

**HIT Policy Committee
Meaningful Use Workgroup
Subgroup #1
Transcript
May 9, 2013**

Presentation

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

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

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

Here.

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

Thanks, David. Neil Calman? Marty Fattig? George Hripcsak, we just lost his connection but will be dialing back in. David Lansky? Marc Overhage? Charlene Underwood?

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

Here.

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

Thanks, Charlene. Mike Zaroukian? Are there any other Meaningful Use Workgroup members on the line that were not part of the Subgroup? And any ONC staff?

Michelle Consolazio Nelson – Office of the National Coordinator

Michelle Consolazio Nelson.

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

Thanks, Michelle. Okay, with that I'll turn the agenda back to you David.

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

Thank you, I'm wondering if I inadvertently deleted the request, the files for today.

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

I'll forward them to you.

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

Yeah, we're and I'm trying to remember exactly how far we got last time.

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

Oh, sorry.

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

George do you recall?

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

I don’t know if George was able to dial back in yet.

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

Okay.

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

His cell phone dropped off.

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

I think we were–

Michelle Consolazio Nelson – Office of the National Coordinator

So, my computer is frozen, so hang on, during the last call we got through a number of items and I think that we are ready to get started on the eligible hospital objective related to structured lab results that get sent to the EP.

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

Okay and which number is that? Do remember?

Michelle Consolazio Nelson – Office of the National Coordinator

121.

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

121, okay, I was thinking we were just slightly less far than that, okay. So, we will go from 121 on. Charlene you’re there?

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

I’m here.

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

Great, so, the first of these is the structured lab results to ambulatory providers and, you know, here the threshold was more than 20 percent, a number of commenters disagreed with the move to core and they wanted, you know, more specificity on the new terms.

George Hripcsak, MD, MS, FACMI – Columbia University

Hi, David, I’m back on, this is George, I had gotten knocked off.

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

Yeah and we were thinking that this is one of the ones that you are either doing it or you’re not doing it.

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

Yeah.

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

So, that the threshold would not be – would not make a big difference. We will get the data from MU2 correct?

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

You know, David, again, depending on the infrastructure some feedback we get from our customers on this is because there is sometimes a cost, there will be practices that accept it or don't accept it. I mean, so if the infrastructure is there you can send it to the hub and it would send it out that's doable. So, there could be some pushback on that front too, right?

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

So, do you think we should be using a different threshold? I think it does make sense to move it to core.

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

Yeah, I do too, because I think that's going to – what we need to drive is to get this infrastructure in place, right?

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

Right, exactly. So, can we make the note that we'll move it to core, we will address what an appropriate threshold is when we see what the MU2 results are.

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

Yes.

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

George that seem okay to you?

George Hripcsak, MD, MS, FACMI – Columbia University

Sure, I mean, the issue here, yeah, okay, I'm just thinking of what – is your argument – like one argument is let's leave it at 20 percent because they're going to go to 100 if they can anyway, the other is we should increase it because they're going to get to 100 percent anyway?

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

Yeah and, you know, the Standards Committee commented that we should consider mentioning LOINC by name and I think we should.

George Hripcsak, MD, MS, FACMI – Columbia University

In the past we let them mention it by name, so is Michelle on?

Michelle Consolazio Nelson – Office of the National Coordinator

I'm on.

George Hripcsak, MD, MS, FACMI – Columbia University

Do we – we don't normally name standards though right, in deference to them?

Michelle Consolazio Nelson – Office of the National Coordinator

No, I mean, typically that's for the certification criteria. We could put a recommendation in for the Standards Committee though to use LOINC.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

But, it's just – yeah, okay. So, maybe, were we suggesting to – I'm just going to ask perhaps put it at a 50 percent threshold but that it will still be questionable based upon experience from Stage 2?

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

Yeah, I think that's reasonable.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

So, I just have been hearing the feedback that we should be naming standards more when they’re mature, but maybe that’s not necessary.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, normally we let the Standards Committee do exactly that so we felt like, you know, like we might name the CCD and then they’ll come back and say, well the CCD doesn’t really cover that situation they’re the experts in it, but now we’ve named it in our objectives, so we try to give the clinical scenario and let them name the standard, but if they’re asking us to name the standard we can put in something that says we suggest the Standards Committee use LOINC.

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

Well, the Standards Committee is suggesting that we mention LOINC by name.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, yeah, yeah.

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

Which I actually think is reasonable although I recognize it’s a different approach. I mean, when the standard is really clear I think it’s reasonable to start to name it. Okay. So, next is the one in the electronic record assisting with follow-up on test results and half of the commenters wanted more specificity around this. The commenters who voted were divided between including it and not and they wanted to know who this applies to. I think we meant just EPs, right and not eligible hospitals?

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

So, can you move the next slide up please? Yeah, thank you, or the next one. Are we on – we’re not on hospital labs are we?

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

No.

Michelle Consolazio Nelson – Office of the National Coordinator

No.

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

Yeah, test tracking.

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

We’re on 122, I’m sorry I’m looking at –

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, me too, I’m sorry.

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

Okay, the screen wasn’t –

Michelle Consolazio Nelson – Office of the National Coordinator

It’s slide 5 if it’s not up already.

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

So, what do you think?

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

So, what was the feedback on this one David?

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

So, the feedback was people wanted more specificity and they wanted to know who it applies to eligible hospitals or EPs. They wanted to know more about the intent of the measure, what kinds of tests are included, what it means to acknowledge. They wanted specificity around the term “abnormal.” They wanted specificity around “three days” whether it was three working days or three week days or 72 hours. So, I thought we meant – this is largely an outpatient problem.

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

Right.

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

I thought we meant just EPs.

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

Yes.

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

The intent of the measure is to improve follow-up especially around important abnormal tests and so specificity around the term abnormal is tricky.

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

It is tricky.

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

Well there are tomes written about this.

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

I know.

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

You know we published a set of recommendations around this, you know, for Massachusetts. I mean, the general principal is for any test result you should be looking at it but acknowledge just means the provider has to check a box saying that they’ve seen it. I guess for abnormal what I would say is abnormal is identified by abnormal, by the laboratory recognizing that many of those are not that important but it’s just too difficult to specify things otherwise. And around the three days I think we could say 3 business days.

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

So, okay, because sometimes, you know, it will be, you know, sometimes it’s an image, you know, so sometimes, you know, you get your results back in terms of is that a lab, does that include it, you know, a cancer study.

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

Right, well here I think we’re just talking about clinical – sorry clinical laboratory test results so not radiology results.

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

All right.

George Hripcsak, MD, MS, FACMI – Columbia University

So, yeah, this is George, we have to decide how to scope it. I mean, there's abnormal test results, we need – if we're going to do that we need to have the ability to identify abnormal test results, that's certification, okay, notify the ordering providers when results are available so that's just the task list and then – or that they're not completed by a certain time. So, what is the measure? What is the EP do?

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

So –

George Hripcsak, MD, MS, FACMI – Columbia University

The EP has to check a box saying “yes, I've seen this lab result?”

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

This is Michelle; can we take a step back? So what's the intent of this? Is it test tracking to make sure that, you know, there aren't open lab orders that are missing or test tracking in the sense that you're making sure that if there is an abnormal you're following up with the patient? And what is this?

George Hripcsak, MD, MS, FACMI – Columbia University

Well this one doesn't do the patient yet but what it says A, just following up on the test. The abnormal part is just making sure that well if – you have to follow-up on the normal, the not done, the normal then the abnormal with the abnormal being the most important to follow-up on and then there would be a second half which would be how do you tell the patient about it?

Michelle Consolazio Nelson – Office of the National Coordinator

So, should there be a second half?

George Hripcsak, MD, MS, FACMI – Columbia University

I'm not sure that this shouldn't be certification only.

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

I think that this – I mean, this is the leading cause of malpractice in the outpatient setting.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah.

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

Yeah.

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

So, I think –

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

That's why I hesitate –

George Hripcsak, MD, MS, FACMI – Columbia University

There is no patient here.

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

Is there any mechanism where you can give the control to the provider or something where results say designated as a normal or something, you know, can be followed up?

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

Sure, so, you know, we’ve built it – for example we’ve built it – which is called results manager which takes all the results for a patient puts them in one place for the provider, it prioritizes them according to how abnormal they are and then providers can very rapidly tell the patient about them and this works really well. I mean, every application should soon have something like this.

George Hripcsak, MD, MS, FACMI – Columbia University

But should we – I mean, because we have this – I know there’s a volume issue on the normal ones and we’re going to be acknowledging 10 percent of them so 10 percent is good, it’s low, although I don’t know if 95 percent of your test results are normal then you have to ask why maybe you’re ordering too many tests. Then you have to acknowledge at least some of the normal. I think the normal workflow is to look at it and not go through an extra step to say you’ve seen it, so, now we can force it, it’s that one more click I guess.

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

It’s very simple to say that you’ve seen it.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah.

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

I mean, we’ve – George are you doing something like this?

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, I don’t think we do the acknowledgment though on normal tests.

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

We do and it’s actually a best practice around this particular area.

George Hripcsak, MD, MS, FACMI – Columbia University

I’d have to ask Pete, Pete knows the answer of whether we actually acknowledge or not.

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

Right. I mean, I chaired, again I chaired this Massachusetts-wide taskforce around this and, you know, this is – the acknowledgment step I think is useful.

George Hripcsak, MD, MS, FACMI – Columbia University

Are there any practices, subspecialties where it makes less sense? I’m thinking of are there subspecialties where you order a huge volume of tests as kind of a test-based practice where acknowledging all the normal ones doesn’t make sense? I can’t think of anything I’m just asking.

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

No, I don’t think so. In fact the standard of practice says if you do a test on a patient you should let them know about what the result was. Here we just said that the provider has to look at it within three days. They don’t have to –

George Hripcsak, MD, MS, FACMI – Columbia University

Are you acknowledging each test?

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

So, what – in your system you’ve designated what you want to manage, right?

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

We do it for every test but you acknowledge tests in the way that they were ordered so, you know, if you did one set of 20 tests you can acknowledge that with one button click.

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

Okay.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay, so I would stick with a low threshold until we figure this out.

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

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

So, now let’s go back to the question for a second.

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

Right, so Michelle did you get the additional details in terms of specificity? So, this is just EP.

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

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

The intent is to improve management of abnormal test results, the kinds of tests are clinical laboratory tests to acknowledge just means a single click of a box, abnormal means is determined by the laboratory and for the three days, three business days.

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

So, the only question I have is I’m not sure, was the original intent just lab results or was it all tests? Because why didn’t we write in lab? I feel like we meant it more broadly.

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

Do you think we meant radiology tests too?

Michelle Consolazio Nelson – Office of the National Coordinator

I feel –

George Hripcsak, MD, MS, FACMI – Columbia University

I do –

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, George go ahead.

George Hripcsak, MD, MS, FACMI – Columbia University

This is George, I think we did mean everything but I think since we’re implementing it and this is the first time I’m not sure we shouldn’t limit it to labs.

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

Well, we do it –

George Hripcsak, MD, MS, FACMI – Columbia University

Because then it –

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

We actually do it for both.

George Hripcsak, MD, MS, FACMI – Columbia University

But that’s not all there is either, it’s not just lab and radiology there’s all kind of things that are test-like and then, so radiology its three days, within three days of what? Sorry.

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

Three days of when the test was performed, the x-ray was performed.

George Hripcsak, MD, MS, FACMI – Columbia University

Three business days so that’s better.

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

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

I don’t know for some of these radiology tests you maybe bordering on – you might need more time. Some of these large studies, I don’t know, on a, you know, you have some musculoskeletal problem you go for an MRI somewhere – I’m trying to think of examples where 3 days is not necessarily reasonable to expect the doctor to have reviewed the film himself, him or herself if he or she wants to. So, I think lab tests makes it easier to start this thing, but what do you think David?

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

Well, I could go either way. Charlene do you have strong feelings?

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

I could go either way too. I mean, I could – you could argue because we’ve got lab orders and radiology orders in place we’ve got the infrastructure but once they do the mechanism they should be able to track anything right in theory?

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

Yeah.

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

So, I’m fine with just labs.

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

Okay. Okay, so maybe make a note that we might broaden this to radiographs down the road. Okay, so let’s see I think the next one is CPOE.

Michelle Consolazio Nelson – Office of the National Coordinator

So, all of the next items were consolidated in the consolidation process. So, I think the question will be are there comments from the public that would make it so that you wouldn’t want to consolidate those items so they may need to be pulled back out on their own.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

So, most of the rest of the items are certification only and family history was actually put into the care summary and view, download, transmit.

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

Okay. So, let’s take a look. So, on the DDIs there were questions about DDI maintenance of never combinations. I mean, there’s just going to be a specific list of those, there’s not a list of – we’re not suggesting adding drug food, drug disease, etcetera.

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

So, I think, it’s just like, you know, how right now we can go get our – the value element catalog or, you know, the value element catalog the National Library that kind of requirement is where are we going to get this information that’s, you know –

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

Right, well it’s a very specific list that ONC commissioned.

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

Yes.

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

Which, you know, which we developed, there are just 16 of them.

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

So, I just, I think the comment needs just to be made about, you know, I can understand 16 but those 16 could change over time, right? So, it’s that ongoing –

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

But, they’re not likely to change over time there could be a few –

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

I get it, I do, I understand that because I was on those calls.

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

Yeah.

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

But you might – with all the stuff – you still might run into one or more that you want to do, so that’s where the question is coming from, it this something static that we’re going to use for ever or is it something that has to be maintained and where do I go get it?

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

Right, well it’s a static list and I would say that additional ones could be added but it’s unlikely that any would be removed.

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

Okay.

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

Okay. The next question is about the standards for drug-drug interactions which relates to RxNorm versus NDF-RT standards now. I think that this is up to the vendor is it not?

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

Yes. I mean, we have to now use – we use First DataBank but there are other, you know, capabilities out there.

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

Right, no, no and the message here is not that anybody would stop using First DataBank. I think most of these comments are just from people who are not familiar with the list.

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

With the list of the standards and all, yeah.

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

So, I mean, I would just leave things. I don’t think I would do anything different based on this particular set of comments. I would just leave things the same. I mean, I – yeah. Should we move to 104?

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

Okay, demographics, oh, yeah. So, this was consolidated?

Michelle Consolazio Nelson – Office of the National Coordinator

This maybe one that we need to bring back to the full Workgroup, because this is where we received the most comments in the RFC and most were related to the occupational industry codes, there were 192 comments, a lot of it was a form letter that was just – we received multiple times, so that’s where the overwhelming support comes from to include them not just as certification criteria but as a use case where they actually have to do something that is measured for Meaningful Use.

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

So, let’s talk about it here anyway and decide what our position is before we get back to the full group. Were most of these – and Michelle was that mostly related to occupation and industry.

Michelle Consolazio Nelson – Office of the National Coordinator

Most were and then there were a lot of comments as well related to sexual orientation and gender identity and we heard from them a couple of times during public comment of the Policy Committee as well.

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

Okay and if we were to have something that was not – in other words there was a Meaningful Use specific question what would it be? It would just be that providers should collect data about occupational and industry information.

Michelle Consolazio Nelson – Office of the National Coordinator

I guess it could probably be similar to the old demographics objective where there was a percentage, you know, for certain percentage of patients, I don’t know though.

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

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

Because you wouldn’t do that – because you wouldn’t do that for sexual orientation and gender identity, well I guess you could.

George Hripcsak, MD, MS, FACMI – Columbia University

You could but actually the comments are –

Michelle Consolazio Nelson – Office of the National Coordinator

It would have to be a low percentage.

George Hripcsak, MD, MS, FACMI – Columbia University

The comments are split on whether we should force it or not force it though on that one. So, it does seem odd to have an objective sitting out there that says enter, occupation and industry code, it is kind of a scalable thing compared to the other objectives which we're consolidating. It seems like if you want to force use under our new scheme consolidation and deeming scheme it would have to be part of a quality measure or something.

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

Right and so far as I know it's not is it?

Michelle Consolazio Nelson – Office of the National Coordinator

No, no there is disability status which is further along. There were suggestions to change the wording of that but that could relate to a quality measure but I don't think that occupational industry code and sexual orientation necessarily would. There are also comments though that it should be gathered from – not from the front desk, which is where, you know, some of the demographic information is typically gathered and it should be more clinical.

George Hripcsak, MD, MS, FACMI – Columbia University

What is industry? You know, I don't know it depends, if you're – so your dentist needs to collect your occupation and industry codes while you're in the dental chair, you know, for that part of Meaningful Use, it just seems –

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

That doesn't make much sense.

Michelle Consolazio Nelson – Office of the National Coordinator

I think that those comments – I'm sorry those comments were more related to sexual orientation and gender identity, and disability status.

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

Oh.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, so you think it was from the full Workgroup, it sounds like from the people talking here that we agree with the overwhelming support to add occupation and industry to the certification criteria but we have reservations about making a Meaningful Use requirement for it.

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

Correct, I mean, we feel like it would be better left this way.

Michelle Consolazio Nelson – Office of the National Coordinator

And that was the discussion before the public comment as well.

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

Yeah. Charlene do you agree?

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

Yes.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

So –

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

Go ahead.

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, where we just making the decision on occupation industry codes? My next question is for disability status it was recommended to change it to functional status and that aligns with some of the quality measures.

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

I like disability status.

Michelle Consolazio Nelson – Office of the National Coordinator

But then the question is that really isn’t something that the front desk would gather within –

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

But we’re not implying that these have to be gathered at the front desk, they can gather them anywhere in the process as long as they capture them, right?

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

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

So, I don’t think that – they can capture them anyplace in the workflow.

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

Right there just has to be a place in the record to put them.

George Hripcsak, MD, MS, FACMI – Columbia University

Is disability – disability status and functional status are kind of related but aren’t they two different things?

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

I think they are for regulation purposes.

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

I think they are too that’s the downside of this; I’m surprised that this college recommended that.

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

Yeah.

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

Did any others Michelle? Where there any other societies that commented on this?

Michelle Consolazio Nelson – Office of the National Coordinator

I’m just looking at the high level, I can pull up – it will take me a minute to pull up the full details.

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

And I also want to ask when we’re going to – well they’ll be in certification – the extent to which providers actually have to fill them in will be dependent on whether they’re mandatory or not in the consolidation like if it needs to show up on a transition of care summary or something.

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

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

Yes.

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

And then we have to specify there if they're mandatory or not?

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

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

So, as of now all of these items are just certification criteria and they didn't get put into anything other than the patient preferred means of communication –

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

And –

Michelle Consolazio Nelson – Office of the National Coordinator

That was added to the after visit summary and a few other things. Sorry, Charlene.

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

That's okay.

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

So, okay, I mean, after the discussion I'm reluctant to call it functional rather than disability.

Michelle Consolazio Nelson – Office of the National Coordinator

Maybe we want both? I don't know?

George Hripcsak, MD, MS, FACMI – Columbia University

I mean it's possible we need both, we need someone who understands this to just tell us what we need. I always thought functional status was the property of every patient, you know, telling us their functional status and disability status the intention was that there is a formal definition say a federal definition of disability we want to record that. Maybe what we meant – maybe we misspoke and when we said disability we really meant functional I don't know.

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

I thought we meant disability.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah.

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

And I think functional status could fall under the care planning piece too, you know.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, that's a different kind of thing. So, I think there's a – so we want to keep it certification and we need someone to advise us on – so we want to keep disability and do we need to add functional or is that something else, is that what we're saying?

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

Well, I say let's look elsewhere to see where to add that, yeah. I think we definitely do want disability. Somebody in my group is writing a grant about this now and there are just a set number of types of disability and there is this whole classification approach and so on. Okay, so I think we're at consensus there.

Michelle Consolazio Nelson – Office of the National Coordinator

So, sorry, did I hear that it should be recommended as an item for the care summary and it will be brought up in Charlene's group?

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

Yeah, you know, when I give the categorization of those different data elements I'll watch for it, okay, the functional status piece.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

Because it can be a goal, you know, sometimes functional status it's certainly a measure and potentially a goal.

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

Right but we're going to leave disability here.

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

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

Okay. Let me just ask about the steering committee's sorry the Standards Committee comments are they disagreeing with basically combining, with making this a certification criterion only?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

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

What –

Michelle Consolazio Nelson – Office of the National Coordinator

They just don't like that we said that 80 percent was topped out.

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

Right.

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

So the next slide is that their comments?

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

Yes. So, you know, we could do something like, you know, make it 95 or something?

Michelle Consolazio Nelson – Office of the National Coordinator

I think the intent of part of the retirement though was that, you know, for Meaningful Use you'll then have to kind of check off that you're doing those things whereas the assumption is that they'll continue to do these things and gather that information for quality reporting and all the other things that have to happen within the EHR.

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

Yeah. So, are we okay with not doing anything else about this?

Michelle Consolazio Nelson – Office of the National Coordinator

I guess the only other question I have is – so the questions that the Standards Committee has do we want to attempt to answer those in any way so that they can better provide specifications or standards, or do we really want leave that up to them?

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

Let’s see so –

Michelle Consolazio Nelson – Office of the National Coordinator

So they’re asking about like a definition for disability status, I don’t think we’re all sure on that, but then they’re asking how sexual orientation will be codified, I don’t think this group knows and that’s one thing that we probably ask of them.

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

Right.

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

This is like Standards Committee stuff should know whether there is a potential even to do it. I know people are worried about the multiple codes, you know, and if there’s a standard out there – I mean, they’re determining if there is a gap and if we can get it or not.

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

Right. I’m just reading their comments again and I think their point about date of disability status –

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

Yeah.

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

Should be included that’s a good point. And there is – I can’t remember what HCPCS is, those are HCPCS?

Michelle Consolazio Nelson – Office of the National Coordinator

I’m Googling I don’t know either. I’m actually not sure, when I Google I don’t get anything that is intuitive.

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

Okay, well, yeah, I think I’ve found it. This is the healthcare common procedure coding system code set.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you.

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

It doesn’t say exactly what they are. Okay, well I think it applies to all procedures, but this is for therapy claims services. So, I think that’s really different than what we’re talking about here. Okay, shall we move on?

Michelle Consolazio Nelson – Office of the National Coordinator

I think we’re ready.

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

Okay, so the next is – okay, the up-to-date problem list and they were concerned that this was too vague. Some people suggested it be part of clinical decision support. I have to admit I’m sort of puzzled by this.

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

So, if it’s consolidated, right?

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

Yes.

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

We have to be certifying that it's up-to-date though.

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

Well the –

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

So, that's –

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

So you have to be certified to –

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

– how they're certifying the fact that it's kept – but up-to-date is a process, right?

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

Yes.

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

I mean, part of it is that if you're going to send problems out either preventing view, download or transmit and/or send them on a transition summary, care summary they've got to up-to-date right? You know, you're – now and then maybe there are some measures some day that says you get good data, right? We're starting to see that, but that's kind of what – to send – now that doesn't say that it's up-to-date before those events happened, right? But, if you think about it you'll be able to start – you'll have access to, you know, the data, your data while you're in the hospital, right or close to when, you know, pretty much on-line.

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

Yeah, I mean from the certification perspective it seems to me like you should just be able to capture the problem list.

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

Right, I agree. So, for certification I think that makes it – I mean, unless you want us to – and then if you try and describe and certify how are you going to maintain and keep this up-to-date, how are you going to make providers do that like how are you going to do that?

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

Right.

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

So, I think for certification purposes – do we have problem list under certification now?

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, so this was never a use requirement this was always certification.

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

Well, but problem list used to be – this was –

Michelle Consolazio Nelson – Office of the National Coordinator

No, problem list – in Stage 1 it was its own measure, in Stage 2 it got moved into the care summary and – well, I'm not sure if it's in VDT, but it's definitely in the care summary as a required element.

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

That's right. So, Stage 3 we were proposing mechanisms to keep it up-to-date but it doesn't make sense just to put it in for certification is kind of our conclusion. Either something – it's a use requirement or it should be good as is.

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

Yeah, I agree with that, George do you have thoughts?

George Hripcsak, MD, MS, FACMI – Columbia University

Well, I think we – well we started moving a lot of things, you know, in this consolidation mode and deeming mode moving whatever we can to certification. I think we didn't, if I remember correctly the discussion, want to burden providers like it wasn't clear what we should measure like how many problems you got right so what's the denominator, what's the gold standard, you know, and then to have a rule that says, you know, well I was alerted 14 times that patient is not previously known to be diabetic or now diabetic, so the use became complicated I think and so that was also I think part of why it's certification and I think the objection on the next screen is just that okay I'm a vendor what do you actually want? I mean, I get the concept but do you actually want me to do? And it seems like anything I can think of is really a form of decision support, some kind of rule driven by data to send it, so why is it in decision support, that was my interpretation.

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

So, should we change the language here so that you're just required to have the problem list? And, I think anything that is from decision support is going to come up in decision support.

Michelle Consolazio Nelson – Office of the National Coordinator

Well, so I think it's already a certified element anyway. So, I think if you wanted it to be part of decision support which maybe I think that's what everyone is getting at, that the certification criteria should fall into that objective to push the functionality of current systems. So, it's more than just the problem list, you know, so if a patient comes in and their sick, and you add something to the problem list that's only for that visit you'll then get decision support on the next visit that probably should be removed or something.

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

Right, so should we just drop this? That would be another option.

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

I would.

George Hripcsak, MD, MS, FACMI – Columbia University

Or a future stage.

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

Right.

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

Because, we're going to spin on this one, because –

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

Right, I mean some of this –

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

I know what you'd like – you want us to be smart enough as vendors – I'd rather see you put it under clinical decision support, you know, to identify potential problems such as they populate the list I'd rather see it happen there. You make decision support more robust. We still have decision support don't we?

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

We do.

Michelle Consolazio Nelson – Office of the National Coordinator

Yes.

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

I would rather it be seen there or, you know, we don’t specify how they do it, but, you know, it’s tools to help them, you know, use the data that’s in the system basically.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, I see David’s point. Well, this would be another category that they could pull from then for Stage 3? Decision support to keep problem list up-to-date would be one of these things they could do as a decision support option is that what you’re saying, Charlene?

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

Yes. I mean, we’re always –

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

Based on the lab results and, you know, blah, blah, blah populate, you know, provide suggestions to populate the problem list that’s really complex stuff, but most of vendors work on it you know.

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

It’s not that hard, I mean, we just have published a set of rules that work really well that we attested.

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

Okay, see I would rather – you would – but can we categorize that under decision support stuff instead?

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

Sure, we can categorize it under decision support. I mean, they’re publically available, anybody, you know, it’s all open source stuff. You could take this stuff tomorrow and put it in your application.

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

I think that’s great.

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

But it would be fine to put it in decision support. Okay, so should we –

Michelle Consolazio Nelson – Office of the National Coordinator

So, I’m sorry, I heard two different things though. Are we putting in decision support as just certification criteria only or are we putting in decision support as using the problem list as George said?

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

Let’s put it under decision support relating to the problem list.

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

I think that’s powerful now we’ll probably get pushback, but, it’s like –

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

Yeah, that’s okay.

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

That’s where we always hear the need and if you’ve got some research that is based on some models, so hopefully by – they can be adopted by Stage 3, you know.

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

Yes, okay, great. Okay, so the next one is maintain an active medication list, people supported it but they – the Standards Committee didn’t want to standardize around this.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, this exactly the same as before.

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

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

It’s vague and, I mean, the comments are that it’s vague and the HIT Standards Committee says, recommend against it. And then the next one is medication allergy, well they don’t say vague, but again the Standards Committee says, not yet.

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

Well, we’re eliminating all the things that are actually going to make care better.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, we had already switched to certification only.

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

Right.

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

Yeah, the – once it’s certification only that’s when the complexity happens. I mean, in certification they do test that you can automatically update and keep it, I mean, they test that it’s concurrent, you know, that we don’t do it after the fact, but that’s a given, but there is no given that the provider will keep it up-to-date, you know, so that’s where there’s a gap, we can’t do that.

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

Yeah, so I’m reading this and thinking about it. I’m not sure that we need this one either.

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

I agree.

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

George are you okay with that?

George Hripcsak, MD, MS, FACMI – Columbia University

Yes.

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

Okay, 107 I think is a similar issue.

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

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

108.

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

Yes, 108.

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

I think we’re planning to retire it.

Michelle Consolazio Nelson – Office of the National Coordinator

So, sorry, David, just confirm 106 and 107 you’re going to remove completely?

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

And 108 the plan is to retire it.

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

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

109 we’re also planning to retire.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

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

Okay.

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

114 this has been incorporating clinical lab tests into structured data.

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

I think we should retire this one. Can we retire this one? How long have we been – we’ve been doing this for years.

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

Yeah, I think we can retire it.

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

I mean, you’ve got the gap that we had was getting it from ambulatory and they filled that, right?

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

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, retire or just leave as certification only? This one place, what are we on 114, right?

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

Yeah.

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

Certified, why do we – if we’ve been certified once why do we need to be certified against this one again? The only reason is if they change the standards.

George Hripcsak, MD, MS, FACMI – Columbia University

No, no does certify only – we’re just saying that it doesn’t come out of the certification standard that you have to be able to accept clinical lab test results.

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

You can’t be an EHR if you can’t accept lab test results.

George Hripcsak, MD, MS, FACMI – Columbia University

But we’re just saying that we don’t take it out of the – and it’s in the certification rule and we don’t need to remove it. Like when we say retire I don’t know what we mean, because our suggestion originally was we’re not going to ask the users anymore questions so the 80 percent threshold is irrelevant because we weren’t going to ask them any more questions anyway. Right, we don’t need a threshold once we went to certification only.

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

For my case I would try and reduce the scope of certification so that the vendors can focus on like CQMs and all of those. I would take it out of certification; I would take it out of Meaningful Use, because we do it today. The only thing that is so important –

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, that’s a good point. Charlene is that true – Michelle, are we – when we retire things are we taking them out of the certification rule, like problem list, vitals, not – yeah, problem list, vitals and demographics?

Michelle Consolazio Nelson – Office of the National Coordinator

Well, we never actually had the conversation I think it’s a good conversation that we haven’t clearly had because I think there are different interpretations. I know –

George Hripcsak, MD, MS, FACMI – Columbia University

Maybe we should –

Michelle Consolazio Nelson – Office of the National Coordinator

I know as part of the – sorry, as part of the consolidation work Christine had thought anything consolidated would still stay as a certification criteria but it was just getting moved somewhere else or, you know, kind of what we’re calling retiring, because that’s what this lab one is for example. So, maybe it’s something that we bring up in the full Workgroup so everybody is clear on what it actually means.

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

And I just have to tell you that the certification process is incredibly onerous and it’s not a – we need to make it sustainable and more nimble and really focus on the things that are important. So, I don’t buy into like keeping everything there because we already did it, you know, if we’re certified on it, you know, they need to certify on that next generation of stuff and I know you can argue there might be some new vendor that comes on the block that doesn’t do some of the old stuff, but, you know, they’re not going to be a vendor for long if they do that.

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

Well, yeah, I would be reluctant to take it all the way out of – take these sorts of things out of –

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

Well, how about you leave it in one batch and you take it out the next one or something? You know, it’s like look at – it takes us a week to certify now, you know, it’s like and that’s because the process is pretty broken.

George Hripcsak, MD, MS, FACMI – Columbia University

So, this is a very good discussion, I mean, so Charlene why don’t you send an e-mail to Paul.

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

All right.

George Hripcsak, MD, MS, FACMI – Columbia University

As an issue and then maybe we can just mention it at a full Workgroup, because like this Subgroup shouldn’t really be deciding this, this is a bigger issue.

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

You’re totally right.

George Hripcsak, MD, MS, FACMI – Columbia University

So, let’s send it to Paul and then we’ll see what we do with that. I understand that motivation is to simplify.

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

Right.

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

Yeah, exactly.

George Hripcsak, MD, MS, FACMI – Columbia University

You know, you’re a giant company and I, you know, frankly, you know, feel okay that it takes a while to certify, you know, what I don’t want is somebody coming in and say not having a coded problem list.

George Hripcsak, MD, MS, FACMI – Columbia University

A new vendor?

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

Yeah, I mean it’s a good conversation to have. Charlene I’m happy to bring it up with Paul, the other point though is for quality measurement, I mean, the thing is people do use different modules which is where the problem comes in but for quality measures you need to be able to capture all this information anyway.

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

Yeah and I’m totally supportive if that’s the end, I’m totally supportive of certifying against the interoperability standards and this quality measures stuff, but some of the functional stuff, you know, I mean, it’s a check the box, but you’d have to test it, you’ve got to validate it, you’ve got to document it, you know, it’s like all that stuff, you know, but I’ll raise the point.

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

Okay. Okay, so now we’re on 115.

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

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

Okay. And that I think we just want to leave the same.

George Hripcsak, MD, MS, FACMI – Columbia University

Yes.

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

Did we get any feedback on these dashboards?

Michelle Consolazio Nelson – Office of the National Coordinator

So, sorry, David, when you say leave the same, so this was consolidated, so it’s no longer a use requirement right now.

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

Right, I mean, leave this as it’s described here.

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

So –

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

I think it’s okay to have it be consolidated.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

But they don’t like the concept of dashboards. So, we consolidate – so, you’re not going to be certifying against a dashboard then.

Michelle Consolazio Nelson – Office of the National Coordinator

I think this would almost be retired or however we define retired.

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

Okay. Well, how does it consolidate Michelle do you know?

Michelle Consolazio Nelson – Office of the National Coordinator

This one was one of the few where it didn’t go anywhere. The assumption was that you would have to be using patient lists and dashboards to produce outcome measures and do a lot of the things that we’re hoping to achieve with Stage 3.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

But there isn’t an actual use requirement to do them.

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

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

But, if – I guess you kind of bring up a good point Charlene though if we thought dashboards were important is that something for certification criteria that we’d want to be explicit about, because, it wasn’t in Stage 2?

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

Or is the assumption that there would be other reporting tools that could be used so it doesn't have to be a certification element.

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

I mean like we do dashboards and all those things because you just have to do something to show them, right?

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

Right.

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

You have to have some mechanism of displaying the information. So, I think by driving it by outcomes the vendors are going to have to create those things for their customers.

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

Yes, okay. Family history, again this is –

Michelle Consolazio Nelson – Office of the National Coordinator

So...

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

Go ahead?

Michelle Consolazio Nelson – Office of the National Coordinator

I'm sorry, so this one was consolidated and put into view, download, transmit and potentially the care summary. So, in Charlene's group we haven't talked about it yet, but in Christine's group they did and they quickly looked at the comments and they were a little bit worried about consolidating because people were concerned about pushing it to core and the thresholds so they weren't sure if it made sense to then consolidate into VDT where it might not be a required element. So, it would have to be required in VDT for it to still be a use case if you will.

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

So, and where were we in Stage 2?

Michelle Consolazio Nelson – Office of the National Coordinator

20 percent.

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

Right and we don't know how people did with that.

Michelle Consolazio Nelson – Office of the National Coordinator

Correct.

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

I mean, I'm reluctant to consolidate it I guess.

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

I would be too, because there is some more work in standardization that can happen here, because it went in – we hadn't recommended this and it went in. I know our people looked at the standard and family history is one that varies all over the place. So, in terms of how different people capture their family history, right?

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

Right.

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

And the different vendors have better and worse family history captured, you know, they compete on that stuff. So, if we can get to where there is a little bit more standardization around it that data can be collected by patients and all because it starts to harmonize, I think that’s all goodness and putting a better framework of standards around it I think will help. So, I think it’s going to take us to Stage 3 to figure that out, because it’s pretty loose in Stage 2.

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

Yeah, so I agree. Is that all right with you Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

Yes. Are there any changes? So, if we pull it back out are there any changes that you do want to make to the objective still raising the threshold and moving to core but perhaps reconsidering the threshold based upon Stage 2 experience.

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

Yeah, I think that’s what makes sense.

George Hripcsak, MD, MS, FACMI – Columbia University

So, I’m just looking –

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

Why wasn’t it – what do they want us to do with clinical decision support?

Michelle Consolazio Nelson – Office of the National Coordinator

So, there was certification criteria for this one that you would be able to use family history in CDS and I’m not looking at the comments but maybe they were suggesting to move it to CDS, I don’t know.

George Hripcsak, MD, MS, FACMI – Columbia University

So, this is going to be not certification, this is going to be use at 40 percent.

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

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

Are you going to remove the certification element of it or keep it?

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

Well, when we read like family history especially in this section it wasn’t so much the clinical decision support it’s having the standards in place to capture it in a more structured way and support the data capture of it.

George Hripcsak, MD, MS, FACMI – Columbia University

I don’t know this sounds – you guys sure you want to do this?

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

I don’t know why we have to mix CDS with it, you know.

George Hripcsak, MD, MS, FACMI – Columbia University

No, no, no, no, no I’m just not even at CDS yet.

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

Okay.

George Hripcsak, MD, MS, FACMI – Columbia University

I'm just, so, 40 percent, so what the commenters say don't move to core but if you do move to core you need to develop exclusion criteria. I'm sorry, are we saying whether it's core or menu?

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

It was menu, it was menu for Stage 2 and it's being moved to core for Stage 3.

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

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

So, that means every EP has to get a family history on 40 percent of their patients?

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

I think you could opt out.

George Hripcsak, MD, MS, FACMI – Columbia University

On high priority conditions. So, it won't even be the ones that are relevant to your specialty we're talking about, which I think is fine by me, I mean, it's going to be, you know, cardiac disease, breast cancer a couple of others.

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

Colon cancer, yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

But why is my dentist asking me about my mother's, you know, breast cancer.

Michelle Consolazio Nelson – Office of the National Coordinator

They've also asked us to define what high priority means. So, do you want to explicitly say those examples you provided?

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

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, in our first discussion we specifically mentioned those, cardiac disease, breast cancer and colon, there may be other too but that's three examples. So, high priority in the sense of both it has a large impact on the population because the prevalence of disease and the severity of the disease, and also that family history has some bearing on it.

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

That's a hard one, you know, like that's kind of what you would like to – high priority, you know, diseases where family history has a bearing but we can't figure that out in our system. So, I mean, you could, you could define the – you know, when you define the problem you could indicate it, but that's kind of rudimentary.

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

What do you mean?

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

I was just – I was trying to – this high priority, you know, you were trying to indicate, you know, if capture high priority diseases where family history has a bearing, I said that's a hard concept for us to automate that really unless there is some indicator that tell us.

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

Well I’d give the –

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

I was trying to get to my denominator.

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

Right, I’d give the specific examples that George does. I mean, we’ve done this, we did this a long time ago and, you know, it’s not that hard. What’s hard is really doing a comprehensive family history.

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

Yeah.

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

Which that is not that worthwhile, but finding out whether somebody, you know, has a family history of colon, breast or cardiac disease is.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, for the primary care provider and some others.

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

Right.

George Hripcsak, MD, MS, FACMI – Columbia University

So, I don’t know what the exclusion is.

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

Right, this has come up with some other – for some other areas and I just can’t remember how we’ve handled it.

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

The high priority of this case then refers to patient’s conditions.

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

Correct.

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

Or the family history?

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

Correct.

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

Okay, all right.

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

Correct and, you know, George as long as the primary care provider did it the dentist doesn’t have to do it themselves it’s not like everybody has to do it.

George Hripcsak, MD, MS, FACMI – Columbia University

Once they’re linked or if it’s in the same institute sure.

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

Yeah.

George Hripcsak, MD, MS, FACMI – Columbia University

Well, I mean, we can – I’ll go along with you, what you guys want to do. I think we’re going to probably get pushback from the group if we make it core 40 percent.

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

Well, let’s go with it and then if we get pushback we’ll revisit.

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

Can we specify types of high priority as you’re definition then?

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

I think we’re going to specify cardiac disease, lung cancer and –

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

Colon.

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

And colorectal, yeah.

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

Colorectal cancer, okay.

Michelle Consolazio Nelson – Office of the National Coordinator

And are you keeping in the certification criteria that’s currently there?

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

Yes. And I have one additional thing that came to me which we haven’t talked about and this relates to devices, as best I can tell there is nothing in the criteria about devices, but the universal device identifier standard is going to be released in June and it seems to me that if a patient has an implanted device that the provider should record the device identifier.

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

I’m going to mute.

Michelle Consolazio Nelson – Office of the National Coordinator

So, David, Christine mentioned in passing as well that she wanted to bring this up.

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

But are you thinking of this as its own objective?

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

Yes, I think so.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. So, I’ll make sure that she knows.

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

And I would think –

Michelle Consolazio Nelson – Office of the National Coordinator

You – I’m sorry.

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

Sorry, I would say both for hospitals and EPs.

Michelle Consolazio Nelson – Office of the National Coordinator

But, so I guess my next question is if it’s just a recording though how are we going to measure it and so then is it just really a certification criteria only item?

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

Well, I think you measure did the person record, you know, putting the – we could add a threshold to say that 80 percent of the time or something that when you put in place an implantable device it really should be 100 percent.

Michelle Consolazio Nelson – Office of the National Coordinator

Right.

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

You should record it. There should be something in certification as well, but this is something that providers are not used to doing. I mean, right now when they put in devices they don’t necessarily write down the device number.

Michelle Consolazio Nelson – Office of the National Coordinator

George are you still there? Do you agree with adding it?

George Hripcsak, MD, MS, FACMI – Columbia University

Sorry, go ahead, add what?

Michelle Consolazio Nelson – Office of the National Coordinator

A device...

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

So –

Michelle Consolazio Nelson – Office of the National Coordinator

Sorry, go ahead, David.

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

Yeah, so if a patient is having a device implanted that the provider should record the device identifier.

George Hripcsak, MD, MS, FACMI – Columbia University

No, I meant, add to what? Where are we putting it?

Michelle Consolazio Nelson – Office of the National Coordinator

It would be brand new.

George Hripcsak, MD, MS, FACMI – Columbia University

Oh, it’s a brand new objective.

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

Yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Where would – we had discussed this right? Where had we put it originally? It was a comment on one of our other objectives where had it been Michelle do you remember?

Michelle Consolazio Nelson – Office of the National Coordinator

We talked about it in passing in Christine’s group, but she just mentioned it in passing, at least that’s the thing I remember the most, I don’t know if it came up somewhere else as well.

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, I remember it was on a slide one day or maybe it was just the letter, maybe it was just the letter requesting it, maybe that’s what I’m thinking of. It would be nice if we could find a place to put it.

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

Yeah, I mean, I can’t think of sort of where to embed it in the other things. I mean, it seems to me just to be slightly different.

George Hripcsak, MD, MS, FACMI – Columbia University

You know, it’s a demographic or a problem list.

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

I mean –

Michelle Consolazio Nelson – Office of the National Coordinator

Well, problem list is gone.

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

–

George Hripcsak, MD, MS, FACMI – Columbia University

Well, not the –

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

This would be one for at least a minimum getting it in for certification, because once the vendors can do this then won’t providers start to do it or not?

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

Well, this is something that they’ve never done before so it’s just a –

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

Right.

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

It’s a little different.

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

So, you’ve got to build it into the workflow is what you’re saying?

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

Yeah, so that’s my argument for making it a Meaningful Use criterion, it’s also got to be –

George Hripcsak, MD, MS, FACMI – Columbia University

Well –

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

Pardon?

George Hripcsak, MD, MS, FACMI – Columbia University

Yeah, but, David I think we’ve got to be careful – well, I’m supportive of making it certification that’s easy. To make it – what motivated us is that we had so many objectives that we’re trying to cut down and consolidate and deem, and now we feel like we’ve peered it down, if now we start pulling back in family history, the device and the other one, I forget what other one I’m thinking of that we did this afternoon, we’re coming back up to the full number of objectives but we’ve eliminated like problem list and medication list and added in family history, it feels like – remember when we started this conversation we were saying what’s most important that no one else is doing is patient engagement and health information exchange, and we still want to do a little bit of quality, that’s where we want the new objectives to be, that’s our highest priority. So, that’s why I worry about adding a new objective which only does device, recording the device number.

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

So, let me give you the flip side of that. I mean, the good parts of this are it does relate to lots of providers who are not the primary care providers.

George Hripcsak, MD, MS, FACMI – Columbia University

Right.

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

Because, you know, you and I don’t put devices in people and it is, you know, it is a new federal standard that is just being released and it’s an opportunity to get people to start to use it. The FDA is, you know, very excited about having people use it and they’re really concerned that without a little bit of a push that they will not.

I actually had a call this morning with the head of the device group for FDA about this. They went to the Standards Committee initially and Standards Committee has reviewed the standard and said that it’s a good standard.

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

Yeah.

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

And the question then is just how do you get people to use it?

George Hripcsak, MD, MS, FACMI – Columbia University

All right, but then to be fair we should be looking at all new standards for things that have value and see how many of those should become objectives.

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

Well, do you have any other ones that are coming out? I don’t think that there are any other really major standards that are similarly important that are going to come out this year.

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

Yeah, I mean, this one has been on our radar it’s just, you know, prioritizing with everything else.

George Hripcsak, MD, MS, FACMI – Columbia University

I mean, I like the idea of it being nice for specialists so I agree with you there, you know, it just feels like a direct – an attempt to use Meaningful Use to directly affect practice not related to the mission of Meaningful Use, the new mission of Meaningful Use, I guess that’s what I’m –

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

Well, I think that the mission of meaningful use involves figuring out how effective some of the things are that we do and the biggest barrier in terms of devices and figuring out how patients are doing has been that we don’t know what’s been put in who, this would immediately tell you as soon as you start collecting it what has been put in who and then you could collect long-term data and find out how people are doing. So, I think this is actually, you know, very directly related to what Meaningful Use is supposed to be used for.

Michelle Consolazio Nelson – Office of the National Coordinator

I will say that ONC is forming a new workgroup with the FDA so maybe they could inform us more, but for now –

George Hripcsak, MD, MS, FACMI – Columbia University

It’s likely that workgroup is going to want a few objectives including this one as the highest priority.

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

Well, if you could – getting rid of some of those objectives for certification I support this one for certification for Stage 3.

George Hripcsak, MD, MS, FACMI – Columbia University

You support this one what? For certification?

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

I think –

George Hripcsak, MD, MS, FACMI – Columbia University

No but for use is the question. Certification I’m fine with.

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

For use, I’m – that’s up to you guys.

Michelle Consolazio Nelson – Office of the National Coordinator

Well, we can just bring it to the full Workgroup and see where it goes from there.

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

Yeah, George, why don’t you humor me on this one and we’ll bring it to the Workgroup and see and, you know, maybe I’ll be able to talk it through, maybe not.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

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

Okay, are there other things that we should be going through today Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator

The one thing – so, when we talked about the problem list we decided to move that to CDS?

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator

I don’t – if you have the Word document maybe we could look at that language and just see if there any language we need to change.

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

Sure, do you remember which one CDS is? Let’s see.

Michelle Consolazio Nelson – Office of the National Coordinator

It’s 113.

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

Okay, 113. I’m trying to find it here.

Michelle Consolazio Nelson – Office of the National Coordinator

And I’m looking at a different document, so I’m sorry I can’t tell you what page.

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

Let me try here, it’s not appearing immediately.

George Hripcsak, MD, MS, FACMI – Columbia University

What am I looking at Michelle, what document?

Michelle Consolazio Nelson – Office of the National Coordinator

In the Word document that was distributed.

George Hripcsak, MD, MS, FACMI – Columbia University

Oh, oh, oh, okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Objective 113.

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

So, its page 3 I found it here. Okay, so let’s see, it says use CDS to improve performance on high priority health conditions. Okay and we’ve said implement 15 clinical decision support interventions or guidance related to 5 or more quality measures. Can we just give this as an example of one of the sorts of things that would be done in an intervention?

Michelle Consolazio Nelson – Office of the National Coordinator

Sure.

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

That would be one way to handle it.

George Hripcsak, MD, MS, FACMI – Columbia University

I’d be okay with that.

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

Yeah, so there are some bullets under one and an example – you could add this as another bullet there.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay, so then if we add it as a bullet then they can choose that as – so two or more of the following areas – so that would be one of the two areas they could choose from.

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

Right.

Michelle Consolazio Nelson – Office of the National Coordinator

And that’s okay, right?

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay. Is it more specific though than – like so we say – this say preventative care which could mean many things.

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

Which say preventative care?

Michelle Consolazio Nelson – Office of the National Coordinator

Maybe as an example – sorry.

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

Sorry, I mean, I would add it as a separate –

Michelle Consolazio Nelson – Office of the National Coordinator

Okay.

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

You know as a separate area. It could be improving the accuracy of the problem list for one or more chronic conditions, accuracy or completeness of.

George Hripcsak, MD, MS, FACMI – Columbia University

Here’s a silly question, is it preventive care or preventative care?

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

I think both are used, that’s a good question.

George Hripcsak, MD, MS, FACMI – Columbia University

I think preventive care is the proper one.

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

Yeah, I think so too.

Michelle Consolazio Nelson – Office of the National Coordinator

Okay I fixed it.

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

Okay, okay, so is that a wrap?

Michelle Consolazio Nelson – Office of the National Coordinator

I think so. Thank you all.

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

Okay.

George Hripcsak, MD, MS, FACMI – Columbia University

Very good, thank you guys.

Michelle Consolazio Nelson – Office of the National Coordinator

Wait, public comment time.

George Hripcsak, MD, MS, FACMI – Columbia University

Oh, yes, yes, yes.

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

Public comment, yes.

George Hripcsak, MD, MS, FACMI – Columbia University

Still on, still on.

Public Comment

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

All right, operator can you please open lines for public comment?

Rebecca Armendariz – Altarum Institute

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

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

All right, thank you everybody.

George Hripcsak, MD, MS, FACMI – Columbia University

Okay.

Michelle Consolazio Nelson – Office of the National Coordinator

Thank you.

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

Thank you, take care.

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

Bye-bye.