

**HIT Policy Committee
Meaningful Use Workgroup
Transcript
May 14, 2013**

Presentation

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

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. This is a public call and there is time for public comment built into the agenda. The call is also being recorded, so please make sure you identify yourself for the recording. I'll now go through the roll call. Paul Tang?

**Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and
Technology Officer**

Here.

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

Thanks Paul. George Hripcsak?

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

Here.

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

Thanks George. David Bates? Christine Bechtel?

Christine Bechtel, MA – National Partnership for Women & Families – Vice President

Good morning.

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

Good morning Christine. Neil Calman? Art Davidson?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Art. Paul Egerman? Marty Fattig?

Marty Fattig, MHA – Nemaha County Hospital

Here.

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

Thanks Marty. Leslie Kelly-Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Here.

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

Great. Thanks Leslie. David Lansky? Deven McGraw? Marc Overhage? Charlene Underwood?

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

Here.

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

Thanks Charlene. Mike Zaroukian?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief
Medical Officer**

Here.

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

Thanks Mike. Amy Zimmerman?

**Amy Zimmerman, MPH – Rhode Island Executive Office of Health & Human Services – State HIT
Coordinator**

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Amy. Tim Cromwell? Joe Francis? Greg Pace? Marty Rice?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks Marty. And Robert Tagalicod? And are there any other ONC staff members on the line? Okay. With that, I'll turn it back to you Paul.

**Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and
Technology Officer**

Thank you MacKenzie. And thanks everyone for participating on this call. So you'll recall that we've been – we spent our first phase looking at both a combination of consolidation and deeming, and now we're cycling back to look at the public comments, which took a little bit of policy stuff to be a change in the structure, and there has been. So we're taking a – we're cycling back to look at the public comment in each of these subcategories, 1-4 anyway, and going by those and trying to reconcile the public comments with where we were in the individual objectives, but also in the context of a new consolidated version. So we're starting out with – and all the subgroups are working on those – that reconciliation. We're starting out with subgroup 1, because they've already finished, presumably because they had less controversial, less changes proposed in the public comments. Unfortunately, David Bates can't join us and Michelle is not here as well, but George Hripcsak will ably guide us through a review of the reconciliation for subgroup 1. Thanks George.

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

Thank you Paul. And thank you again to David and Michelle for – and to the subgroup 1's work, some of whom are on the call and can also help me out. Can we go to the slides that Michelle or that MacKenzie sent around? There we are, next slide. So we're going to go straight into it. The first objective will talk – can you hear me okay Paul?

Christine Bechtel, MA – National Partnership for Women & Families – Vice President

Yeah, but you know what, somebody is probably typing right next to the phone, because it cut you out a couple of times.

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

Yeah, can I just ask that everyone go on mute unless you have – a question. Thanks.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Also it's Neil Calman I just joined.

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

Thanks Neil.

**Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and
Technology Officer**

Hey Neil.

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

Okay. So the first objective is the advanced directive, 112. There were a number of comments, some talked about raising or lowering the threshold; we decided to leave what we had proposed. There were proposals to raise the age or lower the age; we decided to leave the age as is. There were some, because we thought it as an approp – that the same argument we made originally, we still felt was valid and there wasn't a strong push in one direction or the other. Next, the status. We decided that at this point in time, for Stage 3, we would stick with the status because of the various problems actually trying to store and coordinate the advance directive across all the institutions that the patient sees, so we left it as the status being recorded as opposed to in Stage 3 actually uploading it. However, we want feedback, and there's a planned listening session. I believe the listening session was initially planned for the – wait, which Committee – oh, the Consumer Workgroup, I guess, and perhaps the Meaningful Use Workgroup should join that listening session. So that was the proposal. So this is – we proposed to leave the objective as is contingent on not having a different opinion at the end of the listening session. Comments on that?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

This is Leslie, I think that's a great plan. I know there's a lot of interest in participating in a listening session in the community.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Christine. I also think it's a good plan. I'm worried though about timing and I think we need to understand big picture, regardless of this particular item, what kind of timeline we need to be on if CMS and ONC were to issue an NPRM on – in such a fashion as to not delay the implementation of Stage 3, if that's still possible. Because I think – I worry about the timeline for the listening session and how quickly it could be pulled together, depending on the larger timeline.

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

MacKenzie, do we have any actual concrete plans on the listening session?

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

No, there's nothing that's been developed at this point. I know we have it on the agendas in ONC to talk about as well, but there's nothing concrete.

**Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and
Technology Officer**

So I think you're right Christine that it probably won't be in time for our – let's see, we're presenting back in August and September. So, it might just squeeze by, but as you know, it's not as if ONC and CMS have their ears closed when we have hearings, so, the input could still be there, even though it might not be a formal part of our recommend –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Oh yeah, I agree. I guess I'm – but can we pull together a hearing by August/September is – so, the only question.

**Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and
Technology Officer**

So I – so that was re-raised in the last meeting, as you know, and I think we're going to try – ONC is talking about it.

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

And just so we kind of level this at the beginning, there isn't budget for a full hearing on this, it would have to be a virtual listening session, so just an extended workgroup call.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think that – this is Leslie. I think that that's fine, and there's enough interest that when we call it, people will come.

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

Exactly – this is George. I don't think this should be too delayed, I think it's possible for us to do it quickly. Other comments on this objective? Okay, so let's go to the next slide. This is clinical decision support. So a number of changes we made, either because of comments on clinical decision support or because of consolidation from other objectives. So, they'll be some duplication but I'm going to run through it while it's in front of us. First of all, the 15 – actually, it's – I'm sorry, that is blocked by the little bubble, you see the paragraph that says implement 15 clinical decision support interventions or guidance related to 5 or more clinical quality measures that are presented at a relevant point in the patient – in patient care for the entire EHR reporting period. The 15 CDS interventions should include 2 or more interventions at each of the following areas as applicable to the EP specialty. So what's not shown – you see 1 or more blocked out and 2 or more is blocked by that balloon, so I apologize for that.

Next, the first bullet, preventive care, we included the words, "including immunization," because of consolidation that in fact, the part of the immunization portfolio that was about clinical decision support we rolled into the clinical decision support objective. Furthermore, there's a fifth bullet, improving the accuracy or completeness of the problem list for one or more chronic conditions. This was another consolidation of one of the objectives you'll see later, which was consolidated into this, because it was really a form of decision support and we felt it was more appropriate here. Further, down you see in red in red, on tracking the CDS triggers, how they responded and the reason for overriding in the certification criteria. That is, the provider doesn't have to put in the reason for overriding; however, there has to be the ability to write in the reason for overriding within the system.

And then not shown in red here, but a discussion that came from yesterday with Art on the public health objectives, we realized if you go further down you see the fifth item in the certification criteria, it says ability for EHRs to consume CDS interventions from central repositories. For example, rules for drug-drug interaction, rules for reporting to diseases for a public health department and preference-sensitive care lists. Art pointed out – Art, are you on?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Yes, I am.

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

Okay, so I'll take it and then I'll let you comment further. So that middle one, rules for reporting diseases for public health department, that's actually a future stage objective. So what we would like to do is replace that phrase with a different one, which is to add immunization recommendations and rules. In other words, there's an objective that was recommended for Stage 3, that we'll see when we do public health, which was decision support around immunizations. We think this is the certification half of that, that's what we need to put in there and not the one that's put off for after Stage 3. And that one includes both the ability to accept recommendations from outside, that is the public health department sends me a recommendation, but also the fact that they can send me the rules for how I should run on my database or known immunizations to recommend the next immunization. So that's why I say, "add immunization and recommendations and rules." That's not shown on your slide because that already had gone out after our call, but I have notes to myself to add that. Art, do you want to say more about that?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

No. I think you've covered it pretty well there George. We're just trying to get this lined up so actually we could get the immunizations piece in here and since there were, back at the – I think it's 401B level, that registry information, it said to receive, get or access. And we're trying to make sure that each of those different scenarios, because some may solve it in different ways, what it means to get a recommendation or to run a recommendation or to receive the results of a recommendation, because there could be a service out there that does that for someone, so, didn't want to mandate any particular way.

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

Um hmm.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Did we get any comments about the readiness for standards to support this interoperable CDS?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

So it's – I think HITSP, I'm sorry the Standards Committee had some question about that, but we are working with the American Immunization Registry Association, AIRA. And they – last week I was talking with them about this and they're putting together a paper on – or a piece that would help us to describe it's successful in about half a dozen places currently, large – you know, like New York City and other sites as well.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Are we saying the recommendations are discrete consum – or they're just text?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

No, no, they would be – they are discrete. They come in an HL7 message.

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

Well, I think the recommendation could be a text message in an HL7 message –

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Yeah, right –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

But, it doesn't –

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

But Paul's right about the rule part of it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

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

The rule part is already in there as ability of EHRs to consume CDS interventions from central repositories

–

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right, that's what I was going to –

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

– we didn't actually change that, we just –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Well that's what I was referring to, do we know that there are standards – are we really talking about consuming them and acting up – and executing them?

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

The couple of comments for the – so I'm looking now at the public comments for 113 itself. So, same number expressed favor or opposition to the 15 interventions. Comments were varied about the tie to CQM. And they were worried about drug-drug interactions for – as a source of alert fatigue, although we discussed that because we think – the whole purpose is to do this with fewer drug-drug interactions, it's not to do the standard thing that's been done in the past that everyone's been complaining about.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right.

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

So there is expressed concern that standards will not be available for structured SIG. What are the – I'm sorry, what are the SIG?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

The SIG?

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

The use of structured SIG standards –

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

How to – one q.i.d.

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

Oh, okay, got it, got it, got it. So that's a different topic.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. I have a question, too. Do we – are we too prescriptive by saying a central repository, because this could be cloud-based with several different CDS sources that could be available. Is there a way to make a statement that we want it to be consumed or interactive, but not prescribe the actual source technology?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

I think they actually meant from some other repository, because if the –

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

Yeah –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– there are some DDI's, there are some – so I think intent – the phrasing was not one centralized master repository, it's that you go to an external source.

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

Okay, I found the section – so that's right. So I think we need to rephrase that. Thank you.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

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

The point – the Standards Committee said, the certification criteria should specify what the EHR needs to do and not how it should be implemented within an enterprise. In other words, whether it's central or not outside is not our business, it's just the fact that we need to consume outside –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

External –

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

– CDS, external CDS interventions, so we need to rephrase that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

But I'm still concerned that I don't think we have execut – interoperable, executable CDS at this point, do we?

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

Paul, this is Charlene. I would agree there's a concern here and really, I think – there's two pieces of this, so the readiness certainly – the ability to access and download that, I know there are a lot of discussions on that. But also, when we talk in public Policy Committee, I think a signal to have centralized sources of this, like we've got the value element list and those types of things at the National Library of Medicine, I think is an important direction to go. So I would agree with you, I'm not sure how consumable – if we're going to be able to accomplish this. Again, depending on the timeframe of Stage 3, I think it was important to signal it at this point.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah, but I mean I – it's clearly one of our desires, so if it's in future – I mean, signaling is great, I just didn't know whether we could get there –

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

I don't know that either because I don't know the readiness of all the moving piece parts, especially with as broad as an objective – or criteria as that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Go ahead.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. The only standard that I know of that had been looked at in the Health eDecisions group that is available and used right now is actually the Infobutton to trigger the actual specific request for an intervention and it allows for the passing of a message or a response of what's been actually consumed. So it doesn't take the actual CDS application and consume that in the EHR. It has a trigger for a request of an intervention and then once that intervention is selected inside that external application, what feeds back is a message or a response stating what had been done. And that today is the only standard that I know of that would be applicable to this and has been discussed in the Health eDecisions group.

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

Okay.

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

So – well, why don't we do this. Why don't we do the swap of immunizations for reporting diseases, number 1; 2, change central repository to external source and number 3, for that certific – for that criterion, number 5 say if no current standards exist, it will be pushed forward to future stages or something like that. So the signal will be there that at future stages, and that gives the Standards Committee the freedom to say, oh no, we do have the Arden syntax so this could work or whatever.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

I'm remembering now George that Jacob Reider talked to us about, they thought they were going to have this by the end of, I believe, this year. So, this might be a bit of a check, a recheck with Jacob to see if this is still written – if the standards support of this requirement is still on schedule.

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

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

The last notes I read from the meetings, they were on track.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Okay. So, we're, we're, yeah – so I think –

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

We'll leave it as a note for us for now.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

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

But we'll make the first two changes.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health & Human Services – State HIT Coordinator

This is Amy and I have a question, because I had to step out for one quick second. Were you – when you're changing the phrase – the language from central repository to external source, are we talking about just the recommendation coming back to the EHR or are we talking about all of the decision support algorithms, because we had that – I don't know Art, if you talked about the discussion we had yesterday relative to –

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Oh, yes –

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

In fact, we can be explicit – in fact I was going to be explicit, so I – my new phrasing there is add immunization recommendations and rules.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health & Human Services – State HIT Coordinator

Okay, because yesterday in our subgroup, we were sort of talking about the burden it may put on EHRs to have to take all of the rules and calculate it versus just taking in recommendations, if there is some sort of external source that can provide that. Because there is – there may be, at least there used to be, local and state variation based on how states supply vaccine around immunizations in particular.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Yeah, no, I think –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie and if the rules are considered clinical decision support rules, then it can move that software into a medical device under the FDA, which is taxable at a different rate. So most of the time, anything that is using an advanced rule set have – the EHR vendors will want that to sit outside, because it does, for not the burden just technically, but there's a totally different class of software.

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

Well drug-drug interactions are the one that preceded the discussion about public health, so is that true for drug-drug interaction alerts?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

No, there is some line, and I can't describe it, but there is some line when you move to – for the clinical decision support. And I don't know that if it's when multiple variables are involved or anything, so maybe we just should note that when not in conflict with other rules like FDA, we want to consider those being consumed. But it is a different skill set to do clinical decision support in a software system than it is in electronic health records, and maybe Charlene has some comments that could speak to that better.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

It's just a logistic question, is it just my eyes or it's for some reason the slide's out of focus?

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

Yeah, we can't read it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Okay. And the other question I have is, some of the other groups had a PowerPoint that had a summary of the public comments, is that not included in this set or do we not have that here?

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

The public comments, I don't think they're in this slide deck.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Okay.

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

We could pull up the original – I mean, we can get to them, we can just pull up the May 8 and April 24 – I have to get the dates, slide sets, theoretically would have them –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Oh, I see that, yeah. Okay.

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

The slide sets that we worked from.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

So I think, I don't know about – this is Art. I don't know about Leslie's comment, and that might be something we should consider, if there's some sort of FDA issue for us to know about, but back to Amy's comment. I just think that we're not trying to prescribe what it is that someone needs to do, they could either get the recommendation or they can get the rules and deploy them in their EHR. I think as Leslie suggested earlier, let's not mandate anything specific about a technologic approach, just they need to consume something.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah but the sta – the criteria, the certification criteria has to be more –

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

So –

Amy Zimmerman, MPH – Rhode Island Executive Office of Health & Human Services – State HIT Coordinator

Yeah because my concern is this, if they start consuming rules that are out of sync with their local or state rule set, then we're going to be off and so that's why I didn't know whether – I mean, the rules generate the recommendation, but –

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Well then why can't the person or the organization that's trying to apply for meaningful use incentive funds say that it has now subscribed to an external source to do the recommendations? Like an IIS?

Amy Zimmerman, MPH – Rhode Island Executive Office of Health & Human Services – State HIT Coordinator

I agree with that, I was more concerned about them downloading rules and then the burden on the providers of the EHRs of having to have different rule sets.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

But some manufacturers may decide they want to do it that way and they have to follow the local recommendations.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health & Human Services – State HIT Coordinator

Even if they're bringing in 3 different versions of rule sets for immunization based on locality?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

That's the EHRs decision about how they want to solve that.

Amy Zimmerman, MPH – Rhode Island Executive Office of Health & Human Services – State HIT Coordinator

Okay. All right.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

I think it's –

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

So, it's sounding like, clearly consuming the what do you call it, the recommendations is probably feasible and we'll just have to see whether consuming the rules or algorithms is deemed to be feasible by Stage 3 or not. We can certainly signal it now by leaving it like this though.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So, from a practical point of view, just consuming the text, I think that's – recommendation, wouldn't necessarily be a – I mean, you can get that from National Guideline Clearinghouse and that's how you would read and see the citations and see more of the rationale and explanation.

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

– not consuming the text of the rules, we're consuming the recommendations, the health department is sending back, "this child needs to have this immunization," because you just sent all the data to the local health department, they can tell you what the next immunization is, because they're sending you a reminder for that patient –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Okay. Okay.

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

– which could be in text form. That's what we meant by that, not the guidelines.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Yeah, not the guidelines. Absolutely not.

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

This is Charlene. There are just different use cases here; I think there's levels of this. And there's certainly capability out there today, where you can send out information to another system, it will do some sort of a calculation for you and bring you back some additional information. And then in many – in some cases, it can actually be embedded into the workflow, otherwise it can't. So it seems like it's that case. Certainly the provision to download the logic is another step, but today most cases we actually – First DataBank and those, we just get regular updates and then deploy those in our systems and make those available to customers, so that's pretty standard.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Charlene, and actually they do have to go through separate things, like First DataBank is a separate clinical decision support function, and they do have to go through some approval process, and they do send you the result inside the software. But the standards allow for all of the provenance, versioning, accreditation, process, all that stuff comes with the response, so that it's traceable to find out how that rule and who was responsible for firing that rule. Many organizations will feel that the algorithm and rules used are proprietary and aren't going to pass them. So, I think it's just a question of what do we really want in the EHR and what is the EHRs role as it's to trigger specific inter – request for an intervention that's unique to that patient and record, in a meaningful way, the output to include the sources and to be able to trace at a future date, what that particular intervention was.

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

So this is Marty Rice, quick question. Are we asking the EHR to perform analytics or the results from an analytics being able to be taken in?

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

Both.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

I think both. I think those are options.

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

Both.

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

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

And Art, you said the standards are all ready for this, huh? Both the – all the conditions to be transmitted to some central place and the execution and the return results?

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

I think that to say that the – there is a full data set out there that NLM or CDC has deployed is overstating the current situation. There are – each state has, as we're going to describe, has its own system, or most states do, and some of them have been using the bi-directional communication, this recommendation function back to EHRs. So, it's not fully played out at the national level, but in several states and cities, it is.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

You're imaging this would be menu – well, it's only a sub-component of an objective –

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

Right. It's already core.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yup.

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

So it sounds like we can make the clear changes and then we need to gather more information about the possibility of adopting rules.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So what we're saying right now, in this section, saying the certification criteria, i.e. all EHRs should be able to do this following the existing standards, even though not all providers will have access to one of these, and then since this is a core, it would be done by exclusion. If we don't have access to this or it's not relevant, then it wouldn't apply to you.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Exactly. Exactly.

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

Well you being who, the provider or the vendor?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

The provider.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

The provider.

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

Oh, I don't need to do the exclusion on a certification criterion do I?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

No. The provider may or may not have to do this –

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

No, the provider doesn't have to do anything, this is certification criterion, it's just that the EHR has the ability to consume rules period. And then it's optional which rules from the top list they pick, so in that sense, it's menu anyway.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

That's true. You mean, so only if they had available and they chose immunization as – in the preventive care category, would they have to – could they use this.

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

Yeah, so I'm not worried about providers, I just want to make sure the vendors are able to do them. That's why I say we have to look a little bit more about this. I think they can consume reminders by then, the question is, can they consume algorithms by then. And then the other intricacies we heard about like FDA rules and so forth. By the way, can I ask a question, Michelle's not on, is someone – how are we recording this, other than the transcript? Is someone taking notes?

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

So we have audio and Michelle's going to back after, she'll have the audio to go through and re-listen to the call.

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

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

So there's a meeting summary and an audio that gets prepared, but she usually just sits and listens to the audio transcript again.

George Hripcsak, MD, MS, FACMI – Columbia University – Department of Biomedical Informatics
Okay. So Paul, does that sound –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yes. Yeah.

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

Okay. Let's go to the next slide. This is reminders to patients. We were asked mainly to be more specific, so what's clinically relevant, we said clinical, social or family history information, in other words, information beyond demographics, to identify patients. We don't want to be too prescriptive on what we mean by clinically relevant because the whole point was to not be overly prescriptive, so we just went the next step of specificity there. We decided to leave the threshold at the 20 percent. There was a request, remember, this is a change from two office visits as your denominator to 1 office visit and we left it as – we purposely left it as 1 office visit. There were comments to increase the threshold beyond our 20 percent and we felt that leaving it at 20 percent but going down to one office visit was kind of the same thing – similar to increasing the threshold that was part of our justification. Comments on that one?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Well clearly people, it supports our patient specific information resources.

George Hripcsak, MD, MS, FACMI – Columbia University – Department of Biomedical Informatics
So, are we okay with this one?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, I'm okay. Christine.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yes, you've added some clarifications in your red and –

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

Okay. Very good. Next slide, 117, medication administration tracking. There were requests to increase the threshold, actually high, I have to look to see how high, like 80 percent or something, and we felt that 50 percent was a reasonable amount to go above the 30 percent. We also defined mismatches, although it's not in red, it's underlined over there, situations in which a provider dispenses medication and/or dosing that is not intended. Those were the two changes we went on this one, any comments on this one. This one didn't have many public comments. Oh, the – that's right, the Standards Committee suggested increasing to 95 percent, there were no – I just have three words, increase to 95 percent, so I didn't quite understand that, but we felt that 50 percent was a – remember, we always go higher than our thresholds, so we went higher, but not to 95 percent.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

I mean, I think this is going to top out after this actually.

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

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

This is Charlene on that one.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right, this is Mike. My assumption is, if you can do this at all, you can get over 50 percent pretty easily.

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

Right, well and again, it's just a roll out process then, in terms of –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right, right.

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

– across the facility, so that's – the value here is so high that it usually – it'll pop on this one.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Charlene reminds us that yes, you aren't going to stop at 50 percent in one unit, but you may not have all your units in the hospital, and so for the hospital to qualify, if they're in the process of roll out, this is one of the ways of doing that.

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

Yeah, yeah.

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

Oka, that's good. Let's go – any other comments? Let's go to the next one, 118, imaging. Because we're a little bit unsure how this is going to go, we want to see what happens Stage 2. First, we clarified that it's EP menu and EH – hospital core, so that's number 1. Number 2, we confirmed or clarified that we mean you can look at it within the EHR or linked to a separate system, so you reach that link from within the EHR, but then you can go to an outside system, so we made that clear. And then the threshold of 10 percent, I mean, we just are so unsure how this is going to go in Stage 2, we just said we need to review it after our Stage 2 experience. I'm just looking over the comments in my notes.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Well this is Mike, while you're doing that, could I ask one word question? For many of the providers I talk to, this becomes a lot clearer when they hear the word whose result includes an image, than one whose result is an image. Because I think most of us clinicians think of our image-based reports as a combination of text and image. So if it contains an image at all, then that's a lot clearer to us than the result is an image.

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

All right, let's see – I mean but I worry whether – will that get confused in a different way. Let me think if there are any exceptions on that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So I think, yeah, we talked about it and we used this language because we wanted to make sure that the image result comes across.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, and that makes sense, it's just that my concern is that there are some people who would say, well the result isn't an image, there's an image in it, but the result itself is not the image, it's the report. So, it's where we start swirling at the local level trying to say yes, but the EKG findings do include an image, so we need to make that one of the examples.

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

Well, the objective says, imaging results consisting of the image itself and any explanation or other accompanying information. So that was our attempt to clarify that, but you're talking about in the measure itself we say whose result is an image.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah and I have to say, we spend a fair amount of time distinguishing objectives from measures because the objective is where we're going and the measure's what we have to meet, and again, it just helps to become clear when –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

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

Well I think – so I think we could rephrase it and say who's result includes an image and then later in the sentence you have to say that the image is acceptable, not just the other results.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Perfect.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

I'm also recalling we were – somebody, I think it was at Policy Committee commented how ECG was not an image, and I think what we meant really is the ECG would come in as – if it's available and you have a browser, but also let's say if you capture somebody else's ECG which could be an image, that would qualify. So that's a bit complex language, but we did get the comment that we really didn't mean – ECG's is not one of your prototypical images.

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

Wait, say that again Paul.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So, now I'm get – I think what we meant by image, we meant the classical radiological image, that when we said paren, "including ECGs," we were saying, oh, and if your ECG – if this particular ECG happens to reside as an image versus a vector – graph, then that would be okay, too. But I think it just got confusing when we put that –

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

Oh, I don't think I realized that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So, and it's more –

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

Then that's actually more confusing.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

That's right, it turns out to be more confusing because we said, well, an ECG isn't an image, so what do they mean by image. So if we wanted to do e.g.s, we could put, e.g. radiological images –

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

I think that makes sense.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah, and then ECG could be one of the examples at the end of the list, just to show that that could be rendered that way.

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

Yeah, but then you can take an image of a transfer note, and if you're going to do an image of an ECG, why not an image of a doctor's visit note. But that wasn't the purpose of the objective.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

That wasn't the purpose. It's possible we just get rid of ECG because it's more confusing than adds to it –

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

Maybe.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– than clarifying.

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

I mean we want EHRs to do ECGs, but it may not be this objective.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Well, and we actually would rather them do it rendered in the way that ECGs are rendered by the native system.

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

Well, we really wanted to multimedia EHR and ECG doesn't happen to be image, it's a vector with a graph of it, basically, which we do want in a future EHR, but for Stage 3, I think we were being more specific. Should we put in radiologic or no?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike. For the typical provider that I am and work with, I would say, we want clarification that its radiology images –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

W

Yes.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– other imaging studies that we need to know, if it includes pathology images or not, that the EKG representation, we think of as an image, most of us, regardless of the fact that it may be a vector representation in certain systems. But I think those kinds of common examples are worth emphasizing, even if technically some systems are putting them out as images and some systems as vector representations.

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

You know we – yeah, that's hard. So path I think would be great, I don't think we were thinking path when we wrote this, but ultrasound, which is not done in the radiologic department, is done by another department, I would still think would count.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

What about dermatology images, too?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah, the –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

And those – this is – or a DICOM, they have a division of DICOM that supports it, but – this is Leslie. I think it's great to radiology image, but then do a signal for Stage 4, someone used the word multimedia, so that we're staging it so that the EHR will support any media, or multimedia in Stage 4. But start with radiology images and/or DICOM compatible image, which would take us to path, derm, radiology of all modalities, if we wanted to specify that, or specify that in the standards requirement.

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

Yeah so I think on the vendors side it would be unfair to include all multimedia in Stage 3, so we probably should limit it, for this, to radiology or something a little bit – radiologic type images. And then as you said, with a signal for multimedia in the future.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So the question I'm offering here, this is measure definition. Every time we include something, it automatically falls into denominator and so you could imagine all kinds of potential images that would end up in the – so that's why I think it's probably better at this juncture to say, radiologic image, everybody understands that, I think, I mean –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

What about radiologic and photographic, wouldn't we want photographic images to be able to be transferred, too?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

But do you know, even in your own hospital or clinic, do you know how many photographs – what's the denominator? That's what we don't know.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Also would an Adobe be considered a photographic image, so how it's stored – so for instance, I might have a system that's doing image capture in DICOM for pathology, and storing it as an Acrobat image inside my EMR. So, I think it's a slippery slope when you say photographic image. If we do say radiologic, then we're not indicating a particular technology type, we're saying an umbrella of modalities.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

You recall we did when we started down this path, use the greater than 25 percent to try to get around the denominator problem, and possibly that's an approach we may revisit, just because we're in the reduced burden phase.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, this is Mike. I think that would help a lot, too, and especially if you don't want to get too explicit about what kind of image, because the two other ones I stumble on because as I and others read this, we read it as any image. So we're starting to struggle with the graphical display of a DEXA Scan and the bone mineral density standard deviations or we're looking at serum protein electrophoresis and whether or not there are immunoglobulin spikes, because those come to us as graphical displays that we would say – we would interpret as an image.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

And I think that would be good actually.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So, if we use this greater than some number, we would say – first it would give them a – just would reduce the angst, and second, it encourages – so for dermatologists or for immunologists, those may be your images of merit.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right. It encourages innovation around that as well.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

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

Well we have to make a decision, do we put – is that future stage or with this one being radiologic, or do you want to go right now to multimedia?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

I think it's ca – we are able to go to multimedia and that, at the same time, helps the specialists –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

The other –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– that gives the local organization a decision, well what's important to you?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right. So this is Mike. I would endorse that. I like, if you can get rid of the denominator so people cannot worry about what they're missing, but rather focus on getting in what matters and being innovative around the images that matter. You could also include, if you will, that if you think it's a high priority that radiology images must be included in that, so be it. I mean, we could have that discussion. But otherwise, the notion of a number threshold and then flexibility to allow innovation, I think, would be really viewed positively by the typical stakeholder.

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

Well I think the trade-off is if we do radiologic image, 10 percent, we know what we'll get and it'll get done. If we do 25 multimedia images, including radiology and everything else, you may get less on a broader area. In other words, okay, I have my 25 images in – remember that CMS did not adopt our previous attempts at doing greater than 25.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Umm, but it is a bit of a different era in the sense of, we're all sensitized to the burden. We tried that a long time ago, I think, actually years ago, yeah.

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

Well, but I think 10 percent of radiologic or 25 images that are multimedia, and that'll include radiologic is fine by me, we just have to pick which one we want to do in Stage 3.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Isn't this another example, though, like that when we're talking about not being – not creating silly standards, that somebody's really going to be able to do this with radiologic images, why would they not, once they build a system to be able to do that, why would they not be doing it with as many as they possibly can? In other words, as many as can be done by whoever's on the other end of their EHR. If that's the way my radiologist can send them, and I've developed the capability to take 25 images that way, I'm going to take them all that way.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right. And then – and what's really nice is the 25 relieves all concern, all question about denominator and all of that back and forth, and you get to choose. If I'm a dermatologist, it's my images.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Exactly, which I think is really important, again, to make it more general and more applicable to different specialties.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

And less measuring of denominator.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yeah, which is just, it's really, we've tried to get away from that as much as we can, I would support that.

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

All right. We're going to switch – therefore our decision is we're going to keep it as image, we're going to give examples that show that it's broad, but the metric is going to be 25 or more images. Is that what we're saying?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah. It's just 25, would 25 be any problem for anybody – no, remember that the first reporting period is 90 days – I mean, it was in Stage 2. So if we had a problem with – if it repeated itself, then 25 I can imagine for maybe a small practice might be a problem – I don't know whether 25 is the number, that's all.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, it would probably – this is Mike – it would probably need an exclusion for the occasional practice that does not have enough, but beyond that, I think it's solid.

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

All right. So support for all images, multimedia, for at least 25 images unless there's an exclusion.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

And you can give your examples here, e.g., so that people understand what we mean, everything from radiological, which people would really understand, through derm –

Neil Calman, MD – The Institute for Family Health – President and Co-founder

I'm wondering if we should make the number lower, I'm sorry. Because I'm listening to the discussion about the exclusion. You don't want somebody to use the exclusion if they're not going to hit 25 because then they're excluded from the whole, entire requirement and you don't want to – you know what I'm saying. In other words, if you're only ordering an x-ray in a 90-day period, you have to file for the exclusion, but that exclusion basically excludes you from the entire requirement.

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

Well once we get down to 5 or 10, we might as well just do a certification only criteria.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

No, because that – it's interesting. Mike uses – yesterday – using one, and I'm not prop – one seems just somehow it's a little bit trivial, so using a low number means you're actually using it versus the "test" which really didn't work so well.

Neil Calman, MD – The Institute for Family Health – President and Co-founder

I would suggest going down to 10 so that we don't have that many people excluding it based upon the fact that their practice is – if you're in a part-time practice or you're in a practice that's mixed, a family medicine practice where you're seeing a bunch of kids, where you rarely use x-ray, you're going to end up in a situation where you're not going to hit that number and you're going file for an exclusion, even though we would want them to be able to use this functionality.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right. Well, and this is Mike and that's exactly why I'm in favor of the notion of any result that has an image, using a number of examples. Because it's a lot harder, even for part-time practitioners, even over 90 days to say, you really have between all of those things very few results that are an image. But I endorse the notion, if there's any chance of a 90-day period, it probably should be 10 or fewer. And the other thing is, most of us can't know for sure that we're going to have zero, or some really, really low number, so if there's any chance that we're going to have it and its core, we're going to make sure it's in place.

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

The umm, now remember, this is either have an image in the EHR or a link from the EHR, so you don't need to have 10 images in your EHR, you just need to look at an image 10 times.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right. So yeah, the assumption here is that you are linking to the image for a certain number of tests, whose result includes an image.

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

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So – or contains an image, whether it's inside or outside, yup.

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

Okay. Let's see if we can distill that down from the transcript; but I think we've got that. Okay good, should we go to the next item?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yup.

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

Okay, 119, next slide please. Family history was designated as certification only and the subgroup requested that it be moved out of certification, back into use. It was previously merged with view, download, transmit and care summary and the feeling was, that since it's never been asked for, I won't actually – it's not required, it won't actually get used as a certification only criteria and that you need at least one stage where it's required in some way.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So George, this is Christine. I understand the groups concern. The one piece of information that I think you should consider is, our objective was actually to require that it be part of view, download and care summary, therefore it must be collected. So it was a way to continue requiring it, but not have it be listed in – it's a separate objective, but it's also in those other two. And so we've gone through to try to create the list of required data elements, that if those fields are not there, then it doesn't count. So it would, in effect, be required under consolidation.

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

So, I'm one of the ones who was the not – I was probably the non-unanimous, so it's hard for me to argue the other side. Plus it's a Stage 2 –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

A Stage 2 menu –

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

– it's in Stage 2 as menu, that's why. So they needed to make it core once, but you were going to make it required under VDT –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right. Now I mean, I will say, I have a little bit of hesitation about whether that's actually doable, and so it's one of our – it is one of our follow up items. Because as you recall, I mean we expected when we made some recommendations that did make it into the NPRM and the Final Rule, that when you read the Final Rule and it says all of this type of information is required. But then you read the CMS Tip Sheet and it basically says, no, no, no, only 3 of the data elements of the let's say 9, are mandatory, that gave us great concern. So I think it's kind of a judgment call at this point, whether you try to – whether you hope it gets preserved if you consolidate it, but the way to make sure that it does is to keep it separate.

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

So, I agree with –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

This is Leslie. I would add to that, in that, it does give us an opportunity to say, we're going to record it as structured data in a specific way, so that the input is recorded in a normalized way.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well, that's what we were thinking, but maybe we're wrong Leslie, but that's what we thought would happen if you continued to include it in the clinical summary and in view download.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

But I can output any field of my design into a report or a care summary. I don't have to – when it's downloaded into a care summary document, if I haven't specified the intake method; I may or may not in a computable format. So just because it's in a care summary doesn't mean that it's been actually collected and stored with the metadata associated that we want. So I think it's a good place to consolidate and it's a good way to say, hey guys, if we output – if you can create this in a care summary, and that standard includes collecting this based upon the – LOINC or SNOMED or whatever the standard is we're doing it, then we're fine. But if that output allows for just collection and reporting, just like an HL7 message would, then that's not getting us where we want to go, which helps research and it helps the

consumer. If we did this, and then we said in Meaningful Use 3, one of the areas for collecting patient-generated health data is family history, and that should be structured and we name the structure. Then we could do just this consolidation on the VDT, because we've got someplace else that's naming the standard with which you create the family history as structured data. Does that make sense?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I think it does, but I think we assumed that by preserving it as a certification only, a separate certification requirement, that that's what would trigger the naming of the standard, because also remember, it's in Stage 2. So we assumed that would be the case and that the only way – that by putting it in both view download and care summary, building off of the existing certification requirement, it would be captured as structured, standardized data.

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

Yeah, I –

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

I think –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

And let me just say –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think that if we have something in – right now, there's nothing that says that when someone – an EHR certifies a product and then the client buys the product, that the company has delivered the certified standards functionality. And –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

– that's a certification rule?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

No. For instance, there are vendors that I've worked with who will certify using the standard and the test scripts and everything, and then what the client gets delivered is not that. So, as long as we have some way to say that we're using certified technology and the standards within it, I'm okay with this. But there is a gap right now.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So Leslie, that's not the policy issue. I mean, we can –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

That's true.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– talk offline about how certification – just the whole rules governing certification, but that's not a policy issue.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree. But if we're going to eliminate – if we're going to use this as consolidation, I think Christine's assumptions have to be true that in fact once included in a VDT, with that standard, we know that that standard's being carried through from input to output.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

I think you have to assume that from a policy point of view, and then we can talk separately about what ONC can make that more explicit in their rules.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, I think so. I think Paul, that is the one thing that I do think we should double check on before we completely finalize consolidation, because those assumptions that I laid out rest throughout all of the things that we consolidated.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah, of course. Well, it's everything – it's actually our whole program. So the fact that Leslie is aware of this –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families
Well, no.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– I think that's what we have to go back and deal with. But it's been our whole program that you don't just get certified and then you can do whatever you want that you –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

No, I agree with that. I'm referencing the assumption that if we leave item A as certification only, but we require in policy that item A is included in item B, that in fact, the item B or item A data, will be collected and will be used according to certification, etcetera. Because if that's not a true assumption, it affects all the consolidating we did, not just family health history.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

That's all I'm saying.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right. I think we have to assume –

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

If this is a problem, it doesn't matter whether this is certification only or use, if vendor are going around it, they're going around it, it doesn't matter what we write here. So, that's a separate issue –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right.

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

– but on this one, I think that Charlene what you – Christine, what you suggested, we can get – to the best of our ability, we can get the standard, right. And the question just comes down to use, is use as a menu objective followed by VDT enough or does this have to be a not just certification only, but actually an use objective in Stage 3. So that's what we need to answer right now.

Christine Bechtel, MA – National Partnership for Women & Families – Vice President

That's correct.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Could I actually – I thought we had an issue with actually standards for family history, at least I know that we don't use one.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, well we did. And because folks said, this is – somebody more technical can weigh in here, but folks said that the Surgeon General's standards that were put out weren't quite mature enough, etcetera, etcetera. And so, remember that we hoped that there would be refinement, and maybe Leslie can speak to it if it's part of the S&I Framework, for – that it would continue to be refined during Stage 2 for Stage 3. But that John Halamka also said that always as a backstop, you can create the functionality to do something, but the vendors may not do it in exactly the same way and that's what we were trying to avoid. So, it's already in Stage 2, and my guess is folks would be using the Halamka approach, for lack of a better word, but that our intent was that by Stage 3, when there's more experience with the standards, then it would be able to be refined in time.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So I'm just not aware –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

The researcher community – yeah, go ahead.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

No, go ahead. Do you know whether there's any work –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think that Christine is right. The people that are most concerned about whether this goes forward without the structured data is the research folks. And so, it was one area of concern that I think that Becky Kush brought up in the Standards Committee about how do we get this more structured. So maybe this is a task that we need to make sure that the Standards Committee is following through on, and that the certifications and test scripts around this are very specific, but the use can be consolidated.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Can you carry that message over the Standards, by any chance?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Uh huh.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Okay so –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well and I think too, there should be a formal – a little bit more of a formalized process for us to take.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Okay.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

Yup.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yes.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

That's fine. But I'm not aware currently, and I haven't heard on this call, that standards have progressed. So that's one of the reasons we had a certification criteria. I think most EHRs have a way of capturing family history, I just don't know that it's interoperable, to my knowledge, it is still currently not.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Correct.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

It can be used inside, but it's not as if we can blaze ahead and say, well, then we're going to – we can't force the issue, Standards Committee can do something. So we can request Standards Committee help on this, but I don't think we can do something and require something that doesn't exist, that would be –

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

So Paul, this is –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well, but we did it in Stage 2 –

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

– Charlene –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

– so I'm not – maybe I'm not following you or Charlene has more to add.

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

So, I think Paul you are right with your assessment, there is a lot of variability today in terms of how family history is captured. Some people are kind of proud of how they're accomplishing that, and I do agree there's going to be certainly the provision and the timeframe – for patients to enter some of that data, that's all going to happen. So kind of in light of that and the standard in Stage 2 again, it's a – it's no – it's a menu item and it's starting to send some boundary conditions around it. I don't think we've got a lot of experience with that standard that came out of HL7, it was kind of a late add so I don't have a lot of content on it, so I think we've got some learning to do.

But, if we follow the strategy which Christine was proposing, where we're really looking at that content that gets shared and ultimately that becomes standardized in some form, then vendors have a lot of options. We can capture it in whatever form we want and map it to the standard. We can capture it right up front in the standard and then apply it. So, I think thinking it through and using it as something that's consolidated, and in that context it becomes more robust and standardized over time, makes a lot of sense. So, I can't give you the answer that it can be done in this timeframe, because of what you talked about, but it seems like the consolidation approach might give us a nice pathway to get there.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So you're in support of keeping it console – keeping it on the radar, keeping in meaningful use –

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

Absolutely.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– but keeping it in a consolidated way.

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

Yes. Because then we've got flexibility if you want to have a vendor with a ro – a lot of different ways to capture family history and wants more data and all that kind of stuff, you're not constraining that, but what you're constraining is what data – the data that you want to share and potentially use for research.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So, I understand what Charlene is saying, and I get the logic completely. I think the only question I have is, that I think that is exactly what we are doing in Stage 2 already, so –

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

A standard is just a guardrail...I've had feedback that the standard is not mature, it is a menu item. I don't know what the results are going to be in Stage – coming out of Stage 2.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I see. So, is there –

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

Remember, we didn't put it in Stage 2, it was added later, after – you know, because of the standards issue.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So is there – so does it make – I mean, does it create any additional visibility and focus by pulling it out, instead of having it be consolidated. That's my only question. I'm not sure.

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

Umm –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike, can I –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

The vendors always have to do it –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah.

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

And most vendors have family history in their system, it's just mapping it to the standard and it's – and again, the focus has to be on creating the standardization. And it may not be all the data elements in a family history, which is okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

But I think this is the – this is an enabling objective or – yeah, going to use the word objective generically, and what we're doing is we're making sure that every vendor has the tool in their system. So that every provider has the ability, in particular to do CDS on, and I think, as a certification criteria that's part of VDT or care – in one of – in a consolidated way, still gives us that.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike. Can I weigh in from the sort of other end of it, from the – the certification and standards part I understand the issues with that, I think. From the provider end, and I'm new to the group so I don't know if this has already been covered already, I apologize but, the notion of – as my patient's want me to record it because they think it can affect their health. I need to record it so I can, to Paul's point, get the CDS or reminders that I need to keep that in mind when I'm thinking about diagnosis or management thresholds, etcetera. My concern in watching docs focus or not focus on meaningful use is, when something is a relatively new requirement, having it stand out as a distinct measure that they can keep in a manageable list that they know, okay, for now, until this becomes muscle memory, especially if it's a new EMR feature, but even if it's not, I need to really focus on my family histories, make sure they're in, make sure they're staying in and get feedback if they're not. When they become consolidated, they get what I would call "lost in the weeds."

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

In other words, I find out I'm not doing well on this consolidated measure, but I'm giving people an after visit summary and I'm letting them view, download and transmit, why am I not meeting the measure. And somebody says, well it's one of these various consolidated measures that they're going, what? So, in other words, it's so far off their radar screen that it takes time even for them to realize that the reason for this is that they're not recording family histories. So especially until we're sure that basically everybody's doing this as part of muscle memory, I would be hesitant to have it get lost and have to try to tell my providers, remember family histories are really important, even though you're not seeing them as a discrete measure. Does that make sense?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

It makes a lot of sense.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Because I'm seeing some of –

Christine Bechtel, MA – National Partnership for Women & Families – Vice President

I mean I'm perfectly okay with leaving it separate in the sense that I think it's probably the safest thing to do.

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

Okay. It works either way, but –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Because at the end of the day, the physicians still end up seeing it as a measure. I know we're trying to consolidate to make it look like we're decreasing burden and so on and so forth, but it's still something that has to be done, and so –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Correct.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– when those of us are tallying it up at the end of the day, it's still more stuff and so the key is not to hide it until it's so much a part of muscle memory it's not an issue.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I think that's actually a very strategic and wise approach.

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

So, this is George. I guess I was concerned that a lot of people don't – I think it's best if we pick the important areas in the family history, so in the red there is cardiac, breast and colon. And then it's just odd to have ophthalmologist and dentist collecting that for every new patient, and then I guess we need exclusions or something, and furthermore, we're not actually asking them to collect the ones that are relevant to their specialty. But, we really are trying to do the conditions of high priority, because we want to be consistent. It depends on whether you go for the population goal or the individual goal. So that was more my – so I was okay with not forcing use, but have it truly be certification, in which case it then addresses your concern, this doesn't feel like a hidden objective, because it really is just certification and only if you use it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So, I wonder if there is a compromise of keeping it menu, so it does – it's in your face and one way you could look at it is, gosh, as a primary care provider, let's say, we do this anyway, it's important. As a dermatologist you might not find it, so you don't pick the menu. The – what's men – the latitude that menu gives us is, it helps adjust for all the different specialties while keeping it in people's face and clearly it's also a certification criteria. That's one way around the –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Paul, I – this is Christine. I like that approach in theory, because what I worry about is the burden on consumers of always having to provide that, even to the ophthalmologist or whoever that it may not be particularly relevant, but they have to do it. And now, from a consumer viewpoint, I've done it 35 times, and it's getting annoying.

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

Right, but –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

But on the other hand, what – the only thing I do worry about with a menu approach is that it – I'm not totally confident that it's going to be selected as menu item. When I look back at Stage 1, it was really mostly the patient and family engagement pieces that were the least selected. So that's my only hesitation, but I do understand the menu approach, because it hopefully is useful, but we definitely need to keep it as a certification criteria so that people can link to decision support for sure. So I'm not sure how to approach my concern or if there's some other alternative, but, I am leaning towards a menu type of approach, so that it stays visible –

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

Yes.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

– people know it's out there, it gets standardized so hopefully the providers can start sharing family health history across – so consumers don't have to do it every time. But I'm a little worried that nobody's going to pick up on it.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike. As a primary care provider, or just with all the doctors I deal with, this is the thing that would give them the least heartburn about having to do this. They know since medical school they're supposed to record family histories, so I don't think that's the pushback. I think if anything, we attempt maybe to make it easier with things like first degree relatives, in some ways might make it harder, because the clinician may decide what's the most relevant family history and if it happens not to be in a first degree relative, then so be it. But – and I think there is the issue where there is an advantage to say, high priority to the provider, the specialty or whatever, I think we could talk about national priorities if we want to. But they'll feel most empowered if they can decide what they put in, as a priority issue. You're basically saying at the end of the day, you need one or more entry for one or more relatives, whether first degree or otherwise –

Christine Bechtel, MA – National Partnership for Women & Families – Vice President

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– it looks like it'll be first degree, and that's evidence of use that does add value and we learned that in medical school, so it's a little hard to argue.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Christine, my response back to your concern, that I think 7 years into it 2016, that the world's a different place and we use certain levers like menu is pushed to core in Stage 1 and 2, by Stage 3 already today half of the physicians in the country are using these things. So they're going – it's already part of their system and their going to use family history if it's of use to them, and I don't know that we need to make it core and cause the dissatisfaction where we really didn't intend it, let's say in dermatology as an example.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah. I mean, I get that Paul. But, I'll say again, a) we've no guarantee it's going to be a different world, I mean we've been fighting over fee-for-service and shifting it for a hundred years or whatever. But, I think the thing that is helpful to hear is Mike's point that this is actually something that clinicians want, they get the value of it, they want to do it and now we're making it easy. So I think given that, I'm okay with it staying menu. I think the argument you're using is typically one that we use when something has also been core for a while, and that's my hesitation. But, I'm okay with it saying menu, now that I understand a little bit more from Mike about clinical practice.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Well, that's – it's that people are now used to using an EHR, it has nothing to do with even health reform, it's really, this is what you do as a doctor, and now that these people have the tools, they're obviously going to use it.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

I think that's right.

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

Okay. So we have to come – so for now, do we want to just put down leave it with the red change and make it menu, for the time being?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I think that's right so it's not consolidated –

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

Not consolidated, but it – so it is a use, but it is menu.

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

You will have family – family history is on view, download and transmit, right?

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

Yeah, I would think so.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

But if it is, it wouldn't be – like in view download today, if you don't have, for example, allergies filled in or some exclusion for them, then it doesn't count in your numerator. So family health history would be treated – would not be treated that way.

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

It's not a mandatory.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right, because it's a menu item, so it wouldn't be mandatory in view download.

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

Yeah. It would not be mandated there. Okay. All right. Very good. Let's go to 120, electronic – is everyone okay with that for now? Okay, next is 120, electronic notes. We just did some clarifications. The request for things like – first of all, whether it's menu or core. Our intent was to make it core, remember, we had our hearing and that was our main conclusion from the hearing. The Standards Committee says retain as menu set. I don't know the context of that, but we decided to again to stick with the hearing, which said make it core. Oh, I'm sorry; it looks to me like these comments got attached to the wrong objective. These are comments that were intended for family history. They're just sort of under the wrong one, so I take that back, that was not about electronic notes, I think that was an edit problem. Okay, so otherwise, and we kept it as 4 business days, someone requested 4 calendar days; we decided to leave it at 4 business days. There was a wording about unique office visit and we left it as unique office visit. So really, essentially had no changes on it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

By the way, the 4 actually we did think of, I think when we created the number we thought of it as calendar because that's...the reason its 4 is because we would have shortened it, is because of weekends.

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

You know what, maybe we changed it and that is not marked in red, because I'm reading, the comment says change to 4 business days from 4 calendar days. So, let's decide now, do you want 3 business days or 4 calendar days or leave it as is?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So I'll just weigh in as a former residency director and primary care physician, I have great difficulty trusting notes that are not completed soon after they're done, let alone 4 days, let alone 4 business days.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

It's really ugly when you're going from memory that's that old.

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

Okay. So, good. But we want to be consistent. So it seems to me Paul that 3 business days is our usual.

M

Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Actually, I thought it was 4 calendar, which is – could be only 2 business days. It's almost – 2 business – if you wanted to do business days, then 2 seems reasonable, by what Mike just said, too. One is your – it just becomes irrelevant, 2 – the time when somebody else, whether it's the specialist or the patient needs it, is within 2 days, not a week later.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

So I do remember there's something about if you don't do it that day, what's the next day and if it's a weekend, so if it's Friday, then the next day is a Tuesday if you have Monday off. That may have been – so then, Saturday, Sunday, Monday, Tuesday.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Then you will have really forgotten your content by then. Both of the large organizations I work with have 2 business days as the rule.

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

Well, I'm happy to do whatever the group decides. So do you want – I'll put down 2 business days for now.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Well 4 calendar days I think would work for that too, which is what Paul said, so –

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

Change to what –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah I said –

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

So keep it 4 calendar?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So change back to 4 calendar.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

From a patient's point of view, it doesn't matter whether it's a business day or not if they're waiting for something.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right.

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

Change back to 4 calendar days –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– the disease process goes by calendar days.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

Yeah, take a break for the weekend –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right. But – remember we're also toying with the idea of open notes. Just 4 is a long time.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah.

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

All right, so I'll change back to 4 calendar – I don't know when we made the switch, apparently, at some point we made the switch. Okay. Other questions on this, otherwise, we're basically leaving it alone.

Okay, then the next objective is hospital labs, 121. The Standards Committee had asked us to explicitly state it would be LOINC. Normally we don't name standards, right, we leave that to the Standards Committee –

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

George Hripcsak, MD, MS, FACMI – Columbia University – Department of Biomedical Informatics
– but the Standards Committee asked us to stick it in, so we stuck it in. CMS may take it out, but we just followed their request. And then the threshold, the recommendations were something like 20 percent and 30 percent for the request, so we kind of compromised and went up to 50 instead of 80. But then we felt we should review the threshold based on adoption in Stage 2. Comments about this one? Okay, next one is test-tracking, number 122. Let me go there hold on. So, there are several clarifications and a question. For the EP – and they also asked why we're doing it. So we clarified first of all, this is for EPs. The EHR is able to assist with follow up on test results to improve the management of test results. I guess that sounds, now that I look at it, it looks more redundant, but I think the request was why – the intent of the measure. I think we could probably do better on the intent – to reduce errors from missing results is really the intent.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike. I don't know how much people have had a chance to talk about this, but the really thorny thing for this, from my perspective, is that test ordering is not a precise science in terms of dates. There's anything from whatever in a patient-centered way is most convenient for you, any time between now and the next visit is fine with me, or any time in the 2-month window between it. But if we set an expected date and it's not done by that date, or if we set the date too far in one direction or the other, the lab won't do it because it's outside of the window of their policy. So to me, it's really hard to know when a reminder should come, if I really allow for a relatively large window for routine tests.

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

Well what we said, as you can see from the certification criteria, it's to notify the provider either when the result is available, whenever that is, so that's easy. Or when not completed by a certain time, which in this case – you know, it depends, if you want it before the next appointment and the next appointment I guess is the time, that doesn't work so well. Versus someone you see, someone you want to know now what the answer is, so then you give them one week.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, the problem though is the systems often expect a date, then the lab uses the date to say, you're either too early or too late to be here. And then the system uses the date to decide whether it's late or not and/or whether to even cancel the order because – or this can only stay live in the lab system for a certain period of time. Or they have to either be automatically canceled, so as not to overwhelm the lab, or they end up being a reminder that's not relevant.

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

Well the part of it that reminds you that a result is back and is abnormal, it's okay. They asked for clarification, which is that abnormal is determined by the testing facility. But to be more specific on the not completed by a certain time. I mean, that's almost like an additional field that would have to be entered during order entry.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

It is actually.

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

And you're saying for some labs that's required but for others – I don't – do all order entry systems allow you to give a range, like before this date or between this date and that date?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Not that I'm familiar with. And again, for me it's almost a patient instruction piece. Here's roughly the time period that makes sense to do it, but I don't really care if you do it one or two months, whenever you're back from up North or down South or whatever it is, do it before or after, it's all fine. But the lab, once it gets a date, is bound, very often by policy, to do it within a certain timeframe or it expires.

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

I just realized the tests that we're trying to – the errors we're trying to fix here is when you say, I want you to – I see a problem, I want you to get this test in the next week, not before your next visit, but in the next week, and I want to be reminded if they don't do it. On the other hand, if you say, just get it sometime before your next visit a year from now, or two months from now say, you don't even need the reminder because the reminder is the visit when you go back on your previous visit and say, oh, we ordered this, did you get this? So, it's not going to fall through the cracks as badly as the one where you say, get it within a week because I'm worried about you.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

So we may only need to address that first one.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right. So you can see the relevance of the use of clinical judgment to determine when a test needs important follow up. In other words, highly relevant to near term care versus part of the routine that you're doing for medication management and disease management and so on, when the precise timeframe doesn't matter.

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

So what we're doing is, the EP measure is to acknowledge results within 3 business days of when it's performed.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Why is it with perform versus resulted?

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

Uh, that may be a mistake.

W

It should be resulted.

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

Let me write that down, that may be a mistake. But the certification criteria gives the ability to check that the test wasn't done, which is a slightly different thing.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right. And all I'm suggesting is the first one is spot on, everybody realizes it, it's just not everybody is doing it and this will help them be more diligent and vigilant about staying up to date on their lab test reviews. The other one is the one where it gets really thorny really fast, and you could end up with a huge burden of nuisance overdue lab results when you're – in fact, I deal with it now, really, when it really didn't matter that it isn't done yet.

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

Well my point is, we're not measuring on that. So what I would expect is, that that's the option when you write the order, it says, you can say that it's due by this time or not due by this time –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Um hmm.

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

– but we're not taking a denominator and measuring how often they actually do that.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

I'm very sympathetic with Mike. We have this problem, the problem that Mike's talking about, I wonder if the new certification criteria is really to give us the option to mark something as due by such and such or else, and I really mean it. In other words, so the problem that Mike raises is, you have to generically set for all labs, they're due – they're within the range – this is the window where you can get the blood drawn, and this is when it expires and this is when I'm expecting it, but it has all of those problem sets you talked about. What we really want is, when I really want something because I am thinking about something serious, or I really need to know, can we check a box and say, tell me if it's not done by this date.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

That's exactly right Paul, and that's exactly what I do in my system all the time is I send myself a future note of some kind or whatever to say if the results not in the system by this data, I'm calling the patient.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So, see that's his work around. And so we all have work – wouldn't it be better if we just – that's the clinical problem to solve, let's put a certification requirement in that says, we have the ability at the front end, because we know at the front end to check for overdue results. And that satisfies the alert fatigue problem and really gets me what we need.

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

So, this is Charlene. We had this same conversation in the care coordination session, but it was around referrals –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yes, exactly.

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

– and we got into the whole – it was a really complex conversation, but we got into how important it was to track statuses. So if this – that concept could – if this concept could be extended to also relate to referrals, I think it will help me some in the care coordination aspect, too. If we can start to make that consistent across, so all – that's just – I know it's not our conversation today, but it's the same concept we're talking about.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

It is.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Great, great point.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

We're basically – it's really our own care coordination and –

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

Right. Right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– yeah. And this is the same thing, this is coordinating care, even with myself, but I need to coordinate with some future event. So that's a new functionality that I think we could do a service to everybody, because everybody's got their workarounds for this.

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

And then maybe I can make that parallel in the other workgroup.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

It's a very analogous, because Charlene, you're expecting a "result." Your result happens to be a consult note, somebody else's could be a Social Service – we have an action that we really – that's timely and we're expecting a result. And that's really our care coordination, whether it's with yourself or not, kind of a function.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Spot on. Yup.

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

So do we need – I mean, that was my reading of this in the first place, so what do we need to change in the phrasing?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Well it's a separate sentence. So, EHRs, instead of HRs, EHRs must have the ability to identify abnormal and get that back to us, that's point one. Point two is that we need – so providers need the ability to indicate a due date for which the system reminds us when something has passed that due date, and that is the due date for any result, it could be a lab result, it could be a referral result, it could be any other consult result. It could be a patient getting back to me.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yup. And that's a very – this is Mike – very simple approach to it is to be able to say on any particular thing I'm ordering, I'd like to know what's the overdue date for it –

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

Overdue –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– that I'd want an alert about, right.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

And there could be defaults set, during the build –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yup.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– but then I can edit it.

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

Okay. So that's good. And then the second question was, do we want to broaden this beyond laboratory results?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Well, I mean it'll just show up in multiple places –

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

No, I don't mean for your part to the due date, I mean for abnormal.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Any test result, any report where you're asking somebody to go out and have some evaluation done and you want the report back, it should be an option.

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

Well, my concern – not an option for saying the due date, an option for getting an alert saying that it's abnormal –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

– need to make sure that there's a way to tell, other than having someone read it. In other words, if we broaden to images, are they flagged appropriately to determine – so the EHR can determine which ones are normal and which ones are abnormal.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

I see what your point is, but I think what we're talking about here is we need the result whether it's normal or not. So these are high priority tests that we're doing; if it's normal it's great, but I need to know it's normal by this date. If the –

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

No, I'm not talking about the – I'm talking about the first half – that the provider has an option to set a due date, so I agree with that. Now we go back to the whole objective –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

– and the objective is saying EHRs must have the ability to identify abnormal results. And the question at the top of the screen is, should we broaden this objective to images, beyond laboratory tests? That would mean that for all images, we have to mark the ones that are abnormal and send the ones that are abnormal, like even the low priority ones.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So are we talking about the measure or the certification criteria?

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

Measure.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Okay, because in the measure I don't see anything about abnormal results, I just see results. And I would endorse that, any results you get, you should be reviewing them and getting them off your desk.

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

All right, we need to be careful. So do we mean that 10 percent of test results, what's the denominator for that?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So I would have assumed it's any result, lab, path, rad.

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

So test, which is not unreasonable, so lab, rad, path, of course some people would say cardia – whatever. We could start there.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

That's why an order entry is –

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

I think – with orders.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah.

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

Now when the test was resultated, its past resultated.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yup.

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

Okay.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

It may or may not be structured, it may or may not be easy to have a data field that says it's abnormal. Radiology, some of us have our BIRAD score in so we can mark those as normal or abnormal, but most of them are reports. Nevertheless, normal or abnormal, we should be reviewing them within 3 days of receiving them.

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

And then – and I agree with that. And then the certification criterion, the ability – EHRs must have the ability to identify abnormal, as determined by lab test results. Is that only for lab tests for now?

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

I think that's probably all we're ready for. Does anybody have a sense of whether anything else is, other than the pathologist or radiologist working in a system and checking a box to say whether this constitutes a normal or abnormal? I don't know of one, I mean there are a few examples, but I couldn't apply it across, for example, all of imaging studies. I could imagine bone densities and mammograms being capable of doing that –

W

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

– I have trouble getting radiologists to say any chest x-ray is normal.

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

Right, right. All right, because there is no out of normal bounds for a patient.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right.

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

So the test in the measure will be lab, rad, path. We'll change perform to resulted. Abnormal is just for lab tests and then we're going to break out the second half of the sentence to a separate bullet that says option to provide a due date for when a result is due – any result that would apply to.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

At the ordering time.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yup. Perfect. That's –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

I think we need to be a little bit – we need to be precise and explicit in terms of what we want. So it's for the ordering provider to be able to indicate an overdue date.

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

Yes.

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

Right.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yes.

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

Okay. Next slide. Here is one of the – here is our new objective. There wasn't consensus on this one either. It's basically an item that had been sent to us from several sources about device identifiers. When patients have an implanted device, should the EHR be able to record the specific identifier for that patient, and there's progress on standards for that. So –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

So my only comment there was, is it required here. So the question I asked was, for immunizations I know we record the lot number, I assume that's because somebody – one, it's a good idea and that two, there is some regulation or accreditation that requires that. I'm guessing the same would be true for implantable devices, does anybody know?

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

This is Les and Joint Commission requires that you put a product number and lot number, but not a device unique identifier. However, F – CMS and FDA are working to require the unique device identifier, this has been out for public comment, it's been accepted, that is a rule going forward. But, there's nothing then to correlate that back to make sure that the EHR is collecting it. So we want to align all of these things, so that it – we have uniformity and harmonization across all of the requirements. So the question is right now being discussed of a unique identif – device identifiers, what should be required within the EHR, is it just implantable devices or beyond. The low hanging fruit was for an implantable device, and the latest hip recall was one of the examples cited, because that actual – the lot number would not give you enough specificity to know that that particular device was faulty versus this other, because a lot could be manufactured in several different – consisting of – or something. So this is an effort to harmonize device ID requirements across multiple regulatory efforts and make sure that the meaningful use requirement also covers this.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

My point though is, there's a ton of things we could do, and if there's already a requirement, like for example, we could put immunization lot numbers, we don't because it's already done. The vendors will – if it becomes a regulation like you suggested, then the vendors are going to do this anyway –

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– we don't have to use one of our meaningful use chits, that's the point.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think, Paul, one of the concerns was the automation of this. These are quite detailed ID numbers and so forth and so they were hoping, just like we did with medication reconciliation, it's bar coding or scanning this that adds – the unique identifiers can be scanned in as a requirement of MU. So, I can go back and get more details from Terry at the FDA, who's working on this.

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

I mean should this be –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

This not exactly my deepest area of expertise, but David Bates I know weighed in on this with strong support, so we might want to re-talk to him as well. But I thought that we really needed, at least certification only or whatever, but we needed the UDI in order to facilitate home monitoring, etcetera, a much broader sphere of things. So the FDA –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Exactly.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

– reg is going to say you have to create the – do you have to create and offer up the identifier. But the identifiers need to be in the electronic health record.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right. And also for the patients, the patient will have access – they would get access to this if it's required in the electronic health records.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right, which is the big – Hugo Campos, who ONC has invited to speak several times about his – patients need to do that and so – but that the key is really get the UDI in the EHR.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Right. It's the –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So I don't think this is using a chit at all.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I agree.

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

It's the UDI, it's the tracking of the UDI, it can come and go, all those kind of things, so –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

So how would this work within the EHR that would make it useful for the provider?

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

I mean is it a field that says, list all devices the patient has, including what their total hip was and what their total knee was and what their pacemaker is and whatever, and it would be searchable. Because I mean to me, the only function would be if we could – if there's a recall or there's a – or something that you'd want to be able to kind of search through your entire patient database to figure out who has this particular device.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

It's searchable for safety purposes and then also for maintenance, like battery issues going forward.

Christine Bechtel, MA – National Partnership for Women & Families – Vice President

And it's also – I think – I don't think we know enough about it to – I mean, we've had comments on almost every single workgroup in Policy Committee saying we need this, we need this, we need this. So I would be very worried about not including it at this point, in the absence of some compelling reason. But Pew Charitable Trust and a number of other folks, West Health, they've done a lot of work on this and they've all – I mean they testified before Congress and clearly said, you need UDI in Meaningful Use. In part because it also opens some of the data so that you can more seamlessly and in a more interoperable way, receive data from home monitoring devices, the clinical data, not just for identification for recalls. So I think –

Neil Calman, MD – The Institute for Family Health – President and Cofounder

So it sounds very uncertain –

Christine Bechtel, MA – National Partnership for Women & Families – Vice President

– our first – see some work on research on this before we make a decision if there's – I mean, I would like to see it in as a certification requirement as a minimum, but if there's not agreement, I would suggest we do a little bit more homework here and maybe invite somebody to talk to us about it.

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

And George –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

No one has given us a compelling reason not to do this.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Agreed.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

But as certification, but I guess – are we not, we're not talking about this as a meaningful use requirement?

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

No.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

No, we're –

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

No, the proposal is, as a meaningful use requirement, yes, a use requirement. I don't know what the denominator or numerator would be, I guess it would be percentage of devices that you've installed or which you've put the device identifier into the EHR.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

That sounds ridiculous to me.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I think – I would say, I don't think it's a core requirement, obviously, it's like family health history, but in the reverse, for specialists.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

But we're not –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Again, I don't know enough about the details of this to know whether it's – it should be – there should be a menu option use objective or not, but I think we should get more information. But at least agree its certification.

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

Charlene. To put it in sort of frankly, you've got to build us some use cases around this. Because it's – not disagreeing that potentially it can be stored there, but it's got to be stored and managed, it can't be just stored, right, because these things change. So there needs to be some use cases around how it's stored and what you expect it to do, what you expect it to do.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

So right now there is a requirement to record product and lot number. So we record SKUs from – if anything has been implantable, but this is getting to the unique device ID, so that we can start transmitting information unique to that patient. Now, I don't think it is ridiculous, if you put an implantable device in a patient, to know which one it is, and to be able to search for patient recall issues, to be able to –

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

But it can come and go, an implantable device. So, you just have to have some management around it. Like once you've had immunization, you've had it, but you manage implantable devices in a different way.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

If they do have to be extracted.

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

So maybe what we should do is, David really was the one who put this forward, why don't we get some input from David, because you don't want to just cut that short, he's the head of the subgroup. And then think about what it would look like, what it would feel like to a prov – obviously, the fact that your patients have all these devices, the primary care doc can't do anything about it, they're not going to open the patient up to find the ID number. So, it's the specialist who inserts it, do they put that into the EHR and – so it either should be certification only or menu.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Or EH. No, I guess – I guess it's those, whoever's doing the implantable, that's true.

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

That's a good point.

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

Can it go in ambulatory sites, so it's not just EH –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

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

It's not just EH, but EH could be – theoretically.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Leslie you said that you're required to have the – and the lot number, who requires that?

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I believe it's a Joint Commission requirement and so there is requirement for documentation today. Now we're just trying to say that something is unique inside that patient, we have a responsibility to record it, and have it done in a way that's findable, so that when things are recalled, or when things are sunsetted, or when things need to be maintained, we know which patient needs to be addressed. So it's a big patient safety issue.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

This should only be a requirement for the person who puts it in. I can't imagine this is –

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

Correct.

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

Right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

– as a, well, but an ambulatory – that's not an ambulatory care thing that happens. People don't insert these devices in a doctor's office.

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

Right.

Neil Calman, MD – The Institute for Family Health – President and Cofounder

They insert the devices in a hospital or an Am Surg Center or something like that. So I think it makes sense to have that information available and searchable. I don't think it makes sense to have it as a meaningful use requirement for providers, except for those that are inserting these devices.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right. So this is Mike. We have the Joint Commission here this week, but I think one of the things that we might look at is to say, yeah, it's really fundamentally the hospital or ambulatory surgical center that has the responsibility to make sure all of its providers are doing this. And so, I don't think the hospital would have – at least our hospital, would have much heartburn with that notion that says, we agree, we're asking them to record as much as they can about the device now, and if we had better standards to do that. Then we were accountable for it, it wouldn't really be different than our accountability today, we would just have perhaps better information and more retrievable information to work from.

Marty Fattig, MHA – Nemaha County Hospital

Yeah, this is Marty. We have a completely electronic medical record now so we do need a place to record these things, since it's required. It would be very nice to have this as a certification item so that we would have a place. And then, of course, once it's recorded, then we can do all sorts of things with the data.

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

All right. So I think that we need input from – so let's – it's going to be either certification or more and the focus is stronger on EH and we want some input from David and perhaps some other input.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

George, I have a question.

Leslie Kelly Hall – Healthwise – Senior Vice President, Policy

And just – this is Leslie – and by nature of just saying who have an implanted device, if I'm a physician who I'm not implanting, so then it wouldn't apply to me if we create the language. So providers should record the device identifier, when placed – placing implantable devices in patients.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

George, this is Art.

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

Um hmm.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Yeah, does this apply as well to intrauterine devices?

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

Hmmm, don't know.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

That probably doesn't have an ID, right, it prob – it has a lot number, I would imagine.

Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics

Ah.

Leslie Kelly Hall – Senior Vice President of Policy – Healthwise

I think that gets back to the definition of UDI that's good, has come forward under the requirement. So we'd have to do some research on that one.

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

In fact, maybe we could ask David to phrase what the objective would look like, since this is too vague to kind of judge. This is like the concept, not the objective.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

And for me, this is Mike, I would just say it's not about the who records it, it's about making sure it's recorded.

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

Okay. All right. So now let's go – now, what I'm going – well, after this we have our consol – if we can go – is that okay Paul?

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

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

Let's go forward, one, two, three slides. I'm just going to go quickly through this, because we need to end very soon, and if – we might need a future meeting to just finish this off if there's any further discussion. But for now, let me just give you the lay of the land. These are the consolidated items, to tell you kind of where we ended up. So, CPOE, it was suggested that it go to certification only, and we agreed with that and didn't make any changes to the certification criteria that were left. Next slide is ePrescribing, 103, and again, we agreed with the certification and didn't make any other changes.

Next is demographics, which is to certification only, but we added in that certification component, add preferred method of communication. And there was a question about disability status versus functional status. We actually felt they were different, the disability status being the more formal, legal thing and functional status being the more clinical assessment that would go in your notes, so we requested that it stay disability.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

That's correct George.

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

Okay, good.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Because – yeah, the disability stuff is more around what disabilities do you have, so that you can then deliver either care or communication channels or whatever that are concordant with that.

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

Yeah.

Christine Bechtel, MA – National Partnership for Women & Families – Vice President

So, but I think the question is, for the same reason that Mike kind of raised earlier, which is, if you consolidate SOGI, I mean, well, SOGI I think was going to be optional certification. But I wasn't sure about occupation industry codes, disability status, for example, because if the whole demographic set gets consolidated, then it's harder to have eyes on the collection of that additional data. But can you remind me if disability status and occupation and industry were certification only in the original proposal?

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

Ah, let me see what I have here. Hold on.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah, I'll pull it up too.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

In the meantime, this is Mike. My other question is, like we talked about consumers yesterday, the question of preferred method of communication for what kind of communications, since that can vary by the type of communication, appointment reminders, lab results, etcetera, etcetera.

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

So this is Charlene on that one. Today, do you have like the patients fill that in? I mean, I think we've got to be thinking a lot of this – all of these – family history – this is going to be a lot of self-care, people are going to like...because I was worried yesterday when we talked about it again, the degree of, they're going to want different kinds of communications for different things in many cases and just like...do.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

So we went down like a huge rabbit hole on that yesterday, and we said we were going to come back to it in two weeks, so I think we should – it's too difficult of a –

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

I'm okay with that Christine.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Yeah, I just wanted to raise the flag on it to make sure that this group is also thinking about do we mean it in this context too as a recording demographics.

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

In answer to your question Christine, I have Michelle's spreadsheet, that's what I've been looking at, and it looks like we did not make it use, but when made it –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Right.

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

– when we consolidated it to certification only, we left those as certification only, that is, optional. For disability it's so rare that the answer's going to be yes, you can always count the 90 percent of patients who you didn't say anything on, so, I'm not –

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Well I think – I'm looking actually George at the original RFC and all three –

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

Then it was – oh, okay, go ahead.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

– all three were certification criteria.

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

Okay. So that would disagree with that.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

I think the only like new piece – so, there was reg, race, ethnicity, language, gender, date of birth and date of preliminary cause of death in the event of mortality in the eligible hospital or CAH. That was only an EH objective, that was in the original RFC. And I think that was – actually, it's Stage 2 Final Rule. So –

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

Yeah, so the subgroup is suggesting that we leave it as certification only.

Christine Bechtel, MA – Vice President, National Partnership for Women & Families

Yeah. Okay. Thank you.

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

Okay, next slide is problem list. That's ability to update, we put that into CDS, remember, we talked about that already. Whereas for medi – in the next one, medication list and allergy list, we decided to remove for now, that is, let's get the problem list updating through CDS. Theoretically they could do the others as part of any CDS that they want to do, but also limit it to a problem list. The next one is 106, so the next one is 107. We removed those also – the option of doing CDS.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

So this is Mike. Problem lists are sort of one of my key issues in my sense of quality and career and all that, and I don't want to open a can of worms. I just want to sort of declare the issue, which is, to me, we lost an opportunity on problem list to actually get them accurate, complete and up to date by basically setting the standard for one or more and then removing it from a measure. So I don't know that we're doing anything to make sure that they're accurate, complete and up-to-date. Can somebody help me with that or maybe we could take it offline and talk about it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Well the goal – actually, we – so we kept it on for Stage 2. It was – CMS removed it, put it into summary of care –

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

– even though we actually telegraphed that we wanted to maintain it because our intent was in Stage 3 to make it complete, accurate and up-to-date. We then also put in a proposal to make it a special objective for that exact reason, and then it got consolidated into CDS because with some reason in the sense that CDS was the way we were going to support the physician keeping it up-to-date and accurate.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Okay, well that background helps me at least know where this group landed and how it ended up, so –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

If you have any special measu – an idea, because we use this manually, in other words, you have peer review of your problem list in health maintenance. If there's an automated way of doing that, that would be a good opportunity to bring it back as an up-to-date problem list kind of objective.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Okay. We do have a couple of tools that we use, in terms of when it was last reviewed/updated, when it was last assessed, whether or not it could be considered duplicative, etcetera. So, there may be some opportunities, okay.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah. If you want to – but that's – we've always had – we've had similar views.

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

Paul, this Charlene. One of the things –

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

Will you hold on a second. So Paul, I'm going to need to sign off –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

And we have to close the call anyway –

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

Oh, okay.

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

And so let's, the rest are just retired objectives, but there may be some other comments. So on the next call, we can just spend –

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah.

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

– some time going over the end of it.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Great. Charlene, do you need to say something or are we going to –

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

We're trying to – just to give people a little comfort, whether it's up-to-date right at the point of care, but clearly if you're going to like discharge a patient, there needs to manage the data around the problem list so it looks okay for a patient or for another caregiver. So there's work on behalf of the vendor community to try and put some governance around the populating of problem list, but it's still not the same focus it would get if it were a separate objective. So, a little comfort there.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Yeah, but I would agree with Mike, problems, meds and allergies are some of the 50 highest value things that are in the EHR and if we had a way of supporting its maintenance, that would be great.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Right. And I'll actually just toss one concept really quickly. I'm a big fan of the twin list thing that was done as SHARP C by Ben Shneiderman in the group around medicine, so imagine if we did the same thing around problems with various criteria that help us distinguish duplicates and similar and clean them up and make them visible and so on.

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

Yup.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Why don't you give it a little bit more thought and you can talk to us at the next call.

Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Sparrow Health System – Vice President & Chief Medical Officer

Sure. Sounds good. Thanks.

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

All right. I think we need to open it up for public comment. Thank you very much George, I don't know whether he's off already, but that was really nice to walk through and I think there were some updates, good updates that we made as part of this call. And thanks, as usual, for the healthy discussion. Can we open it up for public comment please?

Public Comment

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

Operator, can you please open the line for public comment?

Caitlin Collins – Altarum Institute

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

Paul Tang, MD, MS – Palo Alto Medical Foundation – Vice President, Chief Innovation and Technology Officer

Okay. Thank you. Thank you everyone for joining this call, it's very, very helpful and look forward to talking to you again.

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

Thank you.