



## HIT Policy Committee Quality Measurement Task Force Final Transcript July 21, 2015

### Presentation

#### Operator

All lines are bridged with the public.

#### Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good morning everyone, this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Quality Measurement Task Force. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. Kathy Blake?

#### Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association

Here.

#### Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Kathy. Cheryl Damberg is on vacation. Dan Riskin? David Lansky? Elizabeth Mitchell?

#### Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement

Here.

#### Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Elizabeth. Floyd Eisenberg?

#### Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC

Here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Floyd. Frank Opelka? I thought we had Frank.

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

Can you hear me?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah, thank you. Ginny Meadows?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Did we lose Ginny?

**Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies**

No, I'm here; can you hear me?

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Ginny; yup. Jason Mitchell? Joe Kimura? Lori Coyner? Sally Okun? And from ONC do we have Stephanie Lee?

**Stephanie Lee – Public Health Analyst – United States Department of Health and Human Services**

Hi.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Stephanie. And Samantha Meklir?

**Samantha Meklir, MPAff – Senior Policy Advisor, Office of Policy – Office of the National Coordinator for Health Information Technology**

Here.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Hi, Sam. Okay, with that I'll turn it over to you Kathy.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Great. Thank you, Michelle and thank you to everyone for joining this call. We know that it's summertime that many people have vacations and also we appreciate you recognizing that we're working on a, as always, very short timeline with the intent of being able to offer a report to the full Health IT Policy Committee on August 11, at its next meeting. So we have been asked by ONC to address a number of issues since the release of the 2016 Physician Fee Schedule and in your packets that you should have received is a, I would say very comprehensive summary for the task before us today, which is to look at the appropriate use criteria for radiology and for advanced diagnostic imaging services. So if we could move to the next slide, please.

First, as a matter of reminder for some of you but we've also invited some new members to join us on these calls; this is the roster of a broadly representative group that will be contributing to our thinking on these issues. Next slide includes two additional members that we have asked to join us for the appropriate use related discussion; Charles Truwit, who is based at Hennepin County Health Systems in Minnesota and Michael Mirro, who is based in Indiana and is a cardiac electrophysiologist. Next slide.

So briefly our schedule and I should say to the group that all of the slides are available in the packet that you received prior to this meeting, but we're having today's call for a full 90 minutes and then there is a follow up call in short order to address additional issues that we don't get to today; that will be later this week. And then our last call to wrap up what we would like to send forward to the full committee, that will be on July 30, excuse me July 30 we have further discussion, August 4 is our wrap up call. Next slide.

So the task force has been asked to focus on some very specific issues that relate to the proposed rule for physician payment for 2016, and the first of those is the appropriate use criteria for radiology. The second is the revision of certified EHR technology requirements to allow reporting using CMS' QRDA IG for providers who choose to submit eCQMs. And then we'll also be looking at a Meaningful Use measure for accountable care organizations. Next slide.

So in the materials that you received, there is the summary, as I mentioned, about...and to give you some of the background about appropriate use criteria, about the experience that CMS has obtained over the years, starting back in 2008 with the use of appropriate use criteria with respect to Medicare Imaging Demonstration Project. And as a matter of definition, AUC are considered a set of individual criteria that present information in a way that links a particular condition or presentation, a constellation one might say of descriptors about the patient to one or more services. And then based on that, renders an assessment of the appropriateness of the service that is being ordered or which a physician is considering ordering for that patient.

There are a variety of opinions and views about how to best roll out AUC into clinical practice, but at the same time, CMS through statute has been asked to implement a program that would incorporate AUC in clinical decision support into the area of advanced diagnostic imaging and to include it in the rule. CMS in its own discussions has come to believe that a successful program would be a flexible program and that this program would allow and would include competing sets of AUC. It's recognized that these have been developed by a variety of different organizations, frequently provider led entities and that there might indeed be competition, so to speak, amongst the clinical decision support tool mechanisms and that providers would be able to choose from amongst a series of tools. Next slide.

So if we look at the timelines, and these are largely dictated by statute; as you can see with the sections referred to in each of the tabs here, there needs to be establishment of AUC by November 15 of this year. Mechanisms for consultation with AUC are required by April 1 of next year and then reporting on usage of AUC is required by January 1 of 2017 and then on a yearly basis after that implementation date of January 1, there would be annual identification of what one might call outlier ordering professionals for the particular services that are provided. Next slide.

So as additional background, the second major component of the Medicare AUC Program is identify...identification of qualified clinical decision support mechanisms that could be used by ordering professionals for consultation with applicable AUC under the Act. And that this is envisioned by CMS to be an interactive tool that communicates the information immediately to the user so that there would be a feedback loop that they could then respond to and make adjustments as appropriate. That the ordering professionals would be the ones who input the information regarding the clinical presentation of the patient into the tool and that that might be a feature of an existing system or platform and that then that tool, on the platform, would provide information back. The Act does state that the Secretary is required to specify qualified clinical decision support mechanisms and to do so in consultation with experts including physicians, practitioners, health care technology experts and other stakeholders. Next slide.

So if we then move on towards what are the requirements under this section of the Act, it is required that the clinical decision support tool make available to the ordering professional the applicable AUC and the supporting documentation for the applicable imaging service that is ordered; in other words, on the spot, at the point of decision making, information. That when there is more than one applicable AUC specified for a particular imaging service, there needs to be indication of the criteria that are used for that service or by that service...by that CDS.

It's important to determine the extent to which the applicable imaging service that's ordered is consistent with the applicable AUC, how close is the match. And then it must also generate and provide professional documentation to show that a qualified clinical decision support tool was consulted by the ordering professional, that it was actively used. And that these tools must be updated on a timely basis to reflect revisions of the specifications of the applicable AUC. In other words, it's recognized that as evidence is gained over time that there will be a need for revision and therefore revisions to the specification. It's important to meet all applicable privacy and security standards and then there could be other functions as specified by the Secretary which might include a requirement to provide aggregate feedback to the ordering professional. So that gets to the issue of the annual reporting. Next slide.

It's important I think that even though our time schedule is based on the issuance of the proposed rule that CMS is not including proposals to implement this section in this proposed rule. What it first aims to do is to establish a process for specifying applicable AUCs and that these would serve then as the input to any qualified clinical decision support tool and so those must be first identified the AUC so that then tool developers would be able to establish the relationships that are necessary with the AUC developers. It's recognized that not all AUC developers would also be the developers of the clinical decision support tools.

That said, CMS has indicated that it does anticipate in 2017 that it will provide clarifications, definitions and establish the process by which it specifies those mechanisms. The requirements for those mechanisms will be set forth and will be vetted through the Physician Fee Schedule rulemaking for that year so that developers will have a very clear understanding of the requirements for the tools. It's anticipated, as in most years that the proposed rule would be issued for public comment at the end of June or early July 2016, so six months in advance it would be open for public comment and then the final rule would be published in November of 2016. It is however anticipated, because of the lead times required to develop some of these mechanisms that the initial list of applicable clinical decision support mechanisms will be published sometime after the 2017 final rule is issued. Next slide.

So we have a series of questions that start from the center here, which summarizes that the Secretary is to consider a variety of clinical decision support mechanisms such as we've just talked about. And so there are three questions that we'd like to put forward to the group today and I'll go through each of these and then we'll be able to discuss them in turn. So the first of those is, how are, at the present time, providers successfully EHRs and other health IT tools to consult clinical decision support criteria today? So this is what's the current state of the art, so to speak?

The second of those is whether clinical decision support criteria that exist today could meet the anticipated need and from amongst this group, what are the key forthcoming standards and certification criteria that might be used to support these processes in the future? So the how do we get from today to the future? And then the third is a question for the group about the key strategic considerations that ONC must address to ensure that certified EHRs support these activities? So that does get us back to really, one might say, our roots or the basis for our organization which is that we advise ONC and we are one of a number of groups that will provide input to CMS as a whole as it implements this. We could have the next slide, please?

So, I'll just make brief mention and then we'll go back that there is additional material that you've received with your packet today. The slides for subsequent discussions are there and because of the short timeline that we have, we'll want to make sure that you have a chance to look at those before the next call so that we're able to move through the various topics efficiently. So let's go back, if we could, to slide 11. And so like start with the first question and I would ask the group to share with us experiences or knowledge that you have with using EHRs to consult clinical decision support criteria, what you would think are some examples that we could cite and then how providers are successfully using these. So I'll open it up for discussion by the group.

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

Kathleen, this is Mike Mirro.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Yes, Mike, thank you for joining us.

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

Yeah so, I mean I could comment on specific uses of decision support at the point of care that I worked with a vendor years ago, actually this is some time ago, real early adoption of decision support around heart failure management and implementing the guidelines at the point of care to remind the clinicians on the appropriate use of beta blockers, ACE inhibitor therapy and aldosterone antagonists, and this was developed over 10 years ago. Recently the Epic system has what's called best practice advisories, which is essentially their decision support tool at the point of care and that same functionality has been built by many cardiologists and there's harmonization across at least the cardiology community with using pretty much identical best practice advisories for adherence to process measures for heart failure management.

One area of my personal interest, which is also several other electrophysiologists of course is a best practice around triggering an alert around the ejection fraction, left ventricular ejection fraction so that clinicians would be aware that the patient not only is at risk for symptomatic systolic heart failure with low ejection fraction, but also sudden death. So, those are the types of experiences I've had personally and it has definitely...we've monitored all the clinician behavior within the employed physician group at our health system and it definitely moved the needle on adherence to guidelines; so, at least from the process measure standpoint, we found a marked improvement. We have not linked it to actual clinical outcomes yet, probably too early, but that's our ultimate goal is to show that adherence to the process measures results in improvement in outcomes.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Thank you, Mike.

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

Kathleen?

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Yes.

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

This is Frank. Just to clarify is our focus today on appropriate use criteria within the radiology setting, as the title suggests, or is it more broad?

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

So the focus is for advanced diagnostic imaging because that's the requirement in statute. And so examples that have to do with the use of EHRs could come from a broader spectrum, but we would like it to be primarily directed at advanced imaging so such diagnostic tools as PET scanning, MRI, CT, those sorts of things.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

This is Floyd with a comment. I got the impression your first question was about are there tools that...it seemed as if CMS was looking for are there...is there a set of tools that are out there that they could say if you use any of these, it's okay; that's what I think I took from the request. I want to ask first, is that kind of what you're looking for, are there existing tools that they could make...say, if you use any of these, this would be good?

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

So Floyd, I think that's a good point of clarification. So this group, its primary focus certainly is towards electronic health record systems but I think we all realize that there are a number of tools that have been established as mobile Apps that people may access from their Smartphones and through other mechanisms. So, I think we would welcome reference to those types of tools as well; we don't have to limit ourselves to EHRs.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So...

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

Kathleen, this is Mike Mirro again. I helped develop the focus tool that's used for nuclear imaging and as you mentioned, it's an App which is...so, I'm helping them develop an APIs to get that data into all of the electronic record environment. That's one of the problems with the tool is getting that data then into the EMR environment, so I think it's better to actually, my personal opinion, it's better to build the tools right in the EMRs at the point of ordering and point of care so that it's basically an alert if it falls outside the ordering range if it's inappropriate use, for example, for CT scans. It would seem like it needs to be built into the vendor system and so needs to be an open source tool that all the vendors could adopt. That's just my two cents.

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

So Kathy, this is Frank; you know...you know this is a passion of mine. I'm particularly cautious about building it into the EHRs and I would not recommend that; I would layer it on top in the stack. And the reason I say that is that if it's in an open source cloud that the EHR community can talk to when appropriate use criteria change, and they do change, you don't have to go to 200 EHR companies and change them and get them to change, you go to the primary source and you change the application within the cloud. So, I think there are a lot of clinical decision support tools that fit within the appropriate use environment, but there are a lot of challenges as to are those appropriate use environments based on evidence? Are they based on non-evidence? Is there a change in the evidence? And how do you update the clinical decision support tool so that a clinician who's using it, and we see this, when they're using it, they want to know that the clinical decision support tool they're using is current and hasn't become dated and that they're now being forced to use a tool because it meets a payment criteria but it doesn't meet a clinical step. There will be disruption if you don't have that flow properly controlled.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

And so this is Floyd, I want to follow that with, I agree with updating is difficult within EHRs. I guess my concern is, there are tools that exist, there are vendors that sell applications that could be used with...directly with EHRs where evidence can be implemented. I know the American College of Radiology; I last looked at it a number of years ago, but was looking at developing mechanisms to provide appropriateness criteria. The question is, once you have the criteria, how do you actually connect it to an order within the EHR and that seems to be one of the problematic areas; I'm not sure it's been resolved in many cases without a lot of work.

And I agree with Frank that there needs to be some assurance that what is being used is up-to-date and current and correct. I did see something in the materials that we were given about consensus; I wasn't sure if there was thought about having a consensus-based entity look and approve the types of applications that CMS could say are usable to make sure that they're effective, that they follow certain principles.

**Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

This is Chip Truwit in Minneapolis; if I could answer some of these things. I'm a Chief of Radiology and we've been with Epic since 2006 and I've also been in charge of the ACR Accreditation Committee which supervises accreditation across multiple areas, but in particular, the advanced imaging. We've had clinical decision support here at Hennepin ongoing for now probably easily 5 years and you all hit on a couple of the highlights that are good and not so good.

So we were among the pilot sites for the ICSI Nuance project, which was very effective and did employ appropriate use criteria, developed I believe out of the Brigham. And that plan, and eventually Nuance decided not to carry it forward, which I think was last year and so we've now implemented the National Decision Support Company's ACR Select software. So there are four different softwares out there that use the ACR appropriateness use criteria for advanced imaging and this is a process the AUCs by the ACR have been developed over the past 10+ years. Many, if not most, are literature-based, evidence-based criteria that are out there in the public and they've been seen by CMS for many years. They are what helped define the accreditation standards for radiology and for advanced imaging and now these criteria have been incorporated into these programs.

So to point number 1, including it within...we use Epic, including it within Epic has not been as easy or seamless as we would like. Doing it outside of Epic would be ideal if Epic were perhaps more open to third party data. Now, I'm not meaning to pick on Epic, but that's the one we use. And I think that this is a tremendous opportunity for CMS to leverage its strength and if it encourages the use in the cloud and a set of standards that all of the use criteria...appropriate use criteria, not just radiology, but the other sub-specialties as well, come to a standard that's based in the cloud and then CMS just says that all electronic health records need to adopt this standard and figure out a way to incorporate it by the appropriate date. You're giving plenty of advanced notice and it makes it much easier for the end user, meaning the physician or the ordering provider to accommodate this.

And I have one or two other comments and then I'll pause for a breath. It is unclear to me whether we're talking about outpatient imaging, outpatient plus emergency room, outpatient plus emergency room plus inpatient imaging and if somebody could address that, that would be helpful. We're trying to do it on everything and it's a bear on the inpatient side and on the emergency room side where time is so much more critical than on the outpatient side, in terms of the ordering process.

The last comment I would make is that we're trying, it sounds like by statute, to encourage the ordering provider to be the one to control this and I will tell you as the end performer here of the imaging, that is fraught with both aspiration and frustration. Because many clinicians, I gather there's a cardiologist on the line, I'm sure that they would echo the same thing that many clinicians aren't exactly certain what to order and so it's one thing to order an MRI when they should have ordered a PET or this that and the other; that's not usually the problem.

It's usually they don't know whether to order contrast or not and they order it kind of as a buckshot based on the last exam they ordered and that leads to a lot of frustration and time wasted on our end because we can't easily change the orders and it requires all sorts of phone calls and the like and that gets down to, is it the appropriate use? And it would be ideal if the criteria fed back to the individual immediately and said, this is not appropriate to use contrast or not; but unfortunately, that doesn't seem to always work, in my experience. And I'll shut up and go back on mute now. Thank you.

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

Chip, this is Mike Mirro; can I make another comment? First of all, I am a cardiologist and so is Kathleen Blake. You know, you're absolutely right about that we have a lot of clinicians they don't know exactly what to order and so the order, it's a workflow disaster. As far as I agree with the comments about hosting it in a cloud except that, you know, we have had problems with data fluidity, getting da...you know, with Epic but we seem to be getting over that, but our Chief Information Officer, it's always a problem if something's hosted in the cloud and we're trying to get a data feed in, from a security/privacy standpoint, everybody's very nervous. And so if there is some way that CMS could figure this out so that everybody's comfortable accessing a, if you will a large, appropriate use decision support tool that's hosted in the cloud and going to get in...and obviously if CMS mandated that all the vendors had to support that standard, then it would work, but we need to have somebody big like CMS to help us.

**Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies**

Hey this is Ginny; I'd like to say a couple of things, Kathleen.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Please.

**Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies**

So these are all excellent comments, I really appreciate the discussion today. Just from perspective of both being an EHR vendor plus some of the work I know is ongoing, which some of you may be familiar with as well, you know most EHRs do have some kind of a CDS rules engine that allows different rules to be inserted and applied at the point of care, the point of ordering, typically in this case for different areas like appropriate use of radiology. And the, I know the thought is though that there needs to be more sophisticated ways of doing this, even though today it's a Meaningful Use criteria to have the CDS appropriately embedded. And that's part of the work; I don't think I've heard anybody mention it, of the Clinical Quality Framework.

And there is a pilot going on with the Clinical Quality Framework right now on radiology appropriateness of use and the folks that are actively involved in it are the folks with ACR. So that pilot, I think kind of getting more into question 2 and the results of that pilot will help inform the whole issue of making sure there's a standard way of representing already evidence-based criteria for CDS in an EHR and the methods are really being looked at as well. So the issues around how do you work with cloud-based information to make sure it's timely and up-to-date are definitely something that they're looking at.

But I think if we kind of follow what's happening, it seems like a couple of the issues are what...who should really be providing the actual CDS rules? And it seems like we could maybe have a role in recommending where we think that should come from and then as we think about the way it should happen, without getting too specific, because we don't want to stifle some of the work that's ongoing, we should think about what standards and what capabilities we think are...need to be inherent in this kind of ability.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

And this is Floyd. To follow on Ginny's comments; I agree that there are pilots ongoing and we need to look at those, my concern is a couple of things. The standard that's being piloted is still somewhat in development, so I've heard a bunch of folks here talk about if there were a standard to represent it, it would work. The HL7 group that's working on many of the standards CDS is still balloting and working on them; so, they're not really...I'm not sure if they're stable enough yet to say that there is a standard to use. I think it's great that it's being piloted, it's great that we're learning, but if we're going to suggest it has to be in a standard, that needs to be mature enough.

I'm also a little bit concerned about the data driven processes that would have to happen to do the kind of checking that is really talked about or discussed in this proposal to know that whether or not to use contrast. If the decision was to address that, it requires really good data structured data to be able to process it and some of it is just not structured as we see things today. We also...I saw in this proposal that if the decision support is followed or not followed; today we tend to look at whether decision support is followed by seeing what happened and what orders were written based on diagnoses but not based on, in a sense, auditing the EHR to see did this rule fire and what was the outcome of its firing? And how would you track that, what's the provenance of the information? I'm not sure that that's available or feasible, but I think we need to think about it.

**Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement**

This is Elizabeth; this is another potentially not feasible question but, is there any example and/or opportunity to input patient preferences in these decisions, shared decision making, any...is there any room for that in this approach? And if so, how?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

This is Floyd; I hate to add to that as well. So one of the things that I see in here is physician in a sense non-compliance or the outliers and I'm wondering if there is...there needs to be some method of explaining, I didn't follow the guide exactly because of these factors which may very well include patient shared decision making. And I'm not sure how we would approach that.

**M**

Yeah.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

So this is Kathy and I might put Elizabeth's question back to both our radiologist and our cardiologist on the call, others certainly may have perspectives to share or specific experience. But for both of you who've been involved in AUC development, has there been any incorporation of patient preference into the criteria?

**Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

I'm happy to take that first. We have gone to great lengths to include patients in conversations here in radiology in the department; they're involved in every committee, they're involved in hiring other radiologists, the whole thing. What you're asking now is...would be just, I'm dumbstruck that I haven't managed to do that. I can't control what goes beyond my purview.

And if the referring clinician is two blocks away and is making a decision, I can't frankly tell you whether they asked the patient would prefer an MRI with contrast or a CT with contrast, but I think my suspicion is they might say to a patient, well, you're due for your, you know, follow up from your brain metastasis, you're due for a follow up MR with contrast and that conversation that goes on at that point does involve the patient. And there is involvement in the sense that a patient might say, well you remember, I was allergic to the dye last time and so I don't want to get that again. And so that kind of stuff does occur and we have BPAs built into the system about contrast allergies and they work, I would say some of the time, they don't work perfectly and we still have patients with gloved saves at the last moment that, you know, I can't have that contrast just as we're about to introduce it into them, despite the best of EMRs. But it's very difficult at this point for me to say that we have really incorporated a patient-centric model about this at this point.

I also want to address what I thought I heard about one of the comments just a moment ago and that is, it sounded like there was kind of an obtuse question or comment about physicians gaming the system or not really focusing; yes, there's a blank for other in our system. And in one area in particular, and I'll leave it to you all to guess where that is, where speed is of the essence, it's not uncommon for someone to just move the cursor to the blank and hit the letter A so they can hit carriage return and move on. And that, I'm sure, we're not exclusive to that problem and I recognize that time is time and people are busy and they're saving lives and that's why I asked the question about the inpatient and the emergency cases, which I believe financially are not the same motivation for the CDS. But in the abstract or theoretically, we should be applying this as well and we're trying to, with great difficulty. I'll go back on mute now. Thanks.

**Joe Kimura, MD, MPH – Deputy Chief Medical Officer – Atrius Health**

Hi, this is Joe Kimura...

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

...I'm going to follow up to...this is Kathy, to ask the question also of Mike Mirro and to maybe perhaps hone it in even further by saying then, do the appropriate use criteria themselves, do the actual algorithms, as they're being developed, have those been developed with patient input or is it largely clinical experts who have developed those criteria?

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

At least for nuclear cardiology and echocardiography it's been completely clinician-driven experts, you know a Delphi panel, not including patients. Now, as you know Kathleen, we're talking about imaging in this paradigm, but we're developing criteria for revascularization and things, it certainly would be prudent to have patients represented in those panels. But I do think, as Chip pointed out, at the point of care, when these tests are ordered, the patient's preference is pretty much built into the clinician decision about the imaging test.

So I guess the patient is in the loop, but not formally as far as developing the tool or they're not really in the loop as far as entering some piece of data into the EMR system or their personal health record that could then be part of a decision support tool. That's...I think that's great that that is inserted here, but I don't know how we would have that work, but we could probably figure it out.

**M**

Yeah.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

I think it's something also where then, and I'm really forecasting what our report will look like, that we have the opportunity to indicate where there are points of discussion that we recognize are not currently implemented in existing systems but that might merit further consideration going forward. I do, before we move on and we've started a bit, as I expected to bleed over into questions 2 and 3. But before we do that, I'd like our ONC colleagues to help us address the question that's been asked about whether we are to be considering this issue broadly across all settings be they outpatient, inpatient, emergency room or whether there is a particular setting that we should focus most of our attention on?

**Alexander Baker, MPP – Project Officer, Beacon Community Program, Office of Care Transformation – Office of the National Coordinator for Health Information Technology**

So, this is Alex Baker with ONC; I believe that this will only cover Part B ordering professionals. We can definitely check on that, but this is a requirement that will fall on that set of providers.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

And I think some of the challenge that might be...certainly will need further study is that Part B providers practice in many different settings...

**M**

Sure.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

...and so the degree to which they would have a consistent set of criteria across those multiple settings might encourage more consistent delivery of care.

**Elizabeth Mitchell – President and Chief Executive Officer – Network for Regional Healthcare Improvement**

And Kathy, this is Elizabeth; to that point also, again, I'm not a practicing clinician but access...easy access to the information from other settings, across settings would seem to reduce overuse in some cases.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

No question because information may be in silos, it may be in the outpatient practice and not available to the clinician in the emergency room or elsewhere.

**Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

Can I add a comment here; this is a great part of the conversation and I really, I mean, so far everything's been great but this part I really do want to weigh in. In our setting here at Hennepin, we have a somewhat written/unwritten rule that best practice on low back pain is that an MRI is not ordered for 6 weeks, unless there are extenuating circumstances; specific neurologic dysfunctions or whatever, that would indicate you need to move more quickly. And it's kind of generally accepted across our industry in the imaging world that 6 weeks is a reasonable standard and that's what the evidence-based medicine would suggest.

Our outpatient physicians, and I'm translating Part B to being what we're talking about here; our outpatient physicians in the clinics and we have scattered clinics, they live by that 6 weeks. And so when we get orders for MRI of the lumbar spine, and I'm just picking on lumbar spine, sometimes we still have issues over whether contrast should or should not have been ordered. And people forget and they don't think that through because they're not living in our world and so we have to make those decisions; that's one issue.

The second issue is we have one area in the chain where the 6 week rule doesn't apply and that is in emergency medicine. And I...I'm not saying this to pick on them by any means, they are our colleagues and they have best intention for all of the patients that come through, but there is this sense in our system that it's a one-stop shop and if somebody comes in, they have back pain, it's no different than they got in a car accident and we're going to do everything we can for that patient and wrap it up so they can walk back out the door and they're done which means there's an awful lot of 2 a.m. requests for MRI of the lumbar spine.

Now not to be too facetious, very few people die of an acute lumbar spine. It just doesn't happen very often and yet we do these on-call lumbar spine MRIs. And yet if the criteria were that 6 weeks we're going to wait, because somebody was weightlifting and got some strain in their lumbar spine and they're going to get better with or without an MRI, and I'm not trying to be facetious, we would see a cost saving by not implementing those MRIs in the middle of the night.

So the question is, I'm having difficulty, this is on my local zip code level, and you may say that's your zip code problem rather than this is a national problem, but I don't think it is, I think it's a national issue. And that I think that by limiting the standards to outpatient imaging, if that's what we're doing, then we are not going to capture, and that was just one obvious example with lumbar spine, it's not limited to that by any stretch of the imagination. And I recognize the flip-side is, we're in an era of legal medicine and therefore people are covering their tails and this, that and the other and I understand all that. The emergency room is not making any more money by ordering an MRI, so there's no incentive financially for them to be doing this. And so I guess I'm throwing it out there to hear what other people have to say and that's why I've asked the question about what's covered by this proposed rule. Thanks.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Thank you. So I think that it points to another area, in which we can provide comment, perhaps not a solution, but we can describe the situation that you've described for us and what some of the challenges are associated with it. I think what I'd like to do next, and we as I said have started to move into question 2 and I'd like...and we've been collecting, I'd say, some ideas to answer question 3. But, do we think in question 2; are there key forthcoming standards and certification criteria that might support the use of clinical decision support tools? And I'm going to again ask our ONC colleagues to clarify for the group as a whole, are we talking about a certification process for the clinical decision support tools themselves or for the appropriate use criteria that underlie the CDS? Or are we talking about certification criteria for electronic health records or both?

**Alexander Baker, MPP – Project Officer, Beacon Community Program, Office of Care Transformation – Office of the National Coordinator for Health Information Technology**

Hi, this is Alex again. So hopefully I can clarify this a little bit, but welcome more questions. So I think what we are interested in here...so, as folks saw in the presentation, this year CMS is covering the first piece of this rule and putting forth some proposals about how they will come to approve appropriate use criteria and we would highly encourage you to sort of look at that material and comment individually.

I think for this group though, we're most interested in looking forward so in the future, you know at a later date, CMS will cover this portion of the rule that is about these qualified clinical decision support mechanisms. We want to think ahead about the mechanisms that...the health IT mechanisms, EHR and otherwise that are available to support this use case and specifically, you know, what ONC could potentially do with its levers to support getting to the kind of point that folks were talking about earlier where we have a really effective ecosystem for people being able to access appropriate use criteria in the cloud or however people see...would like to see that kind of environment evolve.

But I think that's the piece that we're most interested in thinking, you know, in two years as CMS is looking out at the different solutions that they would select as these qualified clinical decision support mechanisms, what do we need to do to make sure that the health IT environment is appropriately supporting the kinds of mechanisms we want to see there.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Okay, so what I heard was that you want us to focus very much on what the health IT standards and certification criteria would be and what would...what perhaps is currently available? What people know is forthcoming that would allow implementation to take place? So I'll open it up to the group.

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

Kathleen, this is Mike Mirro. So one of the issues right now with the certification program, there is no really, to my knowledge, ongoing surveillance of vendor behavior of how they may functionally demonstrate that they support standards and functionally can, you know, exchange information such as, you know, and also perform certain tasks like decision support. But then, you know, what is ONC doing to go out and verify that later they're still adhering...they haven't...to my knowledge no one's been decertified but maybe I'm wrong, maybe someone from ONC can answer that.

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

Kathy, this is Frank and I don't necessarily put this burden on ONC; I think ONC can help provide the industry guidance that it needs for setting the kinds of standards that you need. There's a level of technology standard that speaks to what you need in terms of the clinical decision support tools, but then there's also the cer...the necessary certification about the actual clinical material as well. So, you need to certify that the technology is reliably and validly and authentically pulling the data and providing that data for an appropriate use criteria analytic. And then you need to certify that the analytic is meeting the necessary standards that have been set by the industry for achieving the clinical goals. So there are several layers to providing standards and certification and it's critical it's performed or the end user isn't sure that what they're using is current and reliable and valid.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

This is Floyd to extend on some of those comments. I...certification can test than an EHR can do what it's been asked to do; how it's used in the community and during implementations may not be using that functionality and may use different functionality and that is hard for certification to look at, I don't know that that's feasible. A couple of concerns here; one is in reviewing the proposed rule for certification for Stage 3, there were recommendations by many, I think including this group, that the standards for decision su...clinical decision support aren't ready yet, so I think we need to keep that in mind.

The other issue, as an example, I've been working with some EHR vendors talking about immunization work, which some have the information directly, the decision support in their systems, some tend to use third party cloud-type vendors. And the concern is if they were to be certified for giving the correct information, they're being held responsible for what the third party is doing. And if their customers decide to switch third parties, how do...it's really an issue of who is providing the decision support and is it correct and up-to-date? I'm not exactly sure how to handle that, but I think that does need to be addressed. Frank, I think that's what you were talking about as well.

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

Floyd just said it better than me.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

So what I'm hearing is that it's actually a multilayered process that has to do with reliably collecting and pulling the data, making sure that the analytics that are applied to that data achieves the clinical intent of the tool. That there may be challenges with certifying that the tool itself is being used properly and also that standards for clinical decision support, what I did hear is that they are not ready yet. A question I would have for the group, based on the not ready yet observation is, would you make any predictions about when they might be ready and ready for use by individual eligible, Part B providers?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Well, I'll start that off; this is Floyd. I...there was discussion in the Standards Committee I believe, maybe the last meeting or the meeting before, that perhaps some of the standards that are currently in production might be helpful, but they might be overly specified. In other words, perhaps it's not a standard we need, we need to be able to accept an API that somehow uses a...not a decision support standard, but a standard that helps you connect what it's asking for to the order, perhaps, in your system as opposed to a full standard for the decision support; just something worth talking about because I'm not sure that it's clear what that standard should be.

**Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

Can I ask, just a...this is a limited view question but, our electronic health record, we use the four letter word electronic health record that you can click on something that is a URL or you can trigger something that's a URL and that's fundamentally how the system has worked, whether it was ICSI Nuance approach or the current approach. We use the ACR Select program, but there's four different programs and they all kind of work the same way that you can either have an embedded thing within the electronic health records or you're clicking on a button that effectively is linked to a URL and then you're out in the cloud and the result comes back to the same spot and then locally populates a field within the electronic health record that gives you the red, green and yellow or whatever it is relay. I guess I'm confused why this is my own naivety, why this is so complicated?

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So I...this is Floyd; I think it's a matter of a link to something is fine but wha...to populate something in your record that's red, yellow or green, I guess I'm not sure if there's a standard that makes it red, yellow or green or that the red, yellow or green can lead to an orderable event directly within the EHR based on a standard. Not to say it doesn't...

**Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

Now I think I understand what you're driving at. So the, I think the red, yellow, green at least for most medical imaging and again, I'm familiar with the American College of Radiology's AUC and I by no means am professing that that's the only one out there but at least that, and I suspect the other ones, they do have largely evidence-based, and we talked about that earlier in the conversation. And they bring back something that's a red, yellow, green type of go or no-go type of situation.

Where I think they fail, and you've pointed this...and alluded to this is they fail in capturing that data in a meaningful way that gives feedback to the referring physician not for this one time, but over the past 6 months you've ordered a CT without contrast repeatedly every time somebody has leg pain and maybe that it isn't the right way of doing this and there's no learning experience either on the part of the computer or on the part of the individual that goes on. And I think the programs have a lot of work to do in that regard, so that perhaps is standardizing, but I think we're much further along on the AUC than I think we're acknowledging.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

This is Floyd; I also think we have to consider what we mean by decision support. There are many levels and one level is the information's there to help you make a decision up front or to tell you if you might have made the wrong decision and recommend something else. So providing the information red, yellow, green if that means based on what I just read I can now make a decision, that's fine. The question is, can I select the green and make an order happen, just...and that may happen in some systems, but it takes local work and I think...

**Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

Well actually, that's the very topic we've been dealing with yesterday and we are now at the point that we are turning off the green.

**M**

Yeah.

**Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

If you order the correct study and it goes through and it would give you a green, you don't even see that page, it goes right to order, it's done. If you order something that's a gr...whatever your order and it's not an ideal...you order a red for instance and it's not ideal, that comes back and we're only showing the green and the yellow; we're not even giving you the opportunity to show you the red, so that you don't repeat the, you know, or choose another bad outcome. And right there you click on it and it goes right to order. Now unfortunately you are correct, these systems, all you're doing is ordering the electronic health record to then provide you the chance to order.

So it goes click to the next click and then the second click is actually in the record that you're making the order; the first click is only getting you from this cloud-based representation within the electronic health record that's shrouded into the electronic health record, if you will, and then you have to click twice to get the second one being the actual electronic health record. So I think we're close in that regard.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

So, this is Floyd; I guess I don't want to just make it a two-way conversation here but what I'm hearing is you've been able to make this work and it's a great, perhaps best practice example. The question I have, is this based on a standard that other vendors could also implement and every other site could implement the same way? And I think that's what our ask is, does that standard exist or is this something you had to use local configuration to address?

**Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

Unfortunately you are correct, it's a local configuration superimposed on this; it's not a standard and, you know, we're dealing with Epic and others are dealing with other versions. And lastly to say, I must have given you some wrong idea to think that we have had a stunning success. We hate the whole concept of using this; we love the fact that it's going to be, at some point, it's the pain in getting there that we're suffering through. The clinicians don't like using it; the patients actually suffer by delays on this because it creates a little bit of havoc with phone calls and so we're not there. We can see the Promised Land, but we're still seeing a headlight, not daylight at the end of the tunnel.

**M**

So this is...

**Kate Black, JD – Health Privacy Attorney – Office of the National Coordinator for Health Information Technology**

So this is Kathy and I'm going to just ask the group, because I'm sensitive to the time that we have remaining. I think we'll move to question 3, but I'll refer you back to the documents you received and the description that there are a couple of potential approaches to implementation of this part of the statute and rolling it out. And in the documents if you do happen to have them or have printed them out, on Page 3 there is the idea that there would be really establishing a large library of different criteria that then could be used by many organizations or whether there should be a focus on a few priority clinical areas such as the one we've mentioned, low back pain. And I'm curious with this group and with its experience, would you say go broad or go specific and deep, in terms of this particular statute?

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

This is Frank. To your last question, I think you need some proof of concept that gains the kind of confidence you need at the sharp edge before you turn on a wide, broadband effort of this. There are still some significant processes that need to be nailed down so that there's consistency in the algorithms that are used for clinical decision support. There are all kinds of compounding matters particularly in this area of radiology when you just get into the thoughts about allergic reactions. You may find that the EHR contains a documented allergic reaction that lacks the credibility in the documentation and if the analytics don't allow the clinical decision support tool to have the appropriate override, then you'll never get the right answer and if that allergic reaction isn't properly qualified or quantified. So there's a whole host of complexities to these clinical decision support tools and the analytics that drive them. You need some early wins and successes as you scale; the individual story of, I did this in Epic or I did this in Cerner or I did this in Allscripts isn't going to get you the kind of appropriateness you want in scaling.

So I would go slow, build through those barriers to implementation and particularly in some of these complexities in the analytics where you're going to need feedback loops built in to confirm or not confirm particular events before you go broad.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association**

Thanks Frank. Other thoughts in terms of other key strategic considerations that ONC should be addressing?

**Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

I concur with what was just said with the caveat that you don't have a lot of time, it looks like, I mean, 2017 is around the corner.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convended Physician Consortium for Performance Improvement – American Medical Association**

Other thoughts from the group? I think we've addressed some of them with respect to the...a consideration being the potential for using some of the overrides, the other button which might technically meet the requirement that a clinical decision support tool was used, but certainly I think we'd agree, usually does not meet the spirit that we'd want to see. Also the differences, the challenges I would say of dealing across settings; so the same eligible provider depending on where they're located might or might not have different assurance levels to the output from these tools.

What about the issue and I'll ask specifically about certification criteria and do those need to be or is this something ONC should be promulgating with respect to the levers it has with respect to EHR vendors? I've heard differences of opinion there and I'd like maybe for us to home in on that a bit more.

**Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

I'm not sure that I totally understood the question but if it's whether ONC should use levers or encourage CMS to use levers, I think by all means it's time for that. We've got 20 odd or 50 odd or whatever number of electronic health records out there and Epic is 61% at last count; in my state, Minnesota, they're 80+% and there are a bunch of others. And unfortunately there isn't a lot of standards across them; they don't all have a usable API, they're not all easy to work with and any time that we could get something standardized, I think now there's no question CMS has the clout to do that. And I think it would force the vendors to come into compliance, I think, a lot and it would be much more helpful for all of us on the backend, the receiving end of this, if that were done. So I would encourage you to encourage CMS to do that.

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

Kathy, this is Frank again. I think there are a couple of missing pieces to...that have to come together from an ONC governance standpoint before you can really get this to maybe where it needs to be. The EHRs themselves can run a compliant cloud, if you will, if there were two or three different clouds that met national standards and Epic wanted to run one and Cerner wanted to run one; but those clouds were the same standards of interchangeability and could run applications much like you run applications on your Smartphone so that things can migrate across platforms. Those EHRs would then be required and have to have the ability to speak to a standardized cloud architecture and respond to, and have the same certifiable outputs in APIs that met that. So, you're building some, I think, some governing discussions that need to happen to make these EHRs come out of their silos and act more in unison with what's coming out from the delivery system who's demanding scalability in this area.

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

This is Mike Mirro; actually I have to testify at the Senate Health Committee on Thursday about data fluidity, data blocking, you know, so this is a great conversation because I think ex...I totally agree with everything that's being said. And if there could be established a coordinated governance framework like you described that the vendors would all play fair in the sandbox and be encouraged to access, and I think ONCs the only...and CMS are the only organization that are going to make that happen; you know, they really are...they still have...there's a lot of uneven behaviors across the vendor environment as all you know. So, this is spot on.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

This is Floyd just with a comment about, what do we mean by vendor? I'm starting to get a little confused. I think yes, I can understand a Cerner, Epic, Allscripts could be a provider of content and other vendors could use APIs for that content, but we could also have the ACR as a provider of content or other...as an example here, or other specialty societies or commercial ventures, the Wolters Kluwer Incs, Elsevier and others. And if what we're talking about is providing standard APIs that can be used by vendors, shouldn't we consider that they might need to be certified they can do it in a standard way?

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

Yes.

**Frank G. Opelka, MD, FACS – Chief Executive Officer – Louisiana State University (LSU) Healthcare Network**

Floyd, I think you're 100% right.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

We can't just go to the traditional EHR vendors on this one, this is broader.

**Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

While I agree with you in principle, and I certainly by all means want to hold the societies to standards just like the vendors; at the end of the day, the vendor in a hospital, in a medical center, in a clinic, in a physician's office is going to be not the ACR per se, or, well, if it's Kluwer per se, it's going to be one of the electronic health records and whatever qualifies as an electronic health record, and we can use whatever definition is out there, they...that's the group that needs to be accessible so that whatever method we use to implement CDS. It's a method that accepts it and registers it into your electronic health record, allows for input from the physician, even...that would be great if we could have input from the patient in some manner through whatever software is used, and the ability to track the data so that we can ultimately influence behavior.

And I'm presuming the goal is to influence behavior to be more consistent with the criteria and therefore be appropriate in what you're ordering and effectively reducing waste. So while yes, we should hold the various societies to the standard and Wolters Kluwer comes up with its own software and whatever App comes up is invented by somebody; all of those are going to feed data back into some electronic health record and I think that's the issue there. And if you set up a standard then they're going to...the ones on the outside are by definition going to have to live with that standard. So...because it's not going to be able to send data in if it doesn't go in according to that standard.

**Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies**

So this is Ginny and I agree with both of the last two comments about the fact that the data needs to be in some kind of a standards consumable format so that EHRs can consume it using the standards that they're adhering to. I do agree that there should be standards for all of this because without standards we can't really progress and ensure that we're interoperable and that things can be easily consumed and presented to clinicians at the point of care.

I would say that there is work ongoing; I think the challenge is in trying to specify too early what standards should be used as we know that there are not any really usable standards today that would work for this and we know that the CQF activities around QUICK and the FHIR-based profiles are a little far out. So I think that we have to consider that when we're thinking about when and how ONC should actually include those standards in a certification criteria, which makes it a little bit more challenging, I think, for how we progress and what we recommend.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

So Ginny, this is Kathy and the question I'd have for you then is, are there...are you able to describe some intermediate steps or options that would allow ONC and CMS to meet the deadlines imposed by statute while these other standards are being more fully developed?

**Ginny Meadows, RN – Executive Director – Program Office – McKesson Provider Technologies**

Yeah, no, that's a really good question because that absolutely is what has to happen, I mean, we don't have any flexibility as to the date that this needs to be implemented. So I think that I would encourage ONC to think about how they could ensure that there was some kind of consistency and repeatability around the rules that would be used for this particular capability so that there's not a lot of variability around how this is being implemented. Because otherwise we wouldn't really have comparable results, right?

So somehow we need to agree upon what those, you know, who should be the provider of those rules and who would ONC basically say that EHRs should be working with in order to get these rules. And I know that there's a lot of activity already in this area, so they should be looking at what is already out there. The other piece of it is that, you know, we already have CDS embedded into our EHRs today and there's already certification criteria.

So, I would propose that ONC should consider how to extend that CDS certification criteria today so as not to have to implement a standard that's immature at this point, but make sure that it's consistent with both what's being required today, but moving forward, what we know we're all working towards for the future, so somehow kind of thinking about how to marry those two capabilities.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

And then I'm going to ask the group, since there is an existing CDS certification set of criteria or criteria already, are the AUC developers, the authors of the AUC cognizant of and building or using that as they prepare AUC or is that work siloed, so to speak, from those certification criteria? And hopefully that's a clear question; how connected are they to each other is really what I'm trying to find out? Or is that an area where work needs to be done in fairly short order?

**Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

I'm not sure I understand the question, can you restate that? I'm sorry.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Yes. So I'm hearing that there are already CDS certification criteria that the EHR vendors are held to right now and yet at the same time, my question then is, are those criteria being used or considered when the society, be it ACR, American College of Cardiology, others, when they are developing their AUC it's sort of anticipatory building out of the AUC so that the AUC can be implemented in the certified EHRs?

**Charles "Chip" Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

I can take a stab at that; I can't speak for the American College of Radiology on this specifically but I can tell you that their AUC are over 10 years in the making, so I think it would be unlikely...it would be difficult to say that they were thinking of clinical decision support criteria, since they didn't exist 10 years ago. And I think this was really more what is the evidence out there and the ACR, as with many things, and with most societies, wants to be on the front end of this stuff rather than the tail end. Nobody likes being told what to do, they would much prefer to help create what to do and I think the ACR, like many other societies, has been very responsible about this.

But I don't think that clinical decision, this would be for I wouldn't even say 2.0, this would be 3.0 is what we're probably talking about for most of these societies, to go back and reiterate their criteria...their AUCs in light of how they're going to be delivered. And I would, again, I can't speak for the ACR, but maybe that's why they licensed off their AUC to one company, National Decision Support out of Verona, it's an, you know, an Epic spin-off and that company then sub-licenses the criteria to other vendors that want to be in this business and so that's how there are four different companies that have access to the, well at one point there were four, there may now be more; four companies that have access to the AUC from the ACR.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

So there's that intermediate step. Mike Mirro, comments...

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

Yeah, no, I agree. Actually that's A...because I've been involved with the tool development for the American College of Cardiology for the AUC tool, so, you're exactly ri...I guess that was Chip talking. I was...by the way; I was on two phone calls simultaneously here, so I'm sorry. But and ACC does the same thing, you know, because you can't internally manage that, you have to have a middleware vendor essentially that that's their business, providing decision support tools. And then basically we supply the scientific content as it needs to be updated and then they make the changes in the software.

So, that's the way it works best and obviously in the private sector it seems to be working. But I think, again getting back to what role should ONC and CMS play, well they could really have an influence on the governance and interoperability issues that continue to be challenges. And also the standards adoption, and this has been a very useful call, particularly with regards to the lack of maturation of the standards and I don't know, I assume Floyd was probably referring to HL7 FHIR, I would assume, but I don't know what he was probably talking about, but.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

So I'm...thank you. I'm conscious of the time and Michelle I know we need to open the lines up for public comment.

**Public Comment**

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Yeah, thanks Kathy. Lonnie or Caitlin...Caitlin, can you please open the lines?

**Caitlin Chastain – Virtual Meetings Specialist – Altarum Institute**

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. If you are on the phone and would like to make a public comment, please press \*1 at this time.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

While we wait for public comment, Stephanie or Sam, do you want to talk about next steps?

**Stephanie Lee – Public Health Analyst – United States Department of Health and Human Services**

Um, I think we can start consolidating all the notes that we've taken today and then we'll send out some additional materials so then the group can have some time to sort of analyze the comments that we received today. So we can try to get that sent out before the next meeting; I think we'll need to discuss if we want to keep going with this topic for another meeting, since we have 4 in total, and then we can follow up on the group on that. Sam, does that sound okay to you?

**Samantha Meklir, MPAff – Senior Policy Advisor, Office of Policy – Office of the National Coordinator for Health Information Technology**

Thanks, Stef; I'm sorry I had to step out quickly. Thank you.

**Stephanie Lee – Public Health Analyst – United States Department of Health and Human Services**

Sure. Okay, then let's go with that then.

**Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology**

Okay, thanks Stephanie; and we don't have any public comment, so thank you everyone. It was a great discussion today and we'll be in touch shortly.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Thank you all and we'll look forward to bringing a consolidated set of comments for your review.

**Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

Thank you very much, great call.

**Michael Mirro, MD – Medical Director, Parkview Center for Research and Innovation – Parkview Health System**

Thank you.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**

Thank you.

**Charles “Chip” Truwit, MD – Chief Innovation Officer and Chief of Radiology – Hennepin Health Systems**

This was great, thank you so much for including me.

**Kathleen Blake, MD, MPH – Vice President – AMA-Convened Physician Consortium for Performance Improvement – American Medical Association**

Thank you.