes. So should we pick a particular area to do this, rather than have it as general patient ... data?

Amy Zimmerman – Rhode Island Department of Health and Human Services

Let's just take immunizations for an example. I'm trying to think, so I have access to a PHR, it goes into my provider's EHR – then the provider is not, it's sort of like the immunization history question. When you get a record from another provider because the patient transferred under your care, are you submitting what you've actually administered, or are you submitting the history, and where is the history coming from, and is that recorded at the state level? Those are policy decisions that I think were made individually at each different state immunization registry, I think.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I think that the provenance of the data are recorded, so when I was seeing patients and the kid would come in with the immunization card and it was filled out, I would record all of that and then put that into the registry. Why not put that in the registry –

Amy Zimmerman – Rhode Island Department of Health and Human Services

No, no, no, I think that that is fine as long as it is properly coded that way.

Art Davidson – Denver Public Health – Director of Public Health Informatics

But then it could be that, just as George said, the patient entered it directly and at some point a provider may say, I reviewed a card and this is correct.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right. So I think that's fine. I just think that it has to be marked as history or the source of the data, because for instance in certain registries vaccine accountability and vaccine ordering and purchasing are tied and are part of the registry, so you have to count differently what's the providers administered versus what's been given out ... history.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, but a good immunization information system would be able to say, here's history and here's what was provided today.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right, right.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I think we're saying the same thing. I'm just caveating that as we go down that road we need the EHR then to be able to somehow distinguish that, okay?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

As opposed to what the providers administer today versus what they're entering and giving as history.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Even if the EHR does it by dates, you're putting in a date in the past and you know that the provider didn't administer it today.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. So, George and Amy, you're now suggesting that we do specify a domain for patient generated data, or that we leave that open? You kind of moved us over to the immunization piece here. Are we saying that's the data we want patients to be able to potentially contribute, or it's one of several?

George Hripcsak – Columbia University

That's a good question.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I think I'm struggling with whether the patient generated data belongs under the population health measures or under some other measures, and in the end will influence population health. I'm trying to reconcile this in my mind.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes, this is Charlene. I just –

Amy Zimmerman – Rhode Island Department of Health and Human Services

... the demographic one that you talked about yesterday, Art, was include occupation under demographics, so I think that made perfect sense. But I think it's important and valuable and then could be used in a whole different set of ways on a population or registry basis. The question is: is there something specific here that we need to call out, or does it fall under other categories? And I just don't know.

Art Davidson – Denver Public Health – Director of Public Health Informatics

We could drop this and just say, if it gets accepted by the workgroup and then by the HIT Policy Committee, to say that it lives in the demographic section, as we said yesterday, and then the issue is more, okay, how does that get accomplished over there and whether patients contribute, because I know we're seeking a way for patients to contribute data, we're looking for that. The testimony last week was clear, that's an imperative for our group.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right. Yes, I don't want to minimize that. I'm not sure we've all –

Art Davidson – Denver Public Health – Director of Public Health Informatics

We haven't figured out how to do that yet.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Exactly.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And for what domain. So we could drop this category here, this patient generated data in public health and just say, okay, we're hoping that's going to get accomplished somewhere else in the meaningful use objectives.

George Hripcsak – Columbia University

This is George. I would say that if it's not linked to a specific public health objective then it doesn't belong here, as you point out just now. It belongs in patient engagement presumably, because there's no reason why you'd have it here because it would also be patient generated data for all the other objectives that are quality and efficiency.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

George Hripcsak – Columbia University

But if we wanted to do something then we would link it, and it would probably go either to immunization or maybe there's more data we need to ... patient reportable diseases or there are some fields that need to be filled in, and it seems like immunizations might be the best one.

Amy Zimmerman – Rhode Island Department of Health and Human Services

There's another thought here which we didn't really discuss, which is around adverse reactions, and we haven't really talked about that. I know sometimes adverse reactions gets reported by providers, but I'm assuming there's a lot of things that don't get reported. I don't even know if there are adverse reaction registries anywhere anymore, or how that works. I think it goes directly to the Fed but not necessarily to the states.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, so there are a couple of other items that were discussed that are in the next section that I've just kind of bulleted there, so we may –

Amy Zimmerman – Rhode Island Department of Health and Human Services

Oh, I didn't even see it there. But I'm thinking that that's an area where patient generated information that may get ... someplace else, I'm trying to think about where on a population or public health basis would you really get value, not value, but where it's a more logical flow.

George Hripcsak – Columbia University

Okay. Art, do you want to go through your list there -

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

George Hripcsak – Columbia University

... while we're still thinking about the other one?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

George Hripcsak – Columbia University

Because we're going to run out of time soon anyway.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is Charlene. The less prescriptive this... was compelling out of the patient generated data hearing was again there's lots of opportunity so I think we've got to be really sensitive it's a key policy driver, maybe we highlight it, but I would rather keep it flexible in terms of where those opportunities are, at least until we work through that. And I think the area, I don't know if it was Amy that just mentioned relative to adverse events or patient safety related, it seems to make some sense, so I think we should use that context a little bit. I think, again, using patient generated data to capture the demographics ... is a great solution, but I think that needs to be left up to the provider as opposed to getting too prescriptive ... so we just need to identify that and need to capture it.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Back to you.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, thank you, Charlene. I think we're all coming to that agreement. So these last five bullets here were items that came up that I culled from the testimony. The early hearing detection intervention, they've got a specification that they'd like to use. This is the CDC. Getting back to adverse events, the vaccine adverse events reporting system goes directly to the FDA, I believe, and the CDC. I have a question here about, we did hear testimony from Becky Kush, who was at the session last week, about the clinical data interchange standards and whether that might be a method for providers to bring up a record and then report it when they have a vaccine adverse event report, this retrieve form for data capture, the RFD that CDISC has been using for research for about a decade.

The other items were these healthcare associated infections. I think they're fairly far along in this process. They report to the National Healthcare Safety Network, and this is a JCAHO requirement, so this seems like one that has the convergence property or attribute that we were looking for, trying to promote common requirements that would allow hospitals to – there are thousands of hospitals already reporting to this and have obligations to JCAHO on an every couple of year basis to prove that they've done this, so it just seemed like this was one, I didn't write it out but this is one that we might be able to add to eligible hospitals as another activity. It's not for eligible providers.

And the last two, I wrote down this eReferral to Quit Lines that was a very interesting project to me that the EHR was able to send a message in Massachusetts and New Hampshire, I believe, to the Quit Line and refer someone for services, and that ties in, I think, nicely with the Million Hearts Campaign. And the last one, if I had a record, there are I think several hundred variables on a birth record and the EHR could populate some of them, but not all of them, and it seemed like this is a high volume but not very comprehensive report that would still require a lot of human effort of chart review to complete. So out of this last bunch of five, maybe the second and third bullets have an opportunity for us. I know they're not concretely written out here at this point, and I don't know whether anybody had any thoughts about any of these last five. We moved on to this one because I'm talking about patient generated data. I don't know that the FDA would want to receive patient generated data about an adverse event.

George Hripcsak – Columbia University

Well, they do now through AERS, right?

Art Davidson – Denver Public Health – Director of Public Health Informatics

But they do receive it from patients?

George Hripcsak – Columbia University

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Do they?

George Hripcsak – Columbia University

I think so. One of the Web-based systems is for patient reported adverse events.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, because I thought –

George Hripcsak – Columbia University

(Inaudible.)

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay.

George Hripcsak – Columbia University

... in a second.

Art Davidson – Denver Public Health – Director of Public Health Informatics

I know there's VAERs, which is for the vaccine, but that's for providers, I thought.

George Hripcsak – Columbia University

Yes, and consumers, yes, AERS.

Art Davidson – Denver Public Health – Director of Public Health Informatics

AERS?

George Hripcsak – Columbia University

Yes, the Adverse Event Reporting System of the FDA is by healthcare professionals and consumers, voluntary reporting.

Art Davidson – Denver Public Health – Director of Public Health Informatics

So this is not really related to the EHR.

George Hripcsak – Columbia University

Right, AERS is directly to the FDA on a Web site.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

George Hripcsak – Columbia University

So they want to encourage as much reporting and have as accurate of information, so the vaccine adverse events could be reported from the EHR, or would that come under the immunization objective, or does this come under the registry objective in effect? Do you know what I mean, is this like another registry?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. But the patient reporting, unless it goes through the EHR there's nothing that we have as a tool to get providers to do something meaningful. It just seems like having patients report to the public health department, the FDA, it's not our purview regarding meaningful use.

George Hripcsak – Columbia University

Right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

This is why I was saying before that I think on a lot of patient generated data I'm not sure it's really going to fall under the population health basis. I think incorporating patient generated information into the EHR is more likely to fall under some of the other sub-group areas. I'm not trying to ... it, I'm just struggling with thinking about that, because it's all about patient generated data than going into an EHR, or a physician doing something with the information they're getting from the patient.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

George Hripcsak – Columbia University

It seems like two and three could fit under, not patient reported version, but just the EHR reporting of ... adverse events, or healthcare acquired infections, could come under other objectives.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I agree with you. I think that they're fine population health or public health objectives, but not under the patient generated. EHRs have to be able to electronically send hospital acquired infections for eligible hospitals to JCAHO electronically, and I think that's a perfectly fine objective that we consider on a population or on a hospital basis.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Amy Zimmerman – Rhode Island Department of Health and Human Services

I don't see that related to the patient generated part.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right, so this is where, we had on the last bullet this patient generated, you talked about adverse events, and I still think we're struggling with whether patient – this is something we inherited from a discussion nearly two years ago, this bullet, patient generated ... public health, and we don't have a way to do that yet. And I think it may be time for us to rest this one and move on, as you and George were just saying, vaccine events reporting and HAIs from the EHR to the appropriate recipient.

George Hripcsak – Columbia University

Right, so I would say consider whether you want to put either of those into one of the other public health objectives.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, okay.

George Hripcsak – Columbia University

Yes.

Amy Zimmerman – Rhode Island Department of Health and Human Services

We can create new public health objectives for Stage 3, right?

George Hripcsak – Columbia University

We can. I just don't know that I would create a new one for these two.

Amy Zimmerman – Rhode Island Department of Health and Human Services

For a hospital acquired infection or adverse reactions?

George Hripcsak – Columbia University

Right, because if HAIs are really another registry then why create another registry objective. It's like having a cancer objective.

Amy Zimmerman – Rhode Island Department of Health and Human Services

That's true.

Art Davidson – Denver Public Health – Director of Public Health Informatics

So HAI is only for the hospitals.

George Hripcsak – Columbia University

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And all the hospitals are already reporting the cancer registry, so we're trying to get some things that eligible providers would do as well. The hospitals already have the burden of the public health and population health measures. This HAI would be for hospitals only, but vaccine adverse event reporting could be something that eligible providers could do.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Right, I think the other question, I think what I heard George saying is that has that become part of the immunization, like a sub one, or does that stand on its own? Is it specific to vaccine, it's not medication adverse reactions?

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, and that one also could fit under patient safety.

George Hripcsak – Columbia University

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

And I don't know whether this idea about a CDISC method is something that we should ... to the Standards Committee. How would this report get generated, or is that not our concern?

George Hripcsak – Columbia University

Yes, I don't think we figure out, CDISC I thought was more about research data, not this kind of data, for example.

Art Davidson – Denver Public Health – Director of Public Health Informatics

But it's using that method to create a form that then gets sent to the FDA and the CDC.

George Hripcsak – Columbia University

Right, the Standards Committee is tasked with figuring out what –

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. Okay, well I have some good suggestions from this discussion about getting more concrete and I will work on that and try to circulate that to all of you, hopefully by the end of the week. Is that reasonable?

George Hripcsak – Columbia University

Yes.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Any other comments from the group?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is Charlene. I did like us choosing a domain space to kind of, if you will, get it right with two-way communications, and even, as George said, there's potential for the patients to update that or affirm that, so I think that the direction we're going, not trying to do everything but take a step where we're trying to close the loop, I think makes a lot of sense, rather than trying to do everything, especially in this space, and then starting to set the data up to fill out other spaces as we move forward.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right. Any other comments?

Amy Zimmerman – Rhode Island Department of Health and Human Services

I just want to say thank you for trying to take this stuff and put it into words. It's complicated.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

It is.

Amy Zimmerman – Rhode Island Department of Health and Human Services

And I think we all really appreciate the extra time and energy beyond what we're doing and you're trying to cull it down together, so thank you.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Thanks. Well, I really feel like having someone to bounce these ideas off is helpful also, and your comments back help refine this, and I expect that your comments will indeed help us get it even more refined as we move forward, so thank you.

The last comment that we were talking about, HAI, and I just wondered, Marty, do you have any comments about that? Maybe Marty's off now. Well, it's probably time for us to open the lines, if there are any people listening out there. MacKenzie, can we open it up for public comment?

MacKenzie Robertson – Office of the National Coordinator

Sure. Operator, can you please open the lines for public comment.

Public Comment

Operator

If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time. We do not have any comments at this time.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, thank you. Michelle, when is our next meeting?

Michelle Nelson – Office of the National Coordinator

I believe it's the 13th, so I think we should schedule another call just to have one more conversation.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Between now and the 13th?

Michelle Nelson – Office of the National Coordinator

Either between now and the 13th, but definitely before the August 1st Health IT Policy Committee meeting.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Right.

Michelle Nelson – Office of the National Coordinator

I think if we could between now and the 13th, that might be helpful.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay. And our next Meaningful Use Workgroup committee meeting is?

Michelle Nelson – Office of the National Coordinator

The next workgroup meeting is the 28th, and then there's another one on the 3rd. So it might be good to have some information to the group, I would think, by the 3rd because we'll probably do sub-group 2 on the 28th.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay. So can I depend on everybody to comment liberally by e-mail, or should we set up another meeting? We need to be ready by the 3rd, is what I'm hearing, right?

Michelle Nelson – Office of the National Coordinator

Well, it depends how long it will take to get through sub-group 2.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes.

Michelle Nelson – Office of the National Coordinator

Because we didn't finish 1, so we have to get through 2. We may only get through 1 and 2 by the 3rd. It's hard to tell.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is July 3rd, right?

Michelle Nelson – Office of the National Coordinator

Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

This is Charlene. It's July 3rd. Yes, because we've got to get through sub-group 3 too, but I think sub-group – oh my, I cannot be on quite a bit of the call on the 28th, so maybe a little bit.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Well, we'll take this off line.

George Hripcsak – Columbia University

Yes, let's start on e-mail, I think.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes. I think that's probably where, we just need to get it –

George Hripcsak – Columbia University

We don't really disagree on very much. We all understand where we're trying to go. So I think it may just be wordsmithing the objectives at this point and not a lot of discussion anymore.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Yes, I think you're right, George.

George Hripcsak – Columbia University

And we have one more call, though, too, right?

Michelle Nelson – Office of the National Coordinator

Right.

George Hripcsak – Columbia University

So with that one call that might be enough.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Okay, we'll work by e-mail. We have a call on the 13th, and if there's a need through the e-mail to schedule another call, we'll work toward that.

Michelle Nelson – Office of the National Coordinator

Okay.

George Hripcsak – Columbia University

Thank you very much, Art.

Art Davidson – Denver Public Health – Director of Public Health Informatics

Thank you all.

Amy Zimmerman – Rhode Island Department of Health and Human Services

Thanks.

W

Thanks, Art.

Art Davidson – Denver Public Health – Director of Public Health Informatics
Bye.