

**HIT Policy Committee  
Meaningful Use Workgroup  
Subgroup #4  
Transcript  
May 13, 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 #4 on Population Health. This is a public call and there is time for public comment built into the agenda and the call is also being recorded so please make sure you identify yourself for the audio. I'll now take the roll call. Art Davidson?

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
Here.

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

Thanks, Art. Marty Fattig?

**Marty Fattig, MHA – Nemaha County Hospital**  
Here.

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

Thanks, Marty. George Hripcsak?

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

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

Thanks, George. 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. Amy Zimmerman? And Martin Rice?

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

Here.

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

Any other Meaningful Use Workgroup members on the line? And any ONC staff members if you could please identify yourself?

**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. So, with that I'll turn the agenda back to you Art.

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

Thank you, MacKenzie and thank you all for joining today. So, our task today is to finish out the work that we started about 2 weeks ago and earlier today I think Michelle sent out the latest version of the slide set which I haven't got the meeting up yet, I've better check that, try to put that up there as well, but we should be looking at – just a second here let me dial in. So, sorry.

Okay, we should be looking at the second slide, which reviews again all the items our group was supposed to spend some time on and just want to make sure it comes up here for me. So, just one second here. Okay. There it is, okay, so on the first we did go through immunization registries, electronic lab reporting, case reports to public health, syndromic surveillance and registries.

Today we'd like to finish out the other two items, the adverse event reporting and immunization clinical decision support discussions and then revisit probably, if we have some time, the registries and any other topics anybody else feels we might revisit. So, with that unless there is a suggestion otherwise why don't we go ahead and dive into the third slide which has the item from adverse event reporting that Meaningful Use proposed for future stage objective, which was to send adverse event reports, vaccine, device, EHR, drugs, biologics to the FDA or CDC from the certified EHR and it was by attestation, and that someone would be reporting that, and the certification criteria would be that the EHR is able to build and send standardized adverse event report messages to the FDA and CDC.

So, this, as mentioned earlier is in the future stage and if we can go to the comments on the next slide, so here we have several comments that Michelle summarized for us, the majority of the comments was supportive as this promotes an increased number of reports received, and increases the quality of the content.

And then there was a little divergence here that this is a critical function for patient safety and some argued that it not be delayed until a future stage and then others noted that this was present in several EHRs already, but then the next set of comments, which goes more contrary to the last point, is that they felt, some people felt that reporting should not be a function of the EHR and it's usually in another system and indeed in my institution it's in another system because the EHR hasn't been tasked with doing this, but I think it has been in some EHRs. Is there any comment about this? Charlene or George, or Marty? Any thoughts about this? Is this something that we should not try to put in the EHR that parallel reporting systems will likely always exist?

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

Well, there are cases of – I think they will, I don't know you're answer, but clearly there are cases of these kind of events that are outside of the scope of an EHR, this other system in health systems that would have these reports.

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

Yeah, absolutely, I think there are cases when this is outside the scope, but when it is observed by a provider in the course of care do we think it should or should not be part of the EHR?

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

Quick question, this is Marty Rice, my thought has always been with an EHR it's a collecting tool. The reporting usually comes out of some sort of database, so is there some clarity around this? I don't usually think of reporting out of an EHR. I usually think of building a report out of a database.

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

So, an EHR has the database where this could be stored, but I would typically agree with you it's to collect the data and, you know, send that to a reporting system too.

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

Yeah, the intent of this was the data collection side not the data, you could have a database of your adverse event reports but they're going to be pretty sparse. So, it was to send this and I think we made it future stage instead of Stage 3 for precisely the reason that the commenters said that FDA and CDC were not ready or capable of receiving these reports.

The bullet under there I agree with Art that that's not – I mean, I think that the EHR can be a data collection system. I don't know what the question is about secure, if you have someone's HIV information it has to be through a secure system so I don't see how –

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

Yeah.

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

Adverse event reports are – it's not secure enough for them, so I'm not worried about the bullets, but the main bullet there is why we made it future stage. So, the question is not so much is it a critical function that should happen, it's whether it can be done by Stage 3 and that's why I think we did future stage.

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

No, I don't think anybody is trying to suggest that this get pushed into Stage 3 I just wanted to finish out this discussion. I mean, I'm not sure of whether the FDA is incapable of receiving reports and I think that's something, some background that we might be able to try to get between now and the next time we have to generate some suggested Meaningful Use criteria, but this is not – I don't think that the intent of this discussion is to say let's go ahead and try to move this up to Stage 3. I just wanted to get everybody's opinion whether they thought that these comments were valid and worth our re-assessing their truthfulness or finding out their current state, that was mostly my intent.

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

So, what is – so the ask is just comments?

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

Yeah, I think, yeah, so this – right now we're just reviewing some comments around this adverse event reporting and I think what would probably be helpful is part of our future work not something in the immediate term is to find out is the FDA or the CDC capable of receiving this, so that it's either defined as an issue or non-issue, that we find out what are some sites where this does work, because it sounds like some people gave mention that it is working already in some EHRs, so that we're more informed at a future state.

And then I, you know, down in the third major bullet this clarification concerns, I think it's worthwhile for us to begin to catalog what are to be considered adverse events and I don't know that we have a clear definition. I went to the FDA site and started looking around and, you know, they have some definitions for radiologic events but not necessarily for all events. I couldn't find it easily in a brief search there.

So, I think that the questions, the bullets, the comments here are valuable, but as part of our effort probably in the next several months we might just get a little more clarification to state whether we think that these bullets are indeed pointed to issues about even future state uses.

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

Well, is an adverse event – would it only come out of an EHR like, you know, a clinical reporting tool or could it come out of other systems too? That's the reason why I'm very leery to talk about just EHRs and reporting out of EHRs, because I think there are other pieces that might come out of other types of systems to put together an adverse event.

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

There may be several it's just that can the EHR begin the process as another system might begin the process, but in the course of the normal clinical workflow when you see something that's an adverse event as a clinician do you have to go to another system or might you be able to use your EHR to do that? I think that's the – it's not to say that all adverse reports must come from an EHR.

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

Well, it depends on how your EHR is set up, you know, certainly they can do that, there is, you know, technologically it's there.

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

And I think that's what we're getting to in this is to say is that something that we would kind of push toward in a certification criteria mode, you know, that the EHR, that more EHRs are capable of doing that, as you say you have knowledge of one already. Other comments?

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Art, this is Amy and I just want to let you know I joined the call, I'm also in the car so I'm going to keep you muted most of the time unless I have a comment.

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

Okay, thank you Amy, thanks for joining us. So, I hope you're not looking at the document while you drive.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

No, so I'm going to try to follow by listening I promise.

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

Okay, great, thanks. So, then, so I think that, you know, I'm interested in maybe following up on a few of these comments to understand the readiness of the federal agencies and to see if the federal agencies are willing to provide us with an adverse event definition or set of definitions. And then, you know, I don't think we need to do much more than that. I don't think that this is being pushed to be something moved up to Stage 3. So, just a little bit of informational stuff for our group.

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

So, just another informational point, I know there is a new Workgroup that was formed to look at, FDA blah, blah, blah, to look at the potential regulatory framework, and this is strictly related to the topic of patient safety around the use of EHRs and I know from that process they may – one of the things that, you know, the vendors and kind of the community has been recommending is that regardless of where we report adverse events, regardless, they all have to go through a process of understanding root cause and that root cause could be an EHR or something else and whatever that is it should be the same thing, right, as opposed to sending things two different places.

So, it'll will be – I think they're recommendations are due in a September timeframe, so it would be interesting, and again, I recognize this is broader than just HIT related events, but whatever that reporting mechanism is hopefully that discussion will shed some light on this requirement and the reporting requirements for it.

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

And this is a reporting requirement from the FDA?

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

No, this is just work that's being done through ONC to look at the regulatory framework around HIT including reporting. Today the reporting of safety events goes to patient safety organizations, right?

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

Yes.

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

That's the current state. So, are they going to continue that or are they going to have them report them somewhere else, you know, what's going to come out of that process.

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

And who is leading that at ONC do you know?

**Michelle Consolazio Nelson – Office of the National Coordinator**

The workgroup lead is David Bates, so hopefully any work that is done there he'll make sure it gets looped back into the Meaningful Use Workgroup.

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

Okay.

**Michelle Consolazio Nelson – Office of the National Coordinator**

And then also Subgroups that I think Paul Tang is one of the subgroup chairs, so, hopefully we'll just have good communication back and forth.

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

Right, so again, I think that could affect what the, you know – I don't think we need to do any extra work, because I mean, they are going to have define adverse events too, right?

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

Okay, yeah, right, okay, thank you Charlene. I don't think I was aware of that group and thank you Michelle for filling us in, good. So, then we can move onto the next slide, which the Standards Committee said that at present adverse event reporting and not EHRs are supporting this functionality, although there is some testimony from people who said that some EHRs do this, so do we actually know from the comments, Michelle, which EHRs do this?

**Michelle Consolazio Nelson – Office of the National Coordinator**

I'd have to go back and dig through the more in depth comments, but I can look and bring that information back.

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

Yeah, that might be just helpful to see who are some of the vendors that do this so that we can share that back with David and Paul.

**Michelle Consolazio Nelson – Office of the National Coordinator**

Okay.

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

If that's important to them. Okay, so we can move onto the next slide, which is our second item to discuss and this is the clinical decision support item 401B, and you know, given the previous discussion about consolidation and deeming, and our focus here is on consolidation, we would be hoping that there was a way for us to use this immunization CDS and consolidate it with item 113, which we'll come to on the next slide.

So, I'm just going to quickly read, capability to receive, generate or access appropriate age, gender and immunization history-based recommendations including immunization events from an immunization registry or system as applicable by local or state policy and that the measure was the – that it was implemented and you could establish baseline recommendations for example from the advisory committee on immunization practices and allows for some local or state variation.

And that for 20% of patients receiving an immunization the recommendation was sought before giving the immunization and that the EHR uses a standard national, state or local rule set plus the demographic information to make a recommendation.

So, if we go to the next slide the commenters were generally supportive of the objective, concern is about the feasibility meaning and meeting the measure target threshold meaning the 20%. I mean, if it doesn't exist in your state you can't do it and you would be receiving some sort of pass for that measure, but there are states already that are doing this.

And I was speaking with my colleagues in the American Immunization Registry Association, AIRA, and they were telling me that there were six states that already do this. So, we're trying to collect that information and make it available. So, I think that first bullet or sub-bullet maybe true in many places, but not everywhere, it is feasible.

And then concerns with lack of available standards and I'm not sure whether that's entirely true that there is no standard. There is an HL7 message standard that has a space for recommendations. Now, again, I need to go back to the AIRA colleagues and I did share with them some of these comments here so that they could help inform us about what is or what is not available or being used and how much variability there is, because that's what really this comment is saying is that it's not standardized and the vendors certainly would like to see it much more standardized and I can understand that.

Now this next one I don't really understand what the bullet says, incentivizing the wrong behavior, reviewing history might not necessarily lead to improvements in immunization rates and I'm not sure I understand why that would be. If you get the recommendation you could give the right immunization to get them up-to-date. So, I'm not clear on that.

And then HITSP, I'm sorry the Standards Committee said that there is no standard to represent immunization rules. I'm almost positive there is a full HL7 implementation guide that includes these standards. So, want to get, once again, the opinion from AIRA and then share that back with the Standards Committee. Any comments about these?

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

Well, Art, this is George, when you say it's done in 5 states or whatever they're letting people log onto their web-based system to look at the recommendations or they're actually sending it to the electronic health records in their region?

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So, I don't know, I don't know that but I do know in my state one institution is using the state registry for the recommendation to be represented in the EHR. So, in Colorado the Colorado Children's Hospital does have this linkage to the Colorado Immunization Information System and in their system, which is Epic, they have a way for them to see the recommendation. So, I don't know all the details, George, you know, maybe it's a separate pop up window and it's not really in the EHR, but there is something about the workflow that has been addressed.

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

Okay.

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

So, I think, you know, I think here I would say that what we need to do is go back to AIRA and just get a little more detail. Anybody else have any other comments about that?

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Art, this is Amy, I agree I just was saying but I think I was muted. I think New York City Registry has bidirectional flow and I think it's not just sending back, I think recommendations so, but I'm not positive on that, but I agree AIRA would be able to be the best source of information on that.

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

Yeah, so, and they are on the case right now, because I spoke with them last week specifically about this and they are preparing something for us and hopefully we'll have it in about a month, maybe a month to two. So, I think that's a timeline that we can live with or do you think, George, that this needs happen much sooner?

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

No, no.

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

I figured that we didn't have a real rush on this, so about, you know, 1-2 months is what I told them.

**George Hripcsak, MD, MS, FACMI – Columbia University – Department of Biomedical Informatics**  
One to two months –

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**  
Art, this is –

**George Hripcsak, MD, MS, FACMI – Columbia University – Department of Biomedical Informatics**  
Go ahead?

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**  
No, this is Amy again and I was just going ask, how does this fit into the – I'm sorry I missed the beginning of the call and I don't have the slides, but how does this fit into the consolidation? Because you started at the beginning of this conversation saying, you know, this is under clinical decision support, so –

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
We're going to get to that Amy that's the next slide.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**  
Okay.

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
I'm just trying to get through these –

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**  
Thank you, sorry.

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
Comments first and then we'll get to the consolidation piece.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**  
Okay.

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
Thank you though. George did you have something else you wanted to say?

**George Hripcsak, MD, MS, FACMI – Columbia University – Department of Biomedical Informatics**  
Two months to do what?

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
Just to get back to us about – to respond to these comments, to provide us with enough detailed comment or a narrative around the concerns that were raised in this feedback that we got.

**George Hripcsak, MD, MS, FACMI – Columbia University – Department of Biomedical Informatics**  
So, I don't know about that, Michelle, mid-July?

**Michelle Consolazio Nelson – Office of the National Coordinator**  
It will be enough time, the plan is for draft recommendations to be brought forth at the August Policy Committee meeting and then we will bring back comments from the Policy Committee and finalize for the September meeting.

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
I can go back to them George and ask them to make sure it's done in a month. I think I'll do that, okay?

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

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
Okay, so now as Amy wanted us to – unless there are other comments, Marty, Marty, Charlene?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
No.

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

No.

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

Okay, so then –

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

I defer to you guys that do this every day.

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

Okay, thank you and we'll defer to the real experts at AIRA they are the ones who really do this on a regular basis. So, we'll move onto the 8<sup>th</sup> slide which is the one that Amy was kind of pointing us to and on this slide, which is the – I'm just going to make it a little smaller for me to see here, this is the first Subgroup's item 13, clinical decision support and we've updated that slide to indicate that we are trying now to include this clinical decision support as a preventive measure for the EP or EH to consider in trying to meet the clinical decision support objectives and I'll just quickly read that for Amy who is driving.

So, the objective is to use clinical decision support to improve performance in high priority health conditions and you need to implement 15 clinical decision support interventions or guidance related to 5 or more clinical quality measures that are presented at a relevant point in patient care for the entire EHR reporting period, the 15 CDS interventions should include 2 or more interventions in each of the following areas and our area is preventive care and there is chronic disease management including hypertension and diabetes, and then appropriateness of labs and radiology orders, advanced medication related decision support and improving the accuracy or completeness of the problem list for one or more conditions.

So, there are 5 areas and the immunization, this 401B, clinical decision support for immunization fits in the first of those areas around preventive care. So, I guess the question is do we believe that we want to push for consolidation or do we want to somehow retain this as a separate item? No opinions?

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

I'm here, I – well, I mean, we had a reason to consolidate we wanted to reduce the total number of objectives, so has that changed since we had that discussion about consolidation? Do we, you know – is what we need just a little bit more than two words including immunizations.

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

Right.

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

You know, if it's more than those two words than maybe that would be enough.

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

So, I think, you know, in the orange box, that Michelle has put on this slide, there is – she points to the certification criteria to get information from public health sources. So, you know, if we go back up to the, let's see, if we go back up I think two slides back to the, that one there, right, so it says receive, generate or access.

So, how an EHR does this maybe different based on the configuration of the EHR, how it relates to the IIS and how it relates to knowledge sources around the country, specifically for immunizations and I brought this up to the AIRA group last week about how many places are going to write out the logic for immunization up-to-dateness?

Is it going to be 150,000 EPs and 5000 hospitals or is it going to be one place and then everybody can download it from that place and I think that's a little bit of a challenge to AIRA and to CDC about whether they want to take that on, which goes, if you could advance again two slides please, so that this orange box that Michelle has in there about to get information from public health sources.

So, George, I hear what you're saying is, you know, do we want to be more explicit in here, I don't know if we want to necessarily be explicit in this section where it says preventive care including immunizations, but maybe more about how you get the information.

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

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

So, that's down at the bottom, the 5<sup>th</sup> bullet I think is ability for EHR to consume CDS interventions from central repositories, now, maybe the way that's it's written now – it's more written for – around drug-drug interactions.

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

Yeah, it's actually not very explicit whether we mean, whether it's the top half or the bottom half get the recommendations from the public health department and does that count for number one. First is – in other words that's just a pass through health department sends me recommendation, I show it to the clinician versus the health department sending me the rule that I applied or the age and the gender, and stuff like that to get the – to make up the recommendation myself.

And we had phrased it in the original, capability to generate, receive, generate or access, so we left it as either one. So maybe it's just a matter of making sure that this one – you know, because that number 5 under – you know, the –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yeah, it's the wrong area, right.

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

Number 5, I mean, I don't even know from that if that's the rule or the recommendation that we're consuming.

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

So, are you referring to drug-drug interactions as in like –

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

I'm sorry, we lost you there, is that Marty?

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

It's Marty; I'm sorry, Marty Rice.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yes, please go ahead, I'm sorry we lost you for just a minute.

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

Yeah, I get lost sometimes. Would that be updating a terminology group like RxNorm and then that RxNorm is then built into some sort of system or is that actually receiving updates directly from like FDA or something like that?

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

So, I think that's a good question. We were thinking that if you implement an immunization clinical decision support system you're dealing with a couple of dozen antigens given over many years and the rules are pretty complex. So, I don't know that you receive them from the FDA. Typically the rules are generated by this Advisory Committee and Immunization Practices, ACIP, and they have an affiliation with the CDC.

So, would the CDC, they publish every year, they publish the rules, they publish them in English, could someone publish those in a consumable form that an EHR could use? Could you send your data of immunizations to a place where it's evaluated for those rules that have been coded somewhere? So, there is a variety of ways that it could happen.

I think that in the previous one we have the receive, get or access in the 401B, but as George pointed out, all we did here was just add the words including immunization.

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

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
Have we dropped some thought and maybe even part of the process of certification that we might be seeking an EHR to achieve, you know, through some functionality through certification and do we need to add something to this? I mean, we're consolidating.

I think that, you know, George is right, we're not backing off on consolidation, but is there something here that we want to add to this top box that maybe something like the 5<sup>th</sup> bullet below, you know, this item one, which is implement 15 clinical decision support interventions and maybe have not just a list of 5 underneath there but some other bullet that says you should be able to receive, get or access the rules or the logic and use them in your EHR or the results of the logic.

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

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**  
So Art, this is Amy –

**Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality**  
Go ahead, I'm sorry?

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**  
This is Amy and I'm sorry I lost cell range for a little while so I lost part of the conversation when you just started on the consolidation, but whatever we do, and again, I know I've missed a meeting or two, I think we need to keep this – what we want to consolidate – you know, this is important to prevention, it's important to public health and we also want to keep some flexibility and I'm not saying you haven't done that, but whether the rule – whether the actual rules or the recommendation goes back to the EHR, so I think that there has been some discussion about which we're referring to, and maybe it's different in different situations, the mechanism for where and how that happens needs to remain flexible too.

So, when we think about, I'm just going broad in my comment here, when we think about certification or what the EHR functionality does I think we – I'm not sure we want to take a stand on whether it's the recommendation or the rules.

So, for instance while the rules are the rules from ACIP there maybe state variation in how they're applied particularly for states that are universal purchase vaccine states where the state is purchasing the vaccine and then certain rules may apply and others may not or states may have different rules about what's covered and what isn't for that state, as well as whether any of this would go through a state or regional HIE and whether those rules or recommendations would go through or be embedded in there.

So, while I don't know that I have a specific answer to your question I just want to put out there that I think we have to, in the consolidation-way, keep some flexibility for the mechanism yet still achieve what we want to achieve.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Yeah, that makes a lot of sense and I think we do absolutely want to keep the flexibility. And I think that if we hadn't been flexible enough in 401B we should revisit that to make sure that we get it as flexible as we think is required. My concern is that there is no specificity at all in 113, it just says do some preventive CDS and I don't know whether saying I'm going to do some preventive CDS is even going to come close to solving the problem of be flexible across all states for their immunization schedules. Well, you know, what's going to happen is that the vendors are just going to get – they're going to say this is just like the mess like we have in reporting immunizations.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**  
Right.

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

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

I can't get a straight answer and it's all over the map and this is not, you know, feasible. So, that's, I think, a reason why, you know, maybe some qualifiers might be valuable here.

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

So, my concern is that whenever you start looking at updates they certainly should have the ability to update a system regardless of where it is and what it's about. But the fundamental issue comes down to, especially some of the smaller vendors, updating systems is not so easy to the individual – especially like the EPs and we went through this when we were talking about quality measures, how do you actually really keep it a regular update. I mean, it's never going to be real-time and something like that should be real-time with an immunization and that would be really difficult to do on systems that aren't on sentry located servers. So, that's my only concern.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

So, George, if we could – thank you for that Marty. I'm just going to try to go to some of the other bullets there. I have not been involved, have you been involved in any of the Subgroup 1 discussions or maybe Charlene are you in those discussions?

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

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

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

Yeah, so when they said about chronic disease management including hypertension, so are they expecting that any CDS will do?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
Yes, we have kept it pretty general in that Workgroup, yes.

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

So, there is no requirement that it be tailored to some NQF measure?

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
No, we dropped that actually.

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

Okay. So, that here – what I'm concerned about is that we are so –

**Michelle Consolazio Nelson – Office of the National Coordinator**

Well, so can I back up, sorry? Five or more have to be clinical quality measure related.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
But for Stage 3 we dropped it I think.

**Michelle Consolazio Nelson – Office of the National Coordinator**

No, it's still there.

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

I thought we dropped it. It was 15, remember we had that conversation on 15, but I thought we dropped it related to the measures in 15 and tied it – I know we had a whole discussion around it.

**Michelle Consolazio Nelson – Office of the National Coordinator**

All we did was change two or more of the – we had – listed items instead of each of the listed items, but 5 of the 15 has to be related to quality measures and then 2 or more of those listed items, it's a little bit confusing.

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

It is confusing, because I thought we dropped the link to quality measures and just made it related to high priority conditions to make it a little bit more general, because we wanted to get them to think about, you know, managing populations using all the different tools that were in place, so we were trying to get some consistency there across the different, you know, whether it's patient engagement or whether it's, you know, the use of registries or, you know, clinical decision support. So, I mean, I don't think it matters, but it just makes it complex.

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

So –

**Michelle Consolazio Nelson – Office of the National Coordinator**

Well, this will be reviewed tomorrow in the full Workgroup.

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

Yes.

**Michelle Consolazio Nelson – Office of the National Coordinator**

So, some of these questions you might want to bring to the full Workgroup tomorrow too. So, George, be ready.

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

The –

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

So –

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

Oh, go ahead?

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

No, go ahead, George.

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

So, just, you know, just thinking about it, really when we wrote, this is going back and forth, 113 we were – you know, it was two things either you write decision support or you receive rules or you – no, no, I see, I see – you can write your own rules, you could adopt outside rules or you could just receive outside recommendations, those are the three possibilities here, right, in the original – I'm sorry, the original 401B I meant to say.

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

Correct, correct.

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

And now I guess in so far that this is decision – I guess it does make – I mean, I'm going back and forth a little bit in my mind, it does make sense to consolidate because it is another decision support and it's just a decision whether we force it or not to pick one of them but not everybody can do this one anyway because not everyone does immunizations so we can't completely force it, but to – let's see, decision support, implement, interventions – so, an outside reminder would count, a homegrown rule would count and a transferred rule would count. We're worried about these transfer rules, right and whether this is even feasible, so I think the idea of it being loaded into number five on 113, in other words, you know, certification criterion 5.

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

Right.

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

It makes sense for them to be lumped like that I think because we don't really know how to take a central database or rule and distribute it in a way that guarantees that it works and doesn't give wrong recommendations and everything. So, I guess I'm down to just – I guess I'm okay with the merger I just have the question of whether, you know, is there anyone – should we be – do you have to – no I guess we can't do it. Do you have to do an immunization and then we can't because not everyone does immunizations.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right, I don't know that we want to say that you have to, I don't think that's – I think what I'm more concerned about is the waste that will go on if everybody does the rule building on their own.

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

Yeah.

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

And how much the vendors are going to be kind of repeating themselves and how much the EPs and EHs are going to have to be paying for that repeated work.

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

Well, that's a problem and that's a problem in 401B also.

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

Yeah, it is and I think that, you know, I'm hoping that under 5 we figure out a way for health information exchange to, you know, benefit the end user by saying, I can subscribe to a service that my EHR knows how to use and provide me with clinical decision support around immunization.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

So, Art, let me go –

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

Whether it means I bring it into my EHR, whether it means I send my data to them and they give me back the recommendation, I don't know about – I don't care about that, it's just that everybody should not be sitting down to figure out how to do a couple of dozen antigens over 80 years with all the rules that are so complex.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Art, this is Amy, and so the question I have sort of, you know, is – I mean, this is a CDS issue but it's a public health issue, so have we on the other public health measures are we leaving them out of consolidation or are we including them? Like is there a rationale to rethink about – while it is clinical decision support to somehow consider it public health which is outside of that and obviously if you don't give immunizations you're exempt, but –

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

So, this is the only one that's being considered in consolidation out of the three original ones, immunization, electronic lab reporting, syndromic. We are going to have a discussion in just a minute around consolidating some of the registry stuff, but no other ones are part of consolidation other than this one, clinical decision support based on immunizations.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

So, I guess what I'm saying is, is it – now I'm questioning, in my own mind, is it enough like the other clinical decision support issues or is it different enough that it needs to not be consolidated and standalone as public health and I'm weighing that out in my mind as I think about the discussion. And it sounds like the issues are somewhat generic, but it sounds yet like it's a little bit more complicated. And part of the complexity maybe because often times this is sort of a public health responsibility run and administered including some of the clinical decision support rules, although there are national, you know, guidelines at state and local levels. So, I'm just putting it out there – I'm sort of back and forth in my own mind on this one.

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

Right. Other comments? So, I understand that we're back and forth on this. So, George in your comment the certification criteria number five were you saying it made sense or did not make sense to think about this as a central repository issue?

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

Yeah, I'm saying that it does, I mean, yeah, I'm saying that the technology to maintain centrally – now central could mean central national or central state or central city.

**Arthur Davidson, MD, MSPH – Director – Denver Public Health Department**

Right.

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

But to maintain – to do – to have my health department do a knowledge base that then gets distributed to me periodically is similar whether it's drug-drug interactions, rules for reporting diseases for public health or immunization rules. Well, the immunization rules might be bigger, you know, what I mean it's like if you look at the actual logic it's fairly complex as opposed to a drug-drug interaction tends to be simpler.

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

Yeah, I think these are probably a little more complex because they have to do with gender, age, prior immunizations, they are much more complex, yes, I think they are, but I'm sure David Bates could come up with some that are much more complex and rules about drug-drugs as well.

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

Right, right.

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

So, I don't want to say that absolutely.

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

But then that also – if it becomes too complex then it's not going to be feasible by Stage 3 anyway.

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

Right.

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

What this is saying, well, all right, yeah. So, I'll just leave it at that.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

So, Art, are we saying – so based on that are we saying that we think it makes more sense for the EHRs just to be able to receive a recommendation as opposed to the rule set and calculate its own recommendation?

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

No, I think that – back to your point earlier about flexibility, I think that we don't want to dictate what way it's going to happen. Were you suggesting that maybe we should just put down one, Amy?

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Well, you know, I'm torn in my own mind, I mean, I was the one that said we need flexibility in terms of the mechanism, but maybe it makes more sense and it would be simpler on the vendors if we just say you need – we need a standard and we need a way to receive a recommendation and not have to have the rule set which is complicated and constantly changing embedded in each EHR, because that's where you're going to get into the vendor complexity.

Where if you have a set of standards and a way to accept a recommendation wherever the EHR – the EHR has the ability to do that and there is a place for it to go to, you know – I mean, the point there is it makes it even a little bit more bidirectional because you have to send out what the current immunization status of an individual is and have it, you know, on the fly then make a recommendation and return it where if the rules were embedded in the EHR, you know, it would happen, you know, locally in the EHR, you know –

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

Right.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

Brains of the EHR so to speak, but it would simplify it for EHRs if you didn't have to, you know, if there was a way to really get the bidirectional flow where you could seamlessly send out someone's immunizations have it calculated and just receive back a recommendation and it would prevent the duplication, you know, or the challenge of having every vendor then have to take a rule set and apply it.

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

Charlene, what do you think?

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

I agree that – I like the approach Amy suggests that we don't want to constrain it relative to specifying exactly – I like the approach which says there's a means to be able to do that, as soon as you provide the means to be able to do it and the vendors don't all have to do it themselves they're going to go, right?

So, I think it's definitely a valid point and I think if we can look at adding – it would add quality, it would add safety all those kind of things, it would add cost-effectiveness and with just the expansion of all this stuff I think starting to pull together some sources of knowledge for use is a real critical strategy that we should be focusing on. So, I totally support that.

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

So, I've modified point five here now to say something like ability for EHRs to...this is the five under the certification criteria for 113, ability for EHRs to consume CDS intervention rules/results of rules from central (federal, state and/or local) repositories and then the rest is the same, rules for drug-drug interactions, rules for reporting diseases, preference sensitive care.

So, you know, I don't think that we're forcing anything here, because what was there before was to consume interventions and I don't know what that – you know, whether with the most recent comments from Amy and Charlene where adding results of rules means that the brains were outside the system and now you just received the results of that thinking outside your system, which is I think what I've heard a couple of people recommend. Does that sound right or are we still off base?

**Marty Fattig, MHA – Nemaha County Hospital**

Art, this is Marty Fattig.

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

Yes?

**Marty Fattig, MHA – Nemaha County Hospital**

We have for drug-drug; drug-allergy we subscribe to a service would that same thing not happen with immunizations?

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

That's what we're trying to do Marty. The service doesn't yet exist and that's something that we're hoping that either AIRA or CDC will make available and it could be as George has – on previous discussions we talked about maybe the NLM will store this, maybe CDC will store – we don't know where, but it would be a service somewhere, right.

**Marty Fattig, MHA – Nemaha County Hospital**

So, that all it would do then would be bring up recommendations and the provider then would have the information available to make the best decision.

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

Correct.

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

This is Marty Rice, you know, in theory it sounds very good I just think it's a heavy lift for bidirectional and the more different services that EHRs are asked to interact with the more complicated it gets. That's my opinion.

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

Yeah, I think that is a valid point for us to keep in mind Marty.

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

That's my only point with that, so, thank you.

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

Right, but the main thing that we talked about earlier was can we get more information from AIRA about those 5 or 6 sites that seem to be doing a lot of this already, so that's why we need a little more information to say how heavy that lift is and whether that is something that it's all one vendor who has figured out how to do it or is it 5 different vendors, or where the circumstances special in these environments where it's capable of being done.

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

Yeah, thank you.

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

Yeah. Any other comments? So, I think Michelle's right we should bring this up tomorrow.

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

Yes.

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

Well, hold on, what am I bringing up?

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

No, I'll be on the call.

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

Okay, good.

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

It's just that we need to discuss point five on 113 if it includes immunizations because a lot of the way that this was written was probably thinking more about drug-drug interactions and then we – you know, I think I may have thrown in there about rules for reporting diseases, well that's not happening, that's one of the ones that we said is a future state, so we probably don't need this language in there from a public health point-of-view that's just extraneous.

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

Which number was it?

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

That's number, what is that number, Michelle?

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

I'm just looking for it now.

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

Yeah, it's this one here is – its 402B, case reports that's proposed for a future state, that's in our slide set that's slide 14.

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

Yeah, I see it.

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

Yeah.

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

I see, so then if we were to consolidate we might take out rules for reporting diseases for public health department and – I see the problem is not for the users we're being flexible for the users, we're being inflexible for the vendors because they have to supply it whether or not the user uses it. I see. But what you would do is replace reporting – potentially with rules for immunizations.

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

Right, but shouldn't we be thinking about for the vendors that there is a common way for a vendor to consume external knowledge, isn't that kind of the fundamental problem whether it's about immunizations or drug-drug, or whatever it's about external knowledge and somehow using that as triggers inside your system.

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

Yeah, but – yes, that's what we want to happen but then the Standards Committee is going to say, okay what's the standard for that.

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

Right and we're – I mean, is David is going to come forward with some for drug-drug interactions?

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

Michelle, did the Standards Committee comment on five?

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

This is MacKenzie, I just checked my e-mail and Michelle said she had to drop off, so she is getting the audio but she is not on the line right now.

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

Okay. I don't remember the Standards Committee, any Standards Committee comments on this in particular, I'd have to look.

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

Okay, so I think we've covered this and we can return to it tomorrow George in the call.

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

Okay, what's our proposal for tomorrow? It's –

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

Well, I think we want to first understand just as you said, did the Standards Committee make any recommendation.

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

Well, we're not going to – Michelle's gone now, so we won't have any –

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

No –

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

I'm just saying that we won't have any more input on that.

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

No we would – Michelle would be on the call tomorrow won't she?

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

No, no, no.

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

Oh, I'm sorry, I thought that she was just going to be gone today.

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

So, I want to be – we're going to go through like, you know, 20 of these objectives tomorrow so I want to be crisp on how we discuss this one. So, the question is – on number five is, do we essentially replace rules for reporting diseases to public health to consume either recommendations or rules for immunizations.

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

Yes.

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

And then up above preventive care including immunizations I guess is okay.

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

Yes.

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

Okay. So, when we get to this slide you can – we'll speak up on that.

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

Yes. I'll be on the call. Okay, so I think that's – I think we've kind of run through that one 401B now we have just – I don't think we need to go through the ones we went through from the May 1<sup>st</sup> meeting items other than the very last set around 404, 405 and 407 and that would be slide 19. So, if we can advance to – that one there, and I've broken them out on the next – so that was the slide that you saw in the last session and if we go to the next slide which is slide 20, let me just make sure – right, so this is one that I worked on, it's the revised – so the first thing is that the goal here is to merge, if we believe in consolidation and there was the recommendation that we consolidate and one of them was consolidate around registries, and there was a cancer registry as 404, the specialty registry was 405 and the HAI, the Healthcare Associated Infection Registry was 407.

So – and in the discussion with Jim Daniel and with Michelle last week we decided it might be better for us to just separate out EH and EP here, because all the registries aren't the same. So – and in the comments that we went through last time there was some concern about what a mandated registry is. So, on slide 20 which I believe we're now looking at, hold on let me just make sure, yeah, you're all looking at slide 20, it says mandated jurisdictional registries are those required by law, regulation or order. So, I hope that's clear.

And then examples include cancer, healthcare associated infection, children with special needs, early hearing detection intervention. And then I used another term here, voluntary community-based registries are those encouraged but not mandated by the jurisdiction or those willingly joined by the eligible hospitals. So, I gave some definition or at least tried to give a little more wording so that people wouldn't be asking that question.

And then I just modified the language there a little bit, an external entity is defined as such and then they should maintain the registry. And down in the measure area below I added words that are consistent with the current rule that there needs to be some sort of acknowledgment by the owner of the registry for ongoing successful electronic submission and in a mandated registry the health department is the one that's going to be acknowledging ongoing successful electronic transmission.

There is no real clear entity that's responsible for acknowledging voluntary registries in the rule. So, it's something that I think CMS might have to return to is that there is no current source of acknowledgment or process of acknowledgment the same way that we have for on-boarding by public health agencies of their EH and EPs.

So, this is just some wording that I was asked to change from our last discussion and before I go to the next slide maybe I can ask if anybody has any questions about what I've written down here or modified? So, the goal is still to consolidate into one registry objective where it says you must do two registries and they may be mandated or voluntary. No concerns? Okay.

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

It seems like –

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

Sorry, Charlene were you about to say something?

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

Yeah, it seems like – and the reason for two is because they've got to – the reason for two is what?

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

The reason for two registries versus one?

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

Or – yeah, one or more, or something like that?

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

Well, the – so, okay, I guess that's – I thought we had decided last time –

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

I can't remember what we decided.

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

But maybe we haven't really decided this. So, the cancer was there alone.

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

Okay.

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

And there was this other – I mean, in Stage 2 cancer and the specialty registry exists and in Stage 3 we're kind of expanding to allow other types of registries besides cancer but there would still be two. We have not said whether this is core or menu yet, we're just, you know – we're still at – how would you combine into one of objective –

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

Yeah.

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

The two that currently exist in Stage 2? I mean, we could – you know, I think if we can get to this point, we can always go back to the Meaningful Use Workgroup and say – and bring up your question and say, should it be one or two.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
Yeah, because I thought in – and I could be wrong, but in Stage 2 aren't those menu items?

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
Yes they are.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
Right, so that was kind of why –

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
But we haven't said whether this is core or menu in Stage 3 yet I don't think, but I could be wrong. Let's see, it's a menu, no, hold on let me see if I can find the right –

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
But to me it seems like, you know, if you're going to – it would seem like you would want to move it to core and like make it one or more, I mean, it depends on what happens – if no one does it in Stage 2, you know, then it will be hard to move to core, right? So, we don't really know that yet.

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
We don't know that, right and I think that one thing is that, you know, while the cancer people are concerned that we may be – people might move away from cancer and I don't know if that's true, because they will still have to do this even if it's not – it's not stated in Meaningful Use, there are laws in each state that say, you know, you're responsible for reporting these cases of cancer.

So, I think they were concerned that we were now diverting attention away from what they have developed as a solid method for reporting, but I think for the purpose of population and public health more broadly we want the development of registries to take off.

**Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality**  
So, CMS is actively using registries for PQRS.

**Charlene Underwood, MBA – Siemens Medical – Senior Director, Government & Industry Affairs**  
Okay and which ones?

**Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality**  
Many and they've had really good luck with them. I mean, I'm going to throw out a number, but I'm not really totally sure, but I think they have 17,000 participants that have submitted through EHRs and I'm pretty sure it was through registries – to CMS.

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

**Martin Rice, MS, BSN – Health Resources and Services Administration – Deputy Director, Office of Health IT & Quality**  
So, I can't say whether it should be core. I don't have an opinion whether it should be core or menu, but it should be something that's very closely looked at and there are some real good experiences with it.

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
But, I don't think that today we need to kind of get down to whether it's one or two Charlene I think more it's, in principle does the group believe that consolidation and consolidating using some of the wording that we now have there makes sense. I think that's our task.

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

**Arthur Davidson, MD, MSPH – Denver Public Health – Director, Public Health Informatics**  
And then we can, you know, in the Meaningful Use Group debate should it be menu, should it be core.

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

Okay.

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

Should one or two, right? Okay. So, let's move onto the next slide which is just like this one except it just has – it says for EP and the main thing here is that it got rid of the healthcare acquired infections, I hope it did, let me make sure I deleted it, as an example because that's not what the people who are collecting that information at CDC are really – they may be collecting as well at FDA I can't remember, but at CDC they're not interested in what's going on in outpatient areas they're interested in what's going on in hospitals. So, it just separated the two so that there was no confusion about this registry being applicable to an EP.

And again at the bottom you can see where does the letter come from if the PHA is not the registry owner because that's an item that we'll want to discuss at some point whether it's tomorrow or another time with ONC and CMS that might be something for us to consider and then, you know, I think at a more fundamental level how you report to a registry is not entirely clear and maybe Marty's comment about how CMS is doing that with their 17,000 participants might be worth exploring but we don't really know whether it is one mechanism to report a common mechanism to report to all different types of registries, I'm sure it's not and is that something that ONC and CMS want to take a stand on and might the Query Health pilots inform that. So, that's just a question that may come up in the discussion.

So, I don't know if anybody has any comments about these. I don't think that we need to go through all of the slides we went through them on the first and I'm open to other discussion if there is anything else someone would like to bring up.

**Marty Fattig, MHA – Nemaha County Hospital**

Art?

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

Yes?

**Marty Fattig, MHA – Nemaha County Hospital**

This is Marty Fattig, will HIEs be mature enough by this time that they can – that the registries can pull the data they need from an HIE so that we don't have to develop interfaces with each registry on an individual basis?

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

So, I think that the way that the registry gets developed could be based on the available infrastructure and the desires of the people in each of the states or locals or societies. So, I don't know whether an HIE could look into a cardiologist's EHR pull out the pertinent stuff to send it to the American Cardiology Association for implantable defibrillators, you know, I don't know, it may be the HIE can be supportive of that, but I don't think that we're giving any suggestion that we know how to solve it.

I think the only thing that we would suggest here is that potentially from Query Health might there be some sort of standard, content, structure and transport mechanism that registries could depend on, but to say how they get developed.

**Marty Fattig, MHA – Nemaha County Hospital**

Yeah, that's good to know.

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

I don't think we want to weigh in on that.

**Marty Fattig, MHA – Nemaha County Hospital**

I would agree, it's just that as I look through a lot of these measures it would appear to me that a mature HIE would be a great place to pull this data if in fact the EHR is reporting it to the HIE.

**Amy Zimmerman – State HIT Coordinator – Rhode Island Department of Health & Human Services**

This is Amy and I – you know, I mean, I think your question is a good one I think the challenge we have is that there are so many HIE models and HIE means different things in different settings and communities that it's hard to define that, but, you know, there is a lot of work and thinking going on which somewhat relates in the sense it's a little bit different, but with some of the new quality reporting standards something called QRDA 1 I think is the individual one, no 3 is the individual one, there may be capabilities where, I mean, the goal here is to sort of pull something out of an EHR once move it to some sort of an HIE or other data intermediary and then move it where it needs to be so that providers aren't having to do a zillion interfaces and whether – and there is discussion going on in the quality reporting world around – or quality reporting measurement and I would assume it would apply to this, but I don't know if we can guarantee that by Stage 3 we're going to have enough of a universal approach and definition to HIE. I mean, unfortunately I think it's still a bit all over the board and it's very local and regionalized.

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

I agree, this is Charlene.

**Marty Fattig, MHA – Nemaha County Hospital**

Yeah, I agree with everything you said, Amy, I just think it's a discussion that needs to take place.

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

Yeah, I'm certainly open to the HIE solving this problem for an EP or an EH just as Amy said, though, is the HIE really there.

**Marty Fattig, MHA – Nemaha County Hospital**

And today the answer would be absolutely not, so –

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

Well, maybe there are some examples around the country where that is true. I don't know what Regenstrief can do.

**Marty Fattig, MHA – Nemaha County Hospital**

Oh, I agree that there may be some, but as a rule –

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

Yeah, as a rule.

**Marty Fattig, MHA – Nemaha County Hospital**

Yeah.

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

Yeah, I agree with you on that, yeah. Okay, so any other concerns, questions, suggestions? Well, then if not then maybe we'll just open it up see if there are any public comments and we can end early.

## **Public Comment**

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

Okay, operator can you please open the lines for public comment?

**Rebecca Armendariz – Altarum Institute**

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

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

Okay, well, thank you everyone and I'll be speaking with some of you tomorrow and others – we have another call I think scheduled for the 30<sup>th</sup> but I don't know that there will be a need at this point for us to revisit anything. I think Michelle will keep us – and MacKenzie will keep us up-to-date on that. Is that right MacKenzie?

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

Yeah, I'll follow-up with Michelle.

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

Okay, thank you all.

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

And if we don't need it we can just cancel it.

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

Thank you.

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

Thanks for your work Art.

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

Thank you, have a good afternoon, bye-bye.

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

Bye guys.

**Public Comment Received During the Meeting**

1. In reference to CDS-related standards: the scope of the current ONC S&I Health eDecisions Initiative is: "To identify, define and harmonize standards that facilitate the emergence of systems and services whereby shareable CDS interventions can be implemented via (a) Standards to structure medical knowledge in a shareable and executable format for use in CDS, and (b) Standards that define how a system can interact with and utilize an electronic interface that provides helpful, actionable clinical guidance."  
<http://wiki.siframework.org/Health+eDecisions+Homepage>