

**HIT Policy Committee
Meaningful Use Workgroup
Subgroup #1
Transcript
April 22, 2013**

Presentation

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thank you, good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #1 on Improving Quality. This is a public call and there is time for public comment built into the agenda and the call is also being recorded so please make sure you identify yourself when speaking. I'll now go through the roll call. David Bates?

**David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President,
Quality and Safety**

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, David. Neil Calman? Marty Fattig?

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Marty. David Lansky? Eva Powell? Paul Tang? Charlene Underwood?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I'm here.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Thanks, Charlene. And Michael Zaroukian?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Oh, is Michael on? That's good, well, joining.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Are there any other workgroup members, Meaningful Use Workgroup members on the line?

George Hripcsak, MD, MS, FACMI – Columbia University

Well, this is George, David and I are co-leading it going forward.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

Oh, great, okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, sorry MacKenzie; I owe you an updated list for this.

**MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act
Program Lead**

That's okay; is there anyone else that I've missed Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

I don't think so.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Okay and if there are any other workgroup members on the line?

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Marty Rice.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Oh, great, Marty Rice. And any ONC staff members?

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Thanks, Michelle. Okay, I will turn it back over to you, David and George.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Great, so our plan is to basically go through the comments so far and then go through some of the specific areas about which comments have gone through and I think today we're going to – we'll work on eRx, advance directives, CDS reminders and eMAR. George other comments?

George Hripcsak, MD, MS, FACMI – Columbia University

No, that's it.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Great.

Michelle Consolazio Nelson – Office of the National Coordinator

David, this is Michelle. I do want to say so originally the plan was to wait for the subgroups to not go through the RFC comments until the consolidation call we have this Friday, but because this group has the most number of objectives and we had already cancelled one meeting I thought that we should still go forward. I don't think that any of the ones that we'll go through today will be consolidated but I just kind of wanted to give a head's up that there is that possibility because I did decide to go forward with today's meeting. So, just kind of an FYI.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Okay, I think that's fine. Okay, so let's go ahead and get started, the first one that we'll be talking about then today will be eRx. Can we have the next slide? That's the schedule which we talked about. Okay. So, here's the Stage 2 final rule and the Stage 3 recommendations, and questions, and in terms of the public comments about this we got questions in terms of formulary checking about efficiencies and costs, electronic records noted that generic comparison functionality is available in the marketplace and didn't want this to be implemented for certification in ways that would require those who are already providing it to change the way that they were using it.

They felt that it should be required to – there was a comment that they should be required to utilize the drug formulary to check for multiple items. There was a request for specific guidance on drug formulary choices that is to say do we mean, you know, Medicare formulary checks or Medicaid? There was a comment suggesting that this should be only for new medications, that's one that I definitely agree with. And then concerns about who is accountable for the external list. So, thoughts about that?

Michelle Consolazio Nelson – Office of the National Coordinator

David, this is Michelle, I just want to remind the group, so within the consolidation exercise it was decided that this objective would kind of be broken out, so as it read for Stage 3 it was generate and transmit permissible prescriptions but then there was also the piece about the formulary and it was decided that the transmission part of ePrescribing would become a certification only requirement, but the formulary piece would stay as a use case and most of the comments were related to the formulary piece, which you already went through.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, David, this is Charlene, go back through the comments on the formulary then again, just if you'd highlight those?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Sure.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And if you have any sense of the – or, you know, the degree of those comments in on any of those topic areas, did you get any indication of that?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

It's hard for me to tell, Michelle thoughts about that? I mean, you know, I think that there is actually strong evidence that this kind of suggestion works. We do want to have the rule read in a way that would not make people backtrack.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

I think it should – it's really, only, well, it's – one question is should it only be for new medications. The issue if you do that now that I reflect on it a little bit is that, you know, for renewals sometimes the formulary has changed and it would be nice to know about those too. We actually do it I think for both, for both new prescriptions and for renewals.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, that kind of makes sense.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, yeah. So other thoughts or comments? Charlene how are you doing it now?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Again – most and I'd have to check with the other vendors, see most of our support is in the inpatient setting so it's directly with the inpatient formulary so that's a whole different ballgame than ...

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right, right.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

PBM, you know, the outpatient formulary.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

This is Marty Rice; question renewals mean the same thing as refills?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Okay, thank you.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, would this be a certification – would this be just certification or would this be both for meaningful use too?

Michelle Consolazio Nelson – Office of the National Coordinator

So, this is Michelle, just kind of reading over the objective that’s something I think we need to think about because we had said from the consolidation piece that we should keep the formulary piece of the use case.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

But, I’m not sure how you would do that as an objective, you know, what are we measuring?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right, I personally think it might be better to not keep it as a use case and to handle it in certification.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, because then the variation that you get you might be able to – at least you’ve got the infrastructure there.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

George what do you think?

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, I’m sitting here trying to figure out – so first of all I agree with your other comment although you liked new at first you realized that in fact every time you change your insurance which happens more and more often you really do need to check for the patient’s sake.

So, I think the key thing is the EP doing something or is it just happening in the back end and you just want to make sure the system is doing what it’s supposed to do so by making it certification only we know the EHR is capable we don’t know if it’s turned on to do it, but if it is turned on I don’t know what we’re measuring.

But usually the physician or the EP shouldn't be doing anything, you know yes and alert will pop and say "please check this" and then you would – we could count that at least 10 percent – like I don't even know what I'd be counting, it could be an odd thing to count. Like what if you're good at prescribing the right medication for the right – you don't want to be penalizing people who get it right without the alert.

So, I think, it's a hard thing to measure. So, I guess I am leaning towards certification only and not only new. Like the system should be capable, but I guess maybe that comes with it, but it's not just new medications that the system should be capable of checking.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right, that's what I think. Do others agree with that? Marty Fattig are you on?

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Yes I am. I've been contemplating, sitting here thinking about should this be different for eligible hospitals and eligible providers.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

I think that the issues really are different for hospitals and providers.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Yeah, I believe they are as well.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, but I think we've handled it.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

I think the certification piece will handle it.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah I think so too. Okay, so it seems like we have consensus around this, people comfortable with that?

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

I am.

George Hripcsak, MD, MS, FACMI – Columbia University

Yes, so formulary applies to both EP and EH? Does it?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay, just checking.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah. So, should we move to advance directives, which is 112? Let's see what the next slide is.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, there are a bunch of slides on ePrescribing that was only the first slide.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Okay, well let's keep going. So, we've done.

George Hripcsak, MD, MS, FACMI – Columbia University

We've done that one.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

We dealt with the formulary one, okay next slide. Next slide. Okay, next slide. Okay, next slide. Okay and next slide. Okay so let’s I’m just moving forward here.

Michelle Consolazio Nelson – Office of the National Coordinator

So, this is Michelle, I just want to – as we get to advance directives.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah?

Michelle Consolazio Nelson – Office of the National Coordinator

In the past we have talked about having a listening session and then other things have taken priority, I believe, and MacKenzie correct me if I’m wrong, that at the last Standards Committee meeting the Consumer e-Health Team decided to take this up and are going to possibly have a listening session, but I could have heard wrong. I don’t know MacKenzie if you know if I’m making things up.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

I’ll look in the notes now and see if I can pull it out.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay, because that may, you know, have an effect on recommendations, but just kind of an FYI and I know it’s something that this group has wanted to do for some time.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, so if they have it can we listen?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes, yes, we’ll make sure we arrange that.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

So, this is MacKenzie, yeah based on the Standards Committee work plan that they discussed at the last in person meeting the Consumer Technology Workgroup on the Standards Committee volunteered to take this on related to the standards to record advance directives.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Great. Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

And Leslie Kelly Hall leads that group and she is a member of the Meaningful Use Workgroup as well.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

So, the Stage 2 and Stage 3 are, you know, do not really differ substantially here. Go to the next slide. So, people overall were really supportive of this objective. There were a few suggested revisions to the measure percentage. There were some comments about whether it should be core or menu, some said raise, some said lower. I think 50 percent we probably got it about right and people supported core for hospitals, I think that really makes a lot of sense, but menu for EPs that, since it would be new, and that I personally think is also reasonable. But what do people think about that?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University NYC

Yes.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Yeah, this is Marty; I think it's reasonable as well hospitals have been doing this for some time anyway.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right. Right, there were a couple of comments about age, some people thought that the age threshold should be raised, other people thought it should be lowered including AARP, you know, 65 is a pretty standard age figure in our society so I think it's a reasonable choice. People did point out that it wouldn't be applicable to many specialists, that's true, but I think we still, you know, want to include it.

Let's see there were some comments about specifics around, you know, how would you include it? Would you include a scanned copy? Would there be structured data? There were concerns about the standards which we presumably will get more input on from the Standards Committee. And there was a suggestion about allowing patients to submit them directly, which I think would be great, but that's also something that could be addressed by the group that was just mentioned.

Let's see, and there was a legal point that this could create dangerous partial information because you couldn't know that a patient has an advance directive without knowing what it's content is and somebody else suggested that we could inventory state laws and devise an objective that reflects the diversity of laws. None of these last ones, from my perspective, really merit changing what we have. So, what are other people's perspectives about these issues?

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

So, this is Marty – what we're currently doing is we have a check mark box "yes or no" and then we scan in the document. The question always is do we have the most recent.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Exactly.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

The current document and that's a question we have to ask all the time anyway, so I don't know how you do that any other way.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right, I agree, I mean eventually we want to move towards having some things in coded form, it doesn't have to be everything in coded form and you still want the document, but you'd like to know.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Yeah, is there a DNR?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Exactly.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Those types of things have to be right up front, yeah.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah. But, I think that the way that we've handled it here is a good way and that over time I would introduce, you know, more coding around some issues like that.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, this is George, you know, it's a hard problem so no matter how much we try to do we'll never solve the problems that are represented even on these slides. Like we'll upload it but do we have the right one and when was the last update and it would become all of meaningful use eventually just to get this exactly right and it will never be there because it will have to be state specific. So, I think I agree with you that we came to this solution in the first place because of that recognition and that's why I kind of like staying where we are number one.

And then number two on age, I understand the motivation but I think, you know, reaching out to people 18 and older is really outside the scope, because it's a, you know, societal change it's not a meaningful use scope I don't think. I think 65 was because we figured that was where the population – where we had enough people that we could do a threshold.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah. Others, any thoughts, Charlene or George, or Marty Rice?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I mean most of – I think as long as you're not encoding it until we get this other stuff sorted out, you know, we just want to store an image of it, I think most people kind of do that today.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

That was George before by the way.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, right I realized that after I said that, sorry.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And I think we took care of this as we described it, if that is a, you know, like for the practice as well as for the hospital if they're in a setting where it is shared that should be attributable, but I think the way we described it that was fine. I don't think we precluded that they had to store two or anything like that, so, you know, we just didn't want to, you know, if they're sharing one that would even be better at some point, right? So, I think that was how it was described in the original requirement.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yes. Okay. Are we ready to declare victory on this and move to the next one? I think we've had a good discussion. Can you go to the next slide to see if there are any other issues? Next slide. Next slide. Next slide. Next slide. Okay, so now we're up to clinical decision support, next slide.

Okay and so, you know, at the high level about the same number of people expressed being in favor of an opposition to increasing the total end to 15 interventions. Some of the concerns included alert fatigue, lack of CDS interventions relevant to the specialty practice, clarification about whether the 15 interventions are going to be at the practice level or the provider level.

And then some of the comments about the CQMs and focus areas were varied, some opposed them and said it was too burdensome that there weren't enough relevant clinical quality measures, a few contended that the links and focus areas were too arbitrary, some suggested that ONC just focus on outcomes and let providers pick what decision support should improve.

CQMs there was significant opposition to the drug-drug interaction requirement because of alert fatigue although I guess what I would comment is that this can be done in ways that do not induce alert fatigue. And, you know, for these 15 they hardly ever come up so that suggests that people just didn't understand that point.

And let's see there were concerns about lack of standards for structured SIGs, a few commenters were in favor of tracking provider response to CDS, that actually I'm strongly opposed to that one. We've just done a look at the current systems and many systems do not allow you to do that and if you don't do that then you can't make the systems better. So, this is one of our few opportunities to actually get that into place.

George Hripcsak, MD, MS, FACMI – Columbia University

Why was that – that’s an odd one, I wonder why, this is George, what they were exactly objecting to, was that vendors saying it’s too hard to do or was it people thinking that we were asking providers to do something, we weren’t asking providers to do anything.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right. I mean, I – Michelle do you know who? Do you have a sense around that?

Michelle Consolazio Nelson – Office of the National Coordinator

I can go back and look right now.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

But my thought is more that I think that seems like something that people think of as like big brother watching over them, but let me go see.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, I mean, it’s exceptionally important to do it, I can’t, you can’t make things better if you don’t do that and people are complaining a lot about getting too much decision support that doesn’t – and if you don’t have that you can’t turn off the decision support that is not helpful. And what we find in fact is that lots of systems include lots of decision support that is not helpful, so there is a huge need for this.

Okay, others were the clarification was requested around preference sensitive conditions. In addition there is a criterion for ability to consume CDS interventions was generally met with support and then there were just a couple of comments about drug-food interactions.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, David, this is Charlene.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

On the one relative to – and I was just re-reading it, the triggers in terms of for how the provider responded, the challenge as a vendor, when there are so many potential actions that you could potentially take when you chose not to do something, so there is kind of an implicit potential requirement that, you know, there is a lot – you’ve got to give providers the whole set of things to do if, you know, if it’s, you know, if they chose not to do it or something like that.

So, maybe there is a way we can write it such that we can at least track it and maybe not add that on-line requirement. So, I know when we’ve tried to do it, it just brings up a whole myriad of “well, what do you do in this case, this case, this case” that kind of thing that makes it a bit challenging.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Can you just restate that, because I’m not completely sure I followed, I mean.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay, so the way it reads was the ability, CDS, I think the one you’re talking about, triggers, let’s see, it will track the triggers and how the provider responded to improve the effectiveness.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Is that simply it?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety
Yes.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
And then the feedback to that was?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety
Some people just didn’t want to do it because they felt like it was big brother-ish.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Okay.

Michelle Consolazio Nelson – Office of the National Coordinator
So, I was just looking up the – it was the vendors that made those comments.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety
Right, I mean, it’s very, very important to include this from my perspective. You just need to set flags and then track how often things go off and whether or not people paid attention to them.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
And what was the feedback that they gave Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator
So, Charlene Siemens was one of the ones.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Yeah, I’m sure.

Michelle Consolazio Nelson – Office of the National Coordinator
So, let me ...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
I’m just, I could be reading more into it is all I’m thinking.

Michelle Consolazio Nelson – Office of the National Coordinator
I mean, it just says do not support the criteria on tracking triggers responses sent to repositories or preference sensitive conditions. I can read through – I haven’t gotten the full copy, but ...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Right, right.

Michelle Consolazio Nelson – Office of the National Coordinator
Here we go, while CDS triggers and provider response tracking maybe relevant during research stages of an implementation project ongoing tracking and provider responses is not necessarily relevant particularly when demonstrating progress toward key outcomes it promotes very specific behaviors rather than enabling innovative flexible implementations that do not require continuous monitoring of specific granular process step adherence. Objectives for CDS focused on providers should be addressed separately from those focused on patients to avoid establishing certification criteria that cannot be modularized. So, that was one of the comments.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Okay.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, I mean, I would strongly disagree with that. We found for example even in our own system that for example the proportion of allergy warnings that people paid attention to fell over time from about 60 percent. At the beginning they were paying attention to 40 percent and then overriding 60 percent of the time and it went up to 85 percent overrides mostly because we added a few unimportant allergy warnings and we didn’t really realize what the cumulative impact of that was.

It’s not a research thing, it really is important to keep track of these things in an ongoing way and someone central within organizations should be looking at figures like that to make sure that providers are not getting bombarded with unnecessary warnings.

George Hripcsak, MD, MS, FACMI – Columbia University

And then, this is George, the objective says ability to track.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Right.

George Hripcsak, MD, MS, FACMI – Columbia University

So, it doesn’t even say EPs or the EH administration has to track it’s just saying the CDS is a certification criterion so it’s just, it’s an ability – maybe they think it’s doing more than it is, you just want to know.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, that’s all I was thinking.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

I think it’s fairly straight forward. Now, Michelle, in your spreadsheet a few commenters were in favor of tracking, do you mean actually there weren’t many responses and that a few were negative or that a lot were against it?

Michelle Consolazio Nelson – Office of the National Coordinator

So, I wasn’t the one that summarized this but my assumption is that the comments that we did receive were in the negative.

George Hripcsak, MD, MS, FACMI – Columbia University

But there were only a few of them and that’s what you were just looking at?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay, so it’s not like overwhelming response against it or anything?

Michelle Consolazio Nelson – Office of the National Coordinator

Exactly.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, is it all CDSs, is it some CDSs? How do you – is it just ...?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I mean, I think it’s a best practice actually for all CDSs. You should know when the warnings are going off and then whether people are paying attention to them that’s the basic point.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

This is Marty Rice, I think it’s probably a critical piece of understanding how the system is being used and look at it this way.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

I can understand where somebody might be concerned that they were tracking too much information.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

But if you really want to understand how the system is being used and make corrections to how it can be used better, it’s probably better to understand than not.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes. Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

David, do you think that we need to clarify the language at all or do you think it’s fine the way as written?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I think, as George suggested, I think it’s pretty clear as written.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, I ...

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Charlene do you disagree?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

The only ambiguity might be – I don’t know if you could clarify how, you know, it’s like, you know, what you’re trying to do is keep this really simple, right?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, exactly.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And I don't want – and it's like I agree with you if we could keep it simple, you know, but if how implied what action they took or, you know, they might expand on that, that's all. I know you're just trying to track, you know, if they, you know, overrode it or not and maybe not why even, you know, for purposes of even just getting started.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Well, you do want to know why. I mean, if you're going to track whether they overrode it you should...and they give a reason you should find out – you should track the reason.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

So, is this going to be ...

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

And maybe ...

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

I'm sorry.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Go ahead.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Is this going to be – go ahead.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Well, maybe can you just say that and the reasons for – I mean, maybe it's just – maybe you just say it a little bit more specifically?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Sure, so why don't we be more specific.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And just, because I mean you're trying to track the reason that seems like fair, right?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

So, are you going to attribute these, each reason back to the provider or as a group? Will it be cumulative?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

You need the data by provider.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

So that might be the objection, maybe liability issues?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

You know, but, you know, there is no case in the U.S. of somebody being sued around this.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

I don't disagree with you I think it needs to be tracked, but that might be.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah. So, let’s be more specific with the language and go with that. I mean, this is a really important point in terms of making the systems work better.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

The ability to track and the reason for overriding, because I think most people have to put it in, overriding the trigger, right?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Exactly, exactly.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Period.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Not what they did instead or, I mean, you could get really sophisticated here, but that’s what will make everyone crazy.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right, well, we want to avoid that. Okay and what about the drug-drug interaction? The drug-drug interaction comments?

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, I agree with your, this is George, earlier comment, I think that our whole approach was to reduce alert fatigue by doing drug-drug interactions right. I think, what they’re thinking of and the comment is if you get a standard package, an old fashioned standard package, you’re going to be overwhelmed and what we need is the new drug-drug that’s been slimmed down.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

And that’s what we’re talking about so maybe that’s what’s the ambiguity we need to face. Advance medication related decision support – I’m trying to find what we said about it.

Michelle Consolazio Nelson – Office of the National Coordinator

It’s number two George, so the EP eligible hospitals or CAH has enabled the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, well, I can see why they’d be worried by that.

Michelle Consolazio Nelson – Office of the National Coordinator

It’s the same as in Stage 2.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, I think it’s, you know, I think it’s fine.

George Hripcsak, MD, MS, FACMI – Columbia University

But we had done all the work figuring out how we were going to get the drug-drug interactions reduced to a feasible level.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

And so what’s – I can’t now remember the outcome, I mean, I know that we have to shut off our drug-drug interaction that comes from the vendor and then we do our own.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

That’s good.

George Hripcsak, MD, MS, FACMI – Columbia University

So, that’s maybe what they’re worried about. So, what is the status there? Did we come up with a plan, a recommendation in Stage 2 about that Michelle?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Not in Stage 2 I don’t think. I think we made a recommendation in Stage 3 that systems to be checked, as I recall, that all 15 of the ones that are really high risk would be included. I think that’s in certification though, is that – I’m trying to find the reference to that.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, I can’t – is it in certification?

George Hripcsak, MD, MS, FACMI – Columbia University

Well, we did the – Michelle what happened? We did the ... didn’t we do a subcontract to someone like RAND to figure this out?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes, yes.

George Hripcsak, MD, MS, FACMI – Columbia University

What happened with that?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Well, so.

Michelle Consolazio Nelson – Office of the National Coordinator

I think this was before my time, sorry, I don’t know.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

No, we carried it out, my group carried it out.

George Hripcsak, MD, MS, FACMI – Columbia University

Oh, very good.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

There you go.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

And we produced a list of 15 drug-drug interactions that should be included ...

George Hripcsak, MD, MS, FACMI – Columbia University

Oh that’s the 15?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

... in every system, now let me keep going, that should be included in every system and should be turned on. We said that, you know, that systems should be checked to see if those are included and then we also published a list of ones that are often turned on that should not be turned on. So, you know, both those lists are publically available.

George Hripcsak, MD, MS, FACMI – Columbia University

So, maybe we need to refer to that. So, those 15 are different – there are two different 15’s here.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And ...

George Hripcsak, MD, MS, FACMI – Columbia University

One is 15 interventions and the other is 15 drug-drug interactions, right?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Correct.

George Hripcsak, MD, MS, FACMI – Columbia University

That’s just coincidence. All right, so maybe we need to refer to your 15 so they understand we’re not talking about turning on a million drug-drug interactions with lots of false positives.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I think it would be good to do that.

Michelle Consolazio Nelson – Office of the National Coordinator

David, can you give me a hint of how to find it so I can link to it?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Sure, the first author is Phansalkar P-H-A-N-S-A-L-K-A-R and first initial is “S” and it was published in the *Journal of the American Medical Association* just last year.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes. Okay, so and other thoughts about decision support? You know, around 15 and 5 or more clinical quality measures, I feel like we’ve probably got the number about right and I felt like the domains that we covered were reasonable, I understand that people could quibble with them, but I think this is a reasonable set.

Michelle Consolazio Nelson – Office of the National Coordinator

David, one thing that this group was asked to look at is when we did the consolidation work one of the population and public health items got moved here because it was asking for decision support for immunizations and that was kind of already included here, because you have preventative care including immunizations.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

So, the question was is that something that you want to make required because it got moved here or is it still an option?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I would think we would want to make that required. What do others think?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University NYC

Michelle could you ask again?

Michelle Consolazio Nelson – Office of the National Coordinator

Sure, so in Art’s group they had initially put forth a recommendation for there to be basically CDS related to immunizations and during the consolidation work we decided that that really belonged here within the CDS objective itself especially because as part of the 15 interventions one of them was called out as preventative care and we had even put in parenthesis including immunizations. So, the question was though should that piece be one of the requirements? So, should we make them have to do that or should it still be an option of the 15?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, because in this we say...because you can hear the argument like by different groups in each of the following areas. Can we just say maybe more than one or something, generalize it just a little bit, because you can hear them argue for instance like even for four, you know, the drug-drug and drug-allergy interaction, you know, or advanced medication related decision support may not be relevant to certain specialties, right, or you can hear some arguments or prevention may not be relevant to certain specialties. So, can we generalize that a little?

I mean, even if we got them to do two, appropriateness and chronic disease management that might be great. Because 15 in each of the following areas, can we just say more than 1 of the following areas?

Michelle Consolazio Nelson – Office of the National Coordinator

Well, it says should include one or more interventions in each of them. So, you just want a clarification on that language, Charlene, sorry?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I was suggesting because I think we’re going to get pushback on that maybe we just suggest that they do more than one of them, they do two of them or ...?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes and two or more or something?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, yeah, because, I mean, even if we get them to do two they’re, you know, they’re pretty powerful. They have to think through that. They could choose prevention and that would be great prevention and utilization, right? You know, it’s like ...

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, I actually like that. What do others think?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And then you can leave immunizations because that’s fine, you know.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

This is Marty I think that makes sense.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay, so, Michelle do you see what ...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Or more.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

... we’re suggesting?

Michelle Consolazio Nelson – Office of the National Coordinator

No, actually, I have to say I’m not following.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So this ...

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

So in the measure line it says the 15 CDS interventions should include one or more interventions in each of the following areas instead of the way it reads now we’re suggesting one or more interventions in two or more of the following areas.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

As applicable to the specialty.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And then it will, then you don’t have to have exclusions and all that, you know, because you can probably do – I mean, you still have to do some exclusions but it will be less.

George Hripcsak, MD, MS, FACMI – Columbia University

David, could you say the new version again?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Sure the 15 CDS interventions should include one or more interventions in two or more of the following areas as applicable to the EPs specialty.

George Hripcsak, MD, MS, FACMI – Columbia University

So, it’s two or more of these four?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay. I’m okay with that we probably did mean each and we probably were being strict, I’m not sure if we’re being overly strict.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Well, you could certainly, I mean, we do have this clause as applicable to the EPs specialty and some EPs might not do preventative care. I think that there were some – I think it makes sense to be a little bit more lenient.

George Hripcsak, MD, MS, FACMI – Columbia University

I’m okay with two or more, I’m okay with two or more.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay. This deals with the, you know, with the biggest criticism I think. Okay, any other changes that people would like to make around the CDS part of things based on the comments.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

The only...this one, this is on the certification piece, the ability for the EHRs to consume from central repositories do they think that will be ready by then?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I personally don’t think it will be.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, I’m concerned with number 5 of the certification requirements.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, we seem to hear two different things. So, from the Standards Committee they said it won’t be ready, but we also heard a report about the work that’s being done from the Health eDecision side that it would be ready. So, I don’t know if we want to defer to the Standards Committee on that or what you all think?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah and you don’t actually have to do it your record just has to be ready to do it, right? So, this is a push to the vendors.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, I know. I mean, it’s not that this should not be a future direction but this almost feels like a Stage 4 this number 5. Again, I think we should just flag that one as, you know, as potential. I think the bar might be too high for that. Again, we’ve got to wait until we get feedback and see how Stage 2 rolls out but I would flag number 5. Because what we would like to do is like get a prototype, you know, test it and that kind of thing.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

And let’s see there was a – the Standards Committee suggested changing the ability for electronic records to consume CDS rules as structured data using xxx standard with the standard TBD.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I mean, I’m okay with that I suppose. What do others think? I think that’s what was intended.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah and the concern would be the TBD.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right, well, I don’t like, I never like to have something that has a TBD in there.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right, right. I think we just have to mark this one yellow or something, a caution or something, this one is a caution.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

We need more feedback on this one in terms of its liability and the timeframe.

George Hripcsak, MD, MS, FACMI – Columbia University

So, what did we do in public health, this is George, we had a similar rule, right? To consume ...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And we were again ...

George Hripcsak, MD, MS, FACMI – Columbia University

I think we put it off to Stage 4 or something.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right and the issue again is around the readiness of the immunization registries to be able to provide that history back to EHRs. So today it’s ...

George Hripcsak, MD, MS, FACMI – Columbia University

No, no, actually Charlene it was the one where we were going to consume reportable diagnoses.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay.

George Hripcsak, MD, MS, FACMI – Columbia University

... criteria queries, right? And that’s what we put off a little bit.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, okay.

George Hripcsak, MD, MS, FACMI – Columbia University

It was just like this. So, that one was put forward to Stage 4 or later or stage undetermined I forget.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay, any other thoughts about clinical decision support? All right so let’s move onto reminders. Can we have the next slide? The next slide. The next slide. Next slide. Okay, so here’s the reminders section and there was general agreement about the proposed changes but they asked for specificity on what we meant by clinically relevant. There was a general agreement that it was okay to increase the threshold. There was a disagreement with the decrease in office visits from two visits to one in a 24-month period. There was more specificity that was requested around reminder and patient preference terms.

And, you know, more specifically commenters wanted specificity on what would be clinically relevant, they provided some suggestions. They asked whether this would remain menu or core. A number of people suggested making the threshold higher than 20 percent. Some people asked if it would meet Meaningful Use if reminders are sent from non-CEHRT systems and commenters asked what about if the patient opts out from reminders and most commenters suggested keeping the two visits requirement.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes. So, David, since we just did clinical decision support?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

What do you think overlaps in clinical decision – this is a form of clinical decision support in some ways, right?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

It is, it’s sort of a special subset and, you know, the intent is to enable systems to become a little more proactive especially for patients who don’t come in that regularly.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Because you can certainly see when they’re trying to look at those four conditions under CES them thinking this through, right? We need to send reminders out so that they, you know – they’re at risk for, you know, they’ve got to come in for some sort follow-up treatment and that kind of stuff, right? So, it seems like we should relate it back to those conditions that we’re monitoring in CDS at least, right, if they want to know the kind of reminders?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Well, not necessarily, I mean, this is intended to be sort of more outward looking, in other words to be looking at the overall, you know, population some of whom probably don’t have chronic conditions.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay, okay.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I mean, this is really, you know, mostly about you’re due for your mammogram or you’re due for a pap smear that kind of thing. So, what are other people’s reactions? George, any thoughts about this?

George Hripcsak, MD, MS, FACMI – Columbia University

I’m right here.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I was trying to, this is Charlene, trying to sort out how to specify clinically relevant, you know?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I mean, I like the term “clinically relevant,” you know, it basically leaves it to them which is I think what we want to do, right?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

This is Marty, I think this is pretty important and I mean, I think it's kind of tragic that I get better reminders from my vet than I do from my physician.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Exactly.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

You know, and the same type of things could come out regardless male/female your age whether you have a chronic disease or not there's still certain things that you need to be reminded of at least I do.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

I mean, it's really clinically relevant.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

How about maybe can you put patient information or something, you know, just qualify it a little bit more, because it's ...

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, along, this is George, along the same lines it's something to do with separating patients by their disease or clinical history, or something other than their age and demographics. So use of data beyond demographics is kind of clinically relevant or something that is specific to their disease or risk of disease.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

How about using – you used information including demographics but going beyond them such as family history to identify patients who should receive reminders of preventative, etcetera.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah or the patient's clinical history can you be general using the patient's clinical history.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

The clinical and family history?

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes ...

George Hripcsak, MD, MS, FACMI – Columbia University

It could be social too, you know.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Sure.

George Hripcsak, MD, MS, FACMI – Columbia University

Clinical, family, social something other than just demographics.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

How about clinical, family and social? I like that.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Yes and/or.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety
Right.

George Hripcsak, MD, MS, FACMI – Columbia University
Well, you could just say “or” I hate and/or.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Yeah, okay, all right.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety
Okay and what do people think about the threshold? I kind of like using a low number until we find out what the right number is, because, you know, if you’ve already had all the things done you don’t really need a reminder, although probably most of us have not had everything done.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Yeah I like the lower threshold unless, I mean, if we find out that they’re getting 80 percent, you know, from Stage 2 then maybe we change it, but ...

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO
I think this is one of those things that they’re either going to do or not do and I think the threshold probably is going to be irrelevant for those that are doing it anyway.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Yeah, they’ll do it appropriately.

George Hripcsak, MD, MS, FACMI – Columbia University
Yes.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety
Okay. And would it meet meaningful use to send reminders from non-EHR systems? I think it would.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Yeah as long as they’re certified, right?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety
Right. What does CEHRT mean?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Certified Electronic Health Technology.

Michelle Consolazio Nelson – Office of the National Coordinator
Health Record Technology, yes.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety
I mean, I think it would if the reminders are sent from some other system, right? The key thing is whether the reminder was sent.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs
Right.

George Hripcsak, MD, MS, FACMI – Columbia University
Do they have to be using EHR safe data to make the decision of who to send it to?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I think so, right?

George Hripcsak, MD, MS, FACMI – Columbia University

I think, there has to be some link probably otherwise it’s not meaningful use.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

So, it could be sent from an outside technology but it’s based on the clinical, social, family history that’s recorded in the EHR?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Or they can export it and look at it, I mean, there’s a lot of options just so – I think you’ve got it right though in terms of the data you’re looking at you’re just not implying where it’s going to be not that they should export it, but ...

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right and what do people think about the patient opting out? My own view is that this happens infrequently enough that I just – I don’t think it’s that important to address it.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

This is Marty Rice it’s probably – everybody should have the option of opting out especially when it comes to social history.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Sure.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

So, I’m not – we work with federal qualified health centers and there is a lot of information within there that might not want to be passed forward. That’s just my two cents.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right. How would – can you come up with a sentence that would say what you were thinking of?

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Not off the top of my head, but I would imagine it would be things associated with family violence, HIV AIDS.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right and I think patients should be – a sentence something like “patients should be allowed to opt out from providing certain sensitive information” or something like that.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

But isn’t that required anyway? I mean.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I thought it was.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

That’s required anyway.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay, so maybe we don’t even need to.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, I think there are all sorts of controls around that I thought or it seems there are.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

And what do people think then about the two visits requirement? I like the way that we’ve re-phrased it, again, it gets at more people rather than just the people who are showing up at the provider’s office.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

The reason I think the vendors kind of are – they needed a mechanism – the reason for the two visits was it was ensure that the person was in a practice and it made sure that, you know, it was, you know, there were actually cared for in that practice, so in a case maybe where it was a specialist, you know, and they only showed up for one appointment then, you know, they wouldn’t be in the denominator that kind of thing was the thought process probably.

George Hripcsak, MD, MS, FACMI – Columbia University

Do you remember, did we consciously, Michelle, go from, this is George, from 2 to 1?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I think we did and I think the intent was to get more people because the recommendation is that, you know, that people don’t need to come in to see the provider even for primary care more often than every several years.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah and we have the exclusion for specialists that see them only once, right?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And are there for a procedure or whatever.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I mean, I think we have a requirement elsewhere who the primary care provider is be included somewhere. I don’t know if we capture for example what the provider’s relationship with the patient is anywhere. I don’t think we do.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

But, I mean, it could be a cardiologist managing, you know, other areas, you know, heart disease, so it could be – the specialists sometimes see them repeatedly too.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Sure, the issue I think is for the ones – we don’t want to be barraging patients with suggestions when, you know, when it’s not relevant and so the issue is just sort of how to manage that most effectively. We did say that specialists can be excluded for prevention reminders.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, like even a dermatologist if you go back for that annual check, right, they would send you one.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, that’s once a year.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Well or it could be more, but, you know. So, how do we, you know, it’s pertinent, right, that’s what we’re trying to get where you go to someone else and you just are going there to, you know, get a consult on, you know, you’re seeing them once only, but you’ve got both scenarios.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes. Okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, I think you should leave it as is and they may be excluded because there are some cases where they could see them only once a year, right?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

That’s what I would favor too. Okay, are we done with this one? I think we’ve covered the key issues.

George Hripcsak, MD, MS, FACMI – Columbia University

Yes.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay, let’s move to 117 which is the eMAR. Okay, so here commenters agreed with increasing the threshold, they did want us to evaluate experience of Meaningful Use 2 before increasing it and they thought that we could go with a higher threshold than 30 percent. There was also the comment around mismatches that some people are already tracking mismatches but outside of eMAR, I think we should be specific that we think that’s okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

That’s okay.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah and then they ask for...there were questions about the specificity of the terms around mismatch and unintended dosing versus tracked, that comment is slightly unclear to me, but I do feel like – and we did supply the definition of a mismatch, in other words a situation in which a provider dispenses a medication and/or dose that was not intended.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I mean, these are the five rights, right? Patient rights, right drug.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Exactly.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, it's like this is pretty – I don't know, it's just like mismatches, you know, missing one of the five rights and you could say even documentation but at least it's the five rights, right?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I mean, that's pretty clear. And I'm okay, this is Charlene, I think we should – I'm okay with going higher, I mean, by then you would hope, I mean, that functionality is pretty standard and out there today.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, I'm okay with going higher too. This is again, probably something that you're either doing or not doing.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, I mean, it's more the roll out process, it takes a little while to roll it out but generally once the ROI is so much there so fast that people just, you know, put that infrastructure in place once they start to implement that project.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, before we argued that's why we should stay at 30 not why we should go to 80.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Because they were going to do 80 anyway?

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, usually that's what we argue. I mean, we can just be – I think the answer here is we should be consistent, whatever we did in past situations what would have been the right threshold here and then use that and we're all agreeing that it probably doesn't matter that much, the numbers, so we should just try to be consistent.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right, I mean, it turns out that for some fraction of the time it's hard to track things in eMAR and in most institutions that's around 10 percent, so, you know, I wouldn't want to get too close to 90, but I think we could go as high as something like 70 without causing anybody any ...

George Hripcsak, MD, MS, FACMI – Columbia University

Well, but Michelle, what do we normally do when we're at this stage in another objective?

Michelle Consolazio Nelson – Office of the National Coordinator

So, I think what we had done for most of them was 50 percent or 80 percent for something like demographics for example where, you know, you're assuming that if they're doing it they're going to continue to do it. We haven't really used 70 percent for anyone.

George Hripcsak, MD, MS, FACMI – Columbia University

So, I mean, if you want to go up I would go to 50 not 80.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Okay 50 should be fine I think.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Fine.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay. Other and I – we’ll clearly get the Meaningful Use 2 experience. So other thoughts or comments about this one? Okay, so I think this is what we were asked to go through today. Michelle is that accurate?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, I wasn’t sure what we would have time for. In the Word document that was sent out there are more objectives if you want to use the time or if you think that it’s better to just go with the plan and we’ll follow-up on the next call.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, what would people rather do?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Well, if you’re ready I think we should keep going at least until 11:00.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

If you’re ready.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, I’m ready, I actually have a page that I need to answer, George could you start us off on imaging and I’ll be right back?

George Hripcsak, MD, MS, FACMI – Columbia University

Okay. Okay, let’s see so I’m on page 7 of the Word document.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay.

George Hripcsak, MD, MS, FACMI – Columbia University

There are no more slides, right?

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah. So with the Word document we have our imaging objective which, I only read ahead, I worked, I did my homework last night but only for the first five of them.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Well, I mean if you want to wait, you know, but ...

George Hripcsak, MD, MS, FACMI – Columbia University

It’s a good use of time and imaging may not be that hard so let’s do it.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Okay.

George Hripcsak, MD, MS, FACMI – Columbia University

I’m trying to remember what was the change from Stage 2 to Stage 3 first.

Michelle Consolazio Nelson – Office of the National Coordinator

It just went from menu to core I believe.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay, because I'm not seeing much in the way of changes.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

And the summary said the commenters do not agree with changing this objective in measure to core, okay, so they don't think it's ready for core.

Michelle Consolazio Nelson – Office of the National Coordinator

Well, we haven't learned from Stage 2 which is what we heard for a lot of the objectives.

George Hripcsak, MD, MS, FACMI – Columbia University

They say having the report should be core that's fine, image should be menu, Stage 2 adoption, data should be reviewed in determining feasibility for core in Stage 3, especially difficult for EPs who are still adopting certified EHR technology, lack of clarity over the term accessible in certified EHR technology, I think that one is solvable.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

The exclusion criteria needed is moving from menu to core, okay. And then what barriers could be encountered in moving this item from menu to core, summary states the numerous barriers are described and summarized, cost of interfaces and availability are still a barrier, type of images have been expanded beyond PACs which widens the scope of the objective. Evaluation is needed if networking transmission and storage impact of large image files, lack of control over getting images from various image systems, lack of high resolution displays may compromise adequate result viewing and clarity over the term accessible.

And then we have I guess the Standards Committee comment and let me just read that quickly...I'm having trouble actually deciphering this. So, reframe ...

Michelle Consolazio Nelson – Office of the National Coordinator

So.

George Hripcsak, MD, MS, FACMI – Columbia University

... reframe this as sharing images as opposed to receiving images is that the point?

Michelle Consolazio Nelson – Office of the National Coordinator

I think a lot of – so there was a question also asked as part of one of the patient and family engagement ones to include images and I think the biggest clarification people want is it just a link or do you have to include the actual image, because if you include the image then, you know, it takes up a lot of capacity and that's a little bit harder, but if it's just a link to the image then it's not as difficult which is what I believe the Standards Committee is saying as well.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, we said from the beginning it could be from inside or outside the system either one so that implies it could be a link, so we're in agreement there, what were the – didn't we use words that implies that?

Michelle Consolazio Nelson – Office of the National Coordinator

I think, we might need to clarify the language a bit.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

So that they understand that and that will help.

George Hripcsak, MD, MS, FACMI – Columbia University

That's what accessible – that was the whole – I get it now.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

That's accessible through.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Well, I mean as long as you are able to – said view an image either directly or via a link, I mean do we have to say it that clearly, that we tried, I think.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, I don't think we should say link because then that's ambiguous because who knows what link means, but either...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Or on a separate system or ...

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, yeah. So, it's either viewed within the EHR which is okay, we don't want to exclude that or viewed...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

On an imaging storing system or something.

George Hripcsak, MD, MS, FACMI – Columbia University

Well on a separate system that image is stored on but accessed through the EHR something like that and then menu versus core.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, George, can we clarify that? I just want to make sure I write it the way that you all want. Where do you think the clarification should be? Do, you think it should just be like an e.g., and give some examples?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah that would be fine.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

... accessible.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, you could do that.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

View it directly.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, for example view directly in the EHR or viewed in a separate system which is reached by – which is reached via the EHR, in other words I don't want them to just say I have a PAC system 40 blocks away and I'm set.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

So.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Look at it right?

Michelle Consolazio Nelson – Office of the National Coordinator

I'm sorry, Charlene, you broke up can you just repeat that?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, like I've got two terminals sitting side-by-side, I've got my EHR and then I can go over to my terminal right next to it and look at my image right?

George Hripcsak, MD, MS, FACMI – Columbia University

That's yes or no?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

No you don't want that, you want it to be ...

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

You want...that's why this link thing you want to be able to...

George Hripcsak, MD, MS, FACMI – Columbia University

Well that's what we meant by accessible through, i.e., the...well, what we mean is the EP or the...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Access the image either in the EHR or in another system, right?

George Hripcsak, MD, MS, FACMI – Columbia University

Or in another system but reached through the EHR and, you know, even viewing...you know, I understand their concern but even viewing on the same monitor, well, no I don't want to say that, forget it, strike that. It's access through the EHR which means you click a button or a link in the EHR to get to the image even if it's on another system. Now does it have to show up in a window in the EHR or can you click a button in the EHR and have a separate system window come up, Charlene?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Well, I would think – right?

George Hripcsak, MD, MS, FACMI – Columbia University

I'm okay with a separate window, but I don't know what...I mean, the main thing is that it feels, it's easy to get to so that you can just click a button and see the image.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Right, you've got all sorts of ways out there and you don't want to preclude them from having better ways, right?

George Hripcsak, MD, MS, FACMI – Columbia University

Right and comments about menu versus core? Is there kind of some feeling one way or the other that we should keep it – move to core as previously planned or keep it as measures? Keep it as menu, sorry?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

So, George, from a policy perspective what do we want, you know, is it...I mean, clearly in the hospital it should be integrated, but in the practices, at that point? I mean, it seems like if our goal is to get the right diagnosis as quickly as possible having access to the images would be really helpful.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

I think so too.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Yeah, this is Marty; I think it needs to move from menu to core from two to three.

George Hripcsak, MD, MS, FACMI – Columbia University

Both for EH and EPs, this is both EH and EP, right?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

For EH it’s clear.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

So, David, while you were...I don’t know if you heard we just clarified what accessible meant.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

And then now we’re just talking about menu and core.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

So, we’re sure on core EH, it sounds like the group is leaning core EP.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

You physicians does that sound reasonable to you?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, it’s up to you guys, because ...

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

It sounds reasonable to me.

George Hripcsak, MD, MS, FACMI – Columbia University

You know, it’s just a matter of whether the practices will be able to do this or not. I mean, I guess the question is in the hospital often you’re doing mostly your own images; the EPs are – you know, they’re dealing with a lot of, potentially with a lot of different image vendors.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes at imaging centers and all that.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah that’s what I meant, so, I meant, yeah the ones actually carrying out the images not just the vendor of the imaging systems over there. So, it certainly is harder for them. I mean, we could just leave it as core for now with the idea that, realizing that it’s depending on, I mean, maybe we just say that its core for EH and it’s provisionally core for EP depending on progress in Stage 2.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle, just one idea, so there is the other objective related to labs that's kind of pushing on the hospitals to be able to get structured data, structured lab results to EPs. Is there anything that can be done and I'm sure it might not be, you know, the best idea, but is there anything that can be done from the other side to help this happen in the EP offices as well.

George Hripcsak, MD, MS, FACMI – Columbia University

Do we have a feel ...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

It's a lot of the free standing imaging centers that do this.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And, I mean, what's happening now is there are lots of these vendors, you know, imaging vendors that are coming up with cloud and all that kind of stuff so it's doable. I just, it's not very operational yet though it's kind of not the real world out there, you know.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

But, you know, most EPs I think send a large proportion of their business to one or a couple of vendors.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

So they should be able to do it for those anyway as long as they have a threshold.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, but the imaging...a lot of those imaging centers sometimes are – those imaging centers do have EHs or, you know, EHRs.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

This is Marty, I think ...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

That might be a good approach.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Where I see the problem coming in is the specialist that – where patients are referred in from various facilities with their images coming from various facilities, this might be a real challenge for them.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Well that could be hard.

George Hripcsak, MD, MS, FACMI – Columbia University

Michelle, I think that's a good analogy even lab and I'm just trying to think is it more often that the hospital is – a local hospital is doing your lab work than is doing your radiology work I guess I don't really know.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Both arrangements are pretty common.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

But then it’s, you know, what am I going to tell – this is a little more complicated because what this objective is saying – whereas the lab objective was about the structure of the lab data you received, this is about how you view it. So, I guess all we could be saying is if you send – if you wanted to do this, if a hospital is sending radiology information it should be structured, you know, by DICOM or whatever the current thing is. I don’t really think we should go so far as to start dictating exactly what system the hospital should be using so that EPs – I mean, that’s what you’re asking I guess, should we force the hospital to produce systems that allow EPs to link to them from their EHRs, right?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Oh, I thought she was saying more that there are imaging centers that are getting paid for meaningful use and should a requirement be that the imaging centers have to provide access to the EPs.

George Hripcsak, MD, MS, FACMI – Columbia University

You mean the hospital ...

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

And are getting paid, right?

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

This is Marty, as we talk through this I’m thinking we should leave this as menu for eligible providers.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah, but I think that your recommendation is a good one for future state though.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Yes, yes.

George Hripcsak, MD, MS, FACMI – Columbia University

David, what do you think?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I can see good arguments in both directions, you know, I personally would rather see it be core but I am not convinced that is the best course and I’d be fine with making it menu especially for the specialist I do agree this is a considerable challenge.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, I think whether we pick menu or core we should put the – we still need to put in the caveat, or I think the caveat is that we’re going to look to see what happens in Stage 2.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

And whatever we pick go in the opposite direction as we see. Okay, so then is the sense of the group EH is definitely core and EP menu then?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I think that’s where we’ve landed.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay. Are there any other things – I think that covers us, right?

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

I think so.

George Hripcsak, MD, MS, FACMI – Columbia University

Do we want to go further or do we want to ...

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, let’s do one more, how about if we do notes and I’ll take us through that if that’s okay?

George Hripcsak, MD, MS, FACMI – Columbia University

Please do.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay, so about two-thirds of the commenters, about notes wanted additional specificity before providing their opinion and of the one-third who provided an opinion most agreed with changes, lots of commenters wanted clarification about whether it was menu or core, lots wanted to know whether it was EH, EP or both, many commenters suggested a change from four business days, to four business days from four calendars days, which I think would be okay.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yes.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Commenters wondered if the language from unique to office was intentional and they also suggested clarifying the created, edited sign language based on MU2 experience. So, should we go through those? I mean, I was thinking this would become core.

Michelle Consolazio Nelson – Office of the National Coordinator

So, David, this is Michelle, coming out of the clinical documentation hearing I think the recommendation was to move it to core from that group.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

One question that Paul had asked this group to look at, based upon the clinical documentation recommendations, is that for EHs should it just be focused on the discharge summary rather than the entire note? He just wanted to clarify that piece of it.

David W. Bates, MD, MSc – Brigham & Women’s Hospital & Partners – Senior Vice President, Quality and Safety

Okay. What do people think about that? I think it should be both and not just the discharge summary.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Well the only thing and this would raise the bar, but what we heard pretty loud and clear that discharge summary is if it could be available, and I think we heard this from the long-term care group, like immediately not 4 days, it would be hugely valuable. But, you know, and that's just pertinent to the summary itself, so it's kind of a different objective. I think we had a, you know, we just had any notes – the goal was to get as much automated as we could was kind of what we were trying to do with getting the electronic note in there in whatever form it got in there. We weren't specific with the discharge summary, so it's kind of a different problem we would solve.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah, I say let's deal with the discharge summary.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Separate?

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Separately, yeah. What do people think about notes and hospital generally?

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University NYC

Yeah, I mean, I don't know when we're ready but that's the whole point is to go beyond the discharge summary.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

I mean, we've been doing discharge summaries electronically since 80 something, 1980 something, but doing notes is something we did just recently. I mean, that's – and the discharge summary is what you're doing afterward it's not there in time to help you treat the patient; it does help you treat the patient after the discharge. So, I think I would be aiming for a progress note, it's a pretty...at least one note in an entire admission, which could be the admit note I guess, right?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

I thought it specified one per day, was that it?

George Hripcsak, MD, MS, FACMI – Columbia University

Oh, wait, I'm looking again, oh, wait, no, I know – Michelle?

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah?

Michelle Consolazio Nelson – Office of the National Coordinator

And so for Stage 2 it was enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique visits, sorry, that's for the EP side.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Yeah what about ...?

Michelle Consolazio Nelson – Office of the National Coordinator

Enter at least one electronic progress note created, edited, signed by an authorized provider of the hospital or critical access hospital.

George Hripcsak, MD, MS, FACMI – Columbia University

That's one per admission, right?

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

And then did we change that in Stage 3?

Michelle Consolazio Nelson – Office of the National Coordinator

Stage 3 we weren't very clear, which is what all the comments said, all we said was record electronic notes in patient's records for more than 30 percent of office visits within four calendar days. So, we were kind of vague and we didn't really talk about the hospitals much which is why we need to fix that.

George Hripcsak, MD, MS, FACMI – Columbia University

So, basically that's – I don't know what the four days – what were we before in Stage 2 in terms of four days or no days, or what? We weren't specific about it, but no, but we have a rule. Is there a rule about timing?

Michelle Consolazio Nelson – Office of the National Coordinator

So, yeah, for Stage 3 the recommendation was within four calendar days.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, but Stage 2?

Michelle Consolazio Nelson – Office of the National Coordinator

For Stage 2 there was nothing, but it was enter at least one progress note whereas we kind of took that piece out of it and just said that 30 percent of office visits had to have.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, they're both for office visits I guess we now narrowed it down to four days. Okay, so we should – all right. So, I think we didn't – I think we just – this is a whole bunch of clarification thing, right, David? I mean, I think we want to maybe move it to core for both. We don't want to do just discharge summaries. We don't care if it's four business days or four calendars days whatever is more accessible.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

And it does apply to EH and EPs. Oh, there is a question about the created, edited, signed language, I don't know.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Right, well that's based on MU2 experience I think let's wait and see what the MU2 experience is.

George Hripcsak, MD, MS, FACMI – Columbia University

Good.

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Okay. So, I think we're done with this one and we should probably stop here unless anyone has additional comments. Okay, MacKenzie could you open up the line?

Public Comment

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Sure, operator could you please open the lines for public comment?

Rebecca Armendariz – Altarum Institute

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

David W. Bates, MD, MSc – Brigham & Women's Hospital & Partners – Senior Vice President, Quality and Safety

Okay, I just want to thank everybody, very productive call and we have some more things to go through next time.

George Hripcsak, MD, MS, FACMI – Columbia University

Thanks very much, David.

MacKenzie Robertson – Office of the National Coordinator – Federal Advisory Committee Act Program Lead

Thanks everybody.

Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs

Thank you.

Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality

Take care, bye-bye.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you.

Marty Fattig, MHA – Nemaha County Hospital Auburn, Nebraska (NCHNET) – CEO

Thank you.