

**HIT Standards Committee
Implementation Workgroup
Transcript
December 3, 2013**

Presentation

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you. Good morning everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Implementation Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder this meeting is being transcribed and recorded so please state your name before speaking. I'll now take roll. Liz Johnson?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Cris Ross?

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Anne Castro?

Anne Castro – Vice President, Chief Design Architect – BlueCross BlueShield of South Carolina

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

John Derr?

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Timothy Gutshall? Joe Heyman? David Kates?

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Here.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Tim Morris? Stephen Palmer? Sudha Puvvadi? Wes Rishel? Kenneth Tarkoff? John Travis? Micky Tripathi? Gary Wietecha? Rob Anthony? Kevin Brady? Tim Cromwell? Nancy Orvis? Are there any ONC staff members on the line?

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

Scott Purnell-Saunders.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks, Scott and I'll turn it back to you Liz and Cris.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Great. This morning we have been asked to respond to some questions from the Meaningful Use Group and so Scott is going to lead us through a discussion on that and one of the things that beyond this discussion and the presentation is Cris and I have talked about that this is also an opportunity if we have other comments that we'd want to provide back to the Meaningful Use Group on Stage 3 we should do that as well and with that – and unfortunately Cris and I both have obligations at 9:30 and so depending on where the conversation is Michelle and Scott will continue to lead the conversation for those who want to stay and continue to add comments. So, we don't want to cut you guys off but we both do have other obligations. And with that Cris I'll ask you to comment as well.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

No comments other than today we're talking about clinical decision support and I think what we would want to do is if we have an hour and a half or perhaps just an hour if there is a way that we can get through this in less than an hour then we could have a little bit of time to get feedback from the group around other areas on which we might want to comment. But let's see if we can make good efficient use of our time going through this document.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Great, okay, Scott with that we will turn it over to you.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

Great, good morning and thanks everyone for joining the call today. Please open up the MU Stage 3 Implementation Workgroup document present on the screen. While that comes up I'll try to start the discussion and kind of frame it.

Basically the Implementation Workgroup was asked to provide some comment and feedback specifically on the clinical decision support topic as it moves from Stage 2 to Stage 3. Thank you for zooming in I appreciate it. Basically, it's a very kind of wide document and the main point of this is to get to the question that's in the upper right hand corner which is how do these policies get translated to certification criteria and auditing? Second would be, how would this impact certification criteria and test script auditing?

Our charge as the – or part of our charge as the office of certification is to take rules and regulations that have been developed and to make them actionable and implement them into the certification program as it exists currently. We're at a point in state where we are currently working on the rules and regulations to build towards Stage 3 and are working to get those into a better place that not only support the rules and regulations that currently exist but to move the needle forward as we try to push this towards a better overall program.

So, the goal today is to kind of get through this document to provide some feedback to the Certification and Adoption Workgroup on, excuse me the Meaningful Use Workgroup on this particular topic. So, let's go back to the left and just review the overall framework of this and then talk through getting back to the questions. So, slide the document to the left for me please.

So the Stage 2 final rule objective is to use clinical decision support to improve performance on high priority health conditions and then we go through the two various measures. So, measure one implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period, absent four clinical quality measures related to an EP scope of practice or patient population, the clinical decision support interventions must be related to high priority health conditions. In measure 2 the EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.

The former Stage 3 objectives basically broadens that to implement 15 clinical decision support objectives from the previous five that were just talked about and then it goes into listing the details of the 15 interventions and what they should include specific to patient preventative care, chronic disease management, appropriateness of lab and radiation, excuse me lab and radiology, excuse me, advance medication clinical decision support and accuracy or completeness of the problem list and then measure 2 would be to enable drug-drug and drug-allergy interaction checks which is continued from the Stage 2 final rule.

And then we get into the certification criteria to be able to check the CDS triggers, the flag preference-sensitive conditions and provide CDS materials for patients to check the maximum dose and weight based on the calculation, to use structured SIG standards and then to consume external CDS interventions and to use information on systems to support the maintenance of lists.

When we get to the updated Stage 3 objective we're broadening that out to include at least 6 of the NQS domains and the recommended interventions are flexible to include some innovation including preventative care, chronic disease management for example diabetes, coronary artery disease or others, and then the appropriateness of lab and radiology orders, the advanced medication related decision support, the improving of accuracy and completeness of the drug list, the drug-drug-allergy interactions checks again and the CDS being able to capture decision making.

The certified electronic health record technology should also have the functionality to enable intervention tools such as the intention is not to be overly prescriptive but to encourage movement towards tracking the CDS triggers, flagging preference-sensitive conditions and to provide support materials, as we talked about before, to capture appropriate care goals to encourage shared decision making and then check for a maximum dose/weight based on calculation.

Again, the use of the structured SIG standards to consume the external CDS interventions and to use information again related to maintenance of lists, and also related to work that looks into Health eDecisions and the Clinical Quality Workgroup work as well.

So, with all that kind of framing looking at where we came from Stage 2 with the implementation of five to moving to 15 proposed for Stage 3 and the expansion of the 6 NQS domains the goal I guess is to talk through one, how do we get translating these particular policies into actionable criteria for auditing and then how do they get built into scripts or the develop tests procedures for the certification program as a whole.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Scott, this is Michelle, can I just interject with a little bit of background so people understand? So, the Meaningful Use Workgroup, as Scott mentioned there is a former Stage 3 objective and then an updated Stage 3 objective.

What happened was is the Meaningful Use Workgroup had presented some draft recommendations back in August and what they heard from the Policy Committee was that things were a bit too prescriptive and detailed, and so they have gone back and are updating the objectives to be a little bit broader, that being said you'll see that this one is still a bit – has a lot more detail in it because they feel that CDS is so important to being able to focus on outcomes for Stage 3.

So, this one in particular has a lot of detail in it because they feel that it's extremely important. So, I just want to give that background so you understand why there is a former Stage 3 objective column and an updated Stage 3 objective column. Sorry to interrupt Scott.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

No thanks Michelle, I think that background is very helpful.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, in terms of what we need to do today I think we first – before we can make recommendations around certification criterion and auditing we need to talk through the actual objective and make sure we all understand it and I'm assuming Michelle you and/or Scott since you're involved with the Meaningful Use Group can add that color.

And then do we have certification criteria today for the current clinical support so that we would have some idea of what we were looking at? In other words today we're required to do five CDS not counting drug-drug and they have to be related to CQMs, and then we have one that has to do more with productivity and that sort of thing. So, that's the change that we had.

And now we've added this, it doesn't appear to me, for example, that they have called for a particular number just say multiple. So, that's the kind of clarification I'm looking for because when we look at the certification criterion and auditing what is the certification criteria today?

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

For Stage 2, just to clarify right?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Correct.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

I agree that's a fantastic place to start.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah, because it's fairly open ended, I mean, I think having the multiple choice broadening the areas that clinical decision support we're trying to focus on, but, yeah, I think the challenge that we all face and that EHR vendors will face is just like – well, more the certifying bodies are going to face is –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

You know, what constitutes satisfying these criterion, what are examples or what are actuals, because it's not an explicit check list it's just, you know, within the realm, which I think those of us on the phone understand examples of those things but I don't know if the certifying bodies have clarity in terms of what constitutes each one of those.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

So, David, this is Cris, if we look at measure one and measure two I think measure two around drug-drug and drug-allergy within an EHR is a pretty well understood kind of domain, right? People have been doing that for a while, they've had it tested either as part of certification for one or part of a, you know, ePrescribing implementation, etcetera. But are you talking mainly about measure one or are talking about both?

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Mainly one.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

I mean, I think one is the one that is more open ended.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

And again I think we know what each of them are preventative care, you know, diabetics that are overdue for foot exams, the chronic, you know, 50 year olds that need colonoscopies those sort of gaps in care, chronic disease, I may have just used examples for one that constitute two so even in my just sort of vamping there I think that –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Yes.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

The lack of clarity around what one would do, you know, if they have to – it's a Chinese menu that you need to at least demonstrate four out of the six categories what falls into each bucket and what the certifying bodies need.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, the problem that I have is these are the not the six domains. I mean drug-drug and drug-allergy intervention is not a domain. Hang on a second and I'll –

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah, I actually am not familiar with NQS domains. So, I just –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

That's okay.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Took that as a given, but you're right.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Well in Stage 2 does it map against NQS domains for measure one?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

It measures –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Because I'm not sure it does.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

It measures against those domains that were presented in the – hang on I'm looking for it, just a second.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

Right, so I pulled it up, it basically measures against these six areas so it's problem list, medication list, medication allergy list, demographics, lab tests, values and results, and then vital signs.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Got it, but none of those are NQS domain specific.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

I mean, those are pretty generic in Stage 2 which is good.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah I think the reference to NQS domains may be incorrect.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

In Stage 3.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah. It's more six areas not necessarily related to NQS.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

And they might be in NQS but I don't think there is anything specific that matches it up against NQS measures or standards, or anything like that. I may be mistaken, but –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, the way that it works today is you have to do five of them and they have to be related to the quality measures that are MU, the MU quality measures.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And the last one is the high priority health condition and then like what Scott said is – and what the list Scott gave you is a combination list. So when you design a clinical decision rule you have to take a combination of two.

So, for example you have to take something that is introduced on a problem list and then by picking that up with a rule then you have to also do a second trigger that has to do with a medication or medication allergy or demographic or something.

So, it's actually pick the quality measure, pull it out of the problem list or you do a vital sign and a medication it's a combination of two and this is a little different I think.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah, so let's – I mean, assuming that there is still – those are the 2, 4 there are actually 7 bullet points listed under where it says six.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

But disregarding that –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

No, so just to be clear, this is Michelle, so it says recommended interventions so it's not – what they were trying to do in the Meaningful Use Workgroup was be less prescriptive.

So, flexible innovation, so what they are trying to do is say these are the types of interventions that we recommend but we are not going to tell you which ones you have to choose, which for them – so they added in the drug-drug interactions which obviously was an oversight per this conversation, because when you try to map that back to an NQS domain it obviously will not map back.

So, I think that's a good note to – I mean, I can obviously bring that back to the Meaningful Use Workgroup but when you respond to them I think that you should mention that was probably an oversight on their part.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

So, wait –

David Kates – Senior Vice President, Clinical Strategy – NaviNet

But it gives –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Wait, wait just hang on a second we're jumping back and forth between Stage 3 and Stage 2.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

I thought this was trying to do was to establish what are the standards for certification associated in Stage 2. I don't mean to be so directive but we've got to get focused here.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

So, I think we want to get back to what's the certification requirements for Stage 2 just so we can be informed.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Cris and Liz this is John Travis, I'm sorry I'm late; I've lived this because we've been through our 2014 certifications on this for both EP and hospital. What we were to do, it was kind of I think maybe David said earlier or you did Cris, we had to present clinical decision support interventions based on each of the required data elements that you mentioned in the list, so problems, medications, lab results, etcetera, and one combination.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

And then we had to show, if you will, the bibliography and the pedigree of the intervention. So, you know, the implementer or the user would understand it's funding source, it's, you know, empirical reference, you know, bibliography and information, it's versioning and information of that kind.

There is a – disconnect maybe a strong word, but there is a translation of to the use side in Stage 2 that the EP or the hospital has to address which is okay that the certification was of – the certification still, I would argue, is about the capability to present clinical decision support rules on exactly that basis I just described from the use perspective you've got to go determine the association appropriate for you to use those capabilities and then connect it to a quality measure within the EP or hospital measure catalog if you will.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Or, you know, follow the guidance that they give that if you can't identify those then you do it for high priority health conditions. So, there is an audit. From what we've seen I'll jump to a point to keep in the back of our mind, that from an audit perspective as we've seen with our clients they are going to have that burden of proof to bear in Stage 2 when the audit contractor comes a calling to say "how did you create that association" you know how did you do your due diligence to say these are the four, how are they connected for what you choose to implement to the measures or if you didn't do that, you know, how did you pick the high priority conditions, which was really the Stage 1 test was that they are associated to high priority health conditions if I recall. But for our certification we didn't have to associate them to a quality measure per se, you know, so –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic
Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

The capability had to be proven out to use that required data elements as factors in triggering the decision support intervention and that's really what the certification focused on was the capability to use all those factors, use them in combination at least once and then that was what we had to go through. So, I think there is a –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, John –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Something to be thought through – I was just going to say Liz about if you're looking to the use side of things is there a need to have a stronger connection explicitly to the framework that the use is expected to fall within? Because it wasn't there in 2014.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, I mean, you're right.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

That's true.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah we created our own at Tenet just because in order to meet audit requirements we created the referential databases and so on so that we could say this is why, how and whatever. I think you're right. So, from a current certification perspective on CDS what you had to do is be able to prove that you could trigger on the five elements is that the bottom line?

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah and at least one combination of them.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay and so you did not have to tie that to – and this makes sense, but you did not have to tie it then back to a current quality measure like we did?

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

No, no explicit linkage back was required.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

And that's a key issue Liz and John.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

I'm glad you're zeroing in on it because I know at least our organization and John you may even add some visibility to this, you know, we're trying to get to a parsimonious set of things we report on and matching up all of the quality requirements with other data elements that are quasi-quality related like these clinical decision support rules are tricky.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, you could argue problem list is a factor in nearly every quality measure.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Because it's probably part of a denominator statement for nearly all of them. You have stroke, well bingo you've – you know, any quality measure related to stroke, any decision support intervention related to stroke that's probably adequate to meet the use test, but, you know, we weren't compelled to necessarily pick a stroke CQM CDS, we may have, you know, and, you know, we considered things like that but it wasn't a hardwired, you know, and the vendor wasn't expected to show a full catalog of "well here's all our clinical decision support interventions that relate to stroke" you know "and we have 30 of them in our library" you know that wasn't where certification went.

That is a fair expectation perhaps from an implementation stand-point that okay "vendor what kinds of interventions do you have in your standard set related to stroke" or we get it that you can construct it in all the building blocks are there. For us we want to go do these things I think that's the hard thing about this but also good flexibility that the implementer does have the burden of deciding which interventions make sense for them given what they're patient population needs. I think that's inevitable and, you know, it was be fallacy to say, you know, the vendors got 5 things off the shelf I just dropped in without thought. I'm being a bit facetious but, you know.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, if we look back to the objective itself though we talk about – so I think we sort of understand what you had to do and that is all you had to do John?

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, I mean, along with showing the bibliographic information, the pedigree information, you know, all of that which –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Which is –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Shows the source of the intervention and the referenced information about the intervention so a lot of it focused on the attributing testing around you've got a full bibliography, you've got source information, you've got reference information about it, you can show the empirical evidence trail behind it things of that nature.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, so I'm going to go to our question for a just a second Cris and that is, we got certification criterion and auditing. Auditing is a new realm for us so for just a minute I'm going to leave that one on the table recognizing I'm doing so, because I think we've talked about certification.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Right. Well that's – Liz I was about to go to the same sort of place and I'm curious if you agree and whether other people on the Workgroup want to go here which is, it's good to get a baseline of where we are in Stage 2 because if the question put in front of us is whether these new requirements are, you know, perhaps too prescriptive and, you know, how does this support certification and auditing as a baseline, I mean, Stage 2 is not prescriptive but in effect there's a limited number of things you can do to get there and I don't know John if you are anyone else in the Workgroup who has been close to the vendor community, you know, felt like you had multiple options about how to approach Stage 2 –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah I think –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Or whether there was only one way to do it?

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

I think that there was good flexibility for the vendor, the thing I liked is that they didn't say, it was both good and bad, it was bad in the sense that it made the vendor have to go think about how they're going to present it, but they didn't prescriptively say that the intervention had to be a particular kind or that it had to be, you know, real-time triggered by that user doing something interactive and the decision support is right back to them.

Matter of fact the whole nature of incorporation being part of what triggers a clinical decision support and that's one other thing we had to do was to show off of structured data coming inbound from a transition of care summary how for certain categories of data problems, lab results, etcetera, medications incorporated structured data could also trigger and by default that might not be – I shouldn't say by default, but that was not confined to only be interactive to the very end user doing that active incorporating the data, that might be something being done by a support staff and workflow or somebody doing medication reconciliation and it triggers an intervention that goes downstream to notify a physician about something interactive or causes interaction later on when the physician does something that drives off of the incorporated data.

So, they gave a lot of flexibility to the nature of the intervention, the timing of the intervention and, you know, those sorts of things and were very carefully not prescriptive that the intervention only could be say a pop up message triggered by something I directly both entered and then did. And I think that's good.

It didn't explicitly go to the place though of saying, all right even if ONC doesn't prescribe exactly what the vendor must do part of the certification is the vendor has to show a link as to how this intervention pertains to a quality measure, you know, so that's problematic to me when you look at if that has to be proven for every quality measure the vendor were to certify to for example. I mean, how would you corral that?

So, that's a tough one for me unless you're getting into a very exhaustive test where you say of the measures the vendor certifies to the vendor has to use that as a basis of proving they can link to at least, you know, as many as the hospital or EP is expected to implement.

So, if you're looking for a linkage for Stage 3 to go beyond what they did for Stage 2, which was fundamentally based on proving the different data elements could be used as triggers and factors then I think you get to thinking about how does the vendor prove the context of what the implementer is expected to do.

But, be careful not to prescribe it or limit it in such a way that the implementer could only do what the vendor certified to do that takes away a real important element of flexibility to the implementer. Does that make sense?

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

I kind of wandered there, but I was thinking ahead –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

No that was really good.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

That if you're going beyond what the criteria is in 2014, what immediately comes to mind is adding criteria to say the vendor has to prove the linkage between the intervention and the context within which it must be implemented, the quality measures by the –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

National Quality Strategy or high priority health conditions. High priority health conditions isn't maybe as difficult because you could trigger that off of showing that the problem is a high priority health condition stroke, diabetes, COPD.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well that seems to have disappeared altogether.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Well, yeah, it might have.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah and the other thing that's odd, as we try to talk about it from a certification – and like I said we'll leave off auditing until second, I'm confused and I need help from ONC, Michelle or Scott, it says six quality domains, we've always had five, I'm looking for the sixth? We've had care coordination and clinical process effectiveness, efficient use of healthcare resources –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

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Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Go ahead.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

So, Liz you're thinking of the priority areas within the functional objectives but they're actually –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

No, it says here at least four of the six NQS domains.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Right, so what you're speaking of are the domains for the functional objectives but there are actually six domains that are different some of them overlap some of them don't for the quality measures.

So, in Stage 2 quality measures were actually mapped to the National Quality Strategy domains and they were required to do three of the six for Stage 2. So, they're pushing it a little bit further for Stage 3 and asking four of the six. And I'm going to pull up what those six are so I can tell you.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah, because it says – yeah, I understand what you're saying that's why I'm trying to make the difference because are we changing the domain correlation as well I suppose at this time and the reason I'm asking that is because any time that we put anything into an objective and then we write criteria for it if we say there are six NQS domains then my assumption is John Travis that we would then have to create something in every domain to prove that you could do something in every domain?

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

That is –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

This is where we get down to the and/or business.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Well and I think that's going to be the challenge. So, as I look at the six that are listed there, but no those are not really domains.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

These are not domains.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, the domains aren't noted here and that would be good.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Because I know what they are, they're in like for example the physician PQRS measures are organized by them and the hospital measures soon will be, but it would be good to have them in here for reference.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yeah, just to reference them, so some of them, as I said, some of them map to the functional objective domains and some of them don't. So, patient and family engagement, patient safety, care coordination, population and public health, efficient use of healthcare resources and clinical process and effectiveness.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So the only one that wasn't included the last time was population health.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

No population health is actually in there already.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

And I think –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

No, hang on a second, guys, I'm saying that today there are five domains in the Meaningful Use law and the one that's not in there is population health.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

No that is in there. The five that are in the functional objective domains are patient and family engagement, improving quality, safety, efficiency, population and public health, care coordination and I forgot the fifth.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Patient safety?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

No there currently isn't a patient safety one, it's included in the –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Well and the –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Improving quality safety and efficiency. So, I know I'm going to confuse everybody, but after the August meeting when the Meaningful Use Workgroup presented they wanted to do a better alignment with the six National Quality Strategy domains so they have actually mapped and added more functional domains for the functional objectives themselves and so they now all map to the quality strategy domains.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay, so Michelle, help me understand for just a second.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yeah?

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Are you saying in Stage 2 all six were present?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Only for the clinical quality measures, they were not all present for the functional objectives.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right, okay, so now we're saying the same thing. What I'm saying is –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

For the clinical quality there were five domains and now we're doing a better job –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

No for clinical quality they had all six. I'm sorry, I know this is confusing. For quality measures they still had all six so any of the – I think the 64 quality measures that were offered, at least for EPs, mapped back to the six National Quality Strategy domains.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

They did, I see where Michelle is headed with that –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

But for –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Because really if you take a different view of it the Meaningful Use EP measures, as an example, are really a subset of the PQRS measures that are, you know, have been made eSubmission compatible and those there is a mapping of those measures into CMS's National Quality Strategy categories.

I challenge there is real inefficiency measure because those have been like total cost per Medicare beneficiary and we're not getting that through the system, but otherwise, yeah I accept the statement that the measures there are organized and if you looked at the PQRS measure categorization you would be able to see that.

And they're distinct from the Meaningful Use categorization of the functional objectives which grew up under the Meaningful Use Incentive Program. So, they're two different classifications schema that may have correlation but they don't directly map.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I see okay.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Well, just to be – let me make sure I'm understanding this. Michelle that was very helpful but between you and John what I'm trying to get clear is I think John indicated five measures under Stage 2 that were related to certification. I'm not clear, Michelle, with what you're saying are the certification requirements for vendors or the attestation requirements for EPs and EHS. Could we just be crystal clear on that? Because I think that's important.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, what I was referring to Cris were the data types in the criteria that we had to –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

For certification?

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

For certification.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Correct.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

They're not categorized with anything, their problem list, medication list, etcetera. In 2016, if that's what this –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Plans to be tagged as. The suggestion in what we're looking at today is a replacement for that with the National Quality Strategy categories. So there is a problem of translation to be solved as to how do you describe that such that a vendor could certify to it.

So, for example, preventive care, well not preventive care let's – care coordination. So, if we're to prove a CDS intervention for care coordination it's now turned on its ear a bit the former way we would have certified in 2014 because I can guarantee problems are going to be relevant across multiple National Quality Strategy categories.

We're going to be re-purposing the same data types to do multiple proofs of capability across the National Quality Strategy categories. We're going to reuse medication data, we're going to reuse lab results, we're going to reuse problems, you know, we're probably going to reuse every data type.

So mechanically to the system in a way it isn't proving much more to a system functionality. It's proving that we are able to define content in terms of those decision support rules that can support a lot of different clinical objectives in terms of quality related measures or capabilities, it's not that that's invalid but, you know, the construction of the rule at its heart is still going to really be, you know, geared to software capability, the content construction of saying, I've now got to define an actual rule to align to, you know, a patient who needs a foot exam or a patient who needs to have mammography screening or whatever it is that's now what we're saying clinical decision support needs to be aligned to.

So, we're now proving that the vendors are able to define a rule of a particular kind to support a quality measure related objective versus using data elements in concert to generally prove decision support capability that would use those data types. It's a very different view of what you're trying to achieve. It probably makes the vendor do something much more closely aligned to what the implementer has to go and prove.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, can I ask a question going back to Stage 2 to try and – I'm trying to figure out how to get us to Stage 3, get to the six domains, the reason we didn't do population health on the Stage 2 and John I'm asking you is there is no quality measure on the EH side tied to population health, how did you test for that? Because I'm thinking if we can do a similar certification criteria again and get to all six domains but that's the reason we didn't do the six domains for EHs in the past. How did you do that?

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Well, like you say the clinical decision support testing did not require us to prove measures.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

The domain test.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

By domains.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

No.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

All right, okay.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

It only required us to prove we could – now we may have used examples, I don't remember exactly all the examples I remember some of them, but we had to prove that we could fire a decision support rule based on a problem, based on a medication.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Based on a lab value and then a combination. So, I know one for example, you know, the classic one is a patient with diabetes and, you know, the HbA1c level is a classic one.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Or creatinine levels for a patient who has a condition that's sensitive to creatinine levels.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

So the combination lab results –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes, yes. So, kind of back to – for all of the Workgroup, you know, when we talk about doing – it looks like to me, but Michelle you may be more familiar having worked with the Meaningful Use Group, we're going to a domain attachment versus an attachment to this list of 5 priorities. I'm trying to figure out what they're wanting. What they think they're wanting.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

So, the end goal for the Meaningful Use Workgroup is that they want to make sure that providers are using clinical decision support to help them with their quality measures so that they're – you know, they're – it's all tied together. So they're better able to improve upon their patient population for – so eventually they can improve upon outcomes is kind of the end goal.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

So they're trying to tie CDS to quality measures in a way that will have meaning to practices for example. So, you know, maybe they're not saying it in a way to get that message across and if you have suggestions on how to make that clearer I think they would certainly be open to that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Okay. So, Cris the other thing that I'm struggling with as I'm trying to get through this is the quality measures themselves, do we have any idea what the quality measures are going to be or are we just going to stick with NQS quality measures? I mean, like Cris had said earlier we're all trying to get to a single set of quality measures in lieu of every different place that we report has a slight different variation.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I can tell you that they're working really hard to better align the quality measures across the different programs in CMS for Stage 3. There is currently a list of, you know, potential measures that I think we can share publically because it's been shared with the Meaningful Use Workgroup if you are all interested in seeing that list.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Well part of the issue – just to process check here, we've got 20 minutes or this conversation will probably continue after Liz and I go which is great.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

But part of the issue here is, you know, our job is not to question whether clinical decision support is a good idea or not or any of those policies.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Oh no right.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

And we're not doing that, but I think it is our responsibility to raise what's feasible and what's not.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

And so the comment about the harmonization and the quality rules I would just say on behalf of our organization, and I hope we'll get others in the Workgroup to speak up here too, you know, we're having trouble simply harmonizing against all of the quality domains that we need to report to for a variety of stakeholders and now some of those are private and that's our problem not a regulatory problem, but there are difference in standards that are required by CMS for different purposes and for other federally supported and federally qualified kinds of quality activities so that alone is tough.

So, if you were to say, for example, that all the quality measures would be harmonized across all domains then it becomes, I think, easier to implement more sophisticated things like clinical decision support that meets quality standards, but if we're mapping against a really messy quality reporting domain more sophisticated and more intricate reporting requirements in Stage 3 are going to be really hard.

So, I guess I would love to get feedback both from ONC and from the Workgroup to just first I think we should just all get sort of a steady footing on is this an achievable domain and are we trying to do very sophisticated stuff on shifting sand or do we have, you know, firm, level, clean ground on which we can ask vendors and then EPs and EHS to do some sophisticated stuff and I frankly don't have a good handle on that maybe I'm the only person on the call, but I think our organization is struggling on how to report data that meets conflicting in some cases quality requirements.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, just to keep it short and sweet I completely concur we are struggling. We have for every one of the quality measures there are smaller differences now but unfortunately any difference in specification requires a different set of data that's submitted for the requirements. So, we concur with you.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah and Cris and Liz this is Dave Kates, the, you know, on the clinical analytics and administrative analytic stuff that we do now on the Crimson Advisory Board stuff, same issue with most of our members it's just minor variations on that. So, again, just to keep it short and sweet, concur.

I think back to certification of an EHR, what John described and what the Meaningful Use folks are asking for the vendors to be able to demonstrate the capability to generate these measures that, you know, we need to provide flexibility but the requirements can be basically having the flexibility to be able to identify and trigger rules based on the relevant criterion and data domains to support the flexibility given the variation that's out there in the real world.

Now I'm totally in agreement that we want to try and reduce that, but I think from a certification stand-point for all the reasons that we're talking about the criterion need to just show that the basic mechanics of being able to go and use the different domains and fire rules based and then deliver, you know, relevant meaningful information to the end user is still spot on. Then the other, that's a separate initiative to try and bring some sanity to the mess that's out there in terms of the measure rule.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, David, are you thinking that – Dave are you thinking that we would include in the criteria the ability to create – when we say the mechanics I'm assuming the mechanics would be usable regardless of which domain you were in and they wouldn't have to demonstrate it in every domain. Is that a correct assumption in your mind?

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah, I mean, I think what I heard John describe as his experience and what I perceive in the requirements, short answer “yes” like it would be useful to show that a medication, an order and maybe down to a lab order versus a radiology order that those all can be used as either triggering mechanisms or the data that’s contained within them or contained within the patient’s chart around medication, around problems, around, you know, allergies can all – you know, it would be good to demonstrate that a vendor, an EMR vendor or EHR vendor can use those data elements and those triggering mechanisms that would constitute when we think a decision support rule should fire having that capability or start with that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

So, I’m saying you can’t just say you can fire a rule when you enter a medication.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

But you need to show in each of the categories where we think it’s appropriate that a system be able to provide guidance to an end user that it’s capable of doing that.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah I think, if I can paraphrase, you’re certifying – and that’s really what 2014 is doing, you’re certifying the building blocks that allow rules to be defined, you know, a bit agnostic to what they’re related to. I mean there are – you can’t be that academic, but, you know, what I mean, so it’s the general capability that’s being certified now.

I think the question on the table is, is that where the certification remains or is there also a need for the vendor to prove the ability to really maintain and provide a content library of relevant rules that are organized by the quality domains –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Well, I can tell you –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

That’s a step beyond and that is a pretty big leap to prove the capability but leave it to the implementer to construct the rules is kind of the approach we have now.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, the –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

To move beyond that to something where the vendor is outright proving that they've developed intellectual capital, which may not be the business all of them are in.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Right, right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

To show, you know – so they could have a clinical decision support software development toolkit or engine, or receptacle that, you know, an implementer could build content in or a third-party content could be placed in, we're asked to prove exemplar capability now, we're not asked to prove we have a library off the shelf of content and intellectual capital to go meet a National Quality Strategy structure and organization.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

But John you – let me interrupt for just a second because pretty quick I've got to go.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Okay.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

The quandary I have – I don't disagree with what you're saying and I think clearly the Meaningful Use Group is asking us, as we ask ourselves not to make this too prescriptive and not to go too far.

The challenge I have that we haven't gotten to and we won't have time today is the auditing component of it. If auditing and the question that we're asked is auditing of the vendor or is it auditing of the provider, because when you talk about what we certify to we don't certify providers we certify vendors and that would almost infer that there should be some kind of ability to meet the auditor's questions but I may be jumping to the wrong conclusion.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

No, I think you're exactly on track and I don't know that that's a prescription either. I take it as a statement or at least maybe that's a suggestion of where we try to shape it that that is asking the vendor what kind of trail do you leave that the – because the audit burden is prove you had the capability –

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Active throughout the reporting period.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Correct.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

So you could either – and I've gotten some hints, I don't have hard science to prove, but it seems that the audit contractors prefer to understand that the capability, well, I shouldn't say that, but let me put it this way, there are two ways broadly that I've seen attempted, one is clients of ours who have tried to prove that the ability was turned on.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

And then the other approach is let me show you actual log events of interventions firing.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

But even if you show them – so today this is not honest with this particular portion of the rule it's really honest around things like drug-drug, but the challenge becomes if you only prove that it's turned on, since we're doing now our 23rd audit it is – they ask you to prove it was on during the entire reporting period.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Right.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

And eventually I think they're going to ask you to show it's on during the entire federal fiscal year. So, I think, you know, Scott and Michelle, and Cris for another meeting we need to talk about the audit piece of it.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, I'd offer the question and leave it there, is that a useful type of capability.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I don't –

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

That doesn't prove that I ever actually used it, it was on.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

It's like I had the light bulb on in the room but I didn't actually sit down to read anything. So, you know, is the more useful thing to prove that the interventions that I'm basing my claim on were actually used, did they actually fire.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

I mean we – and so you know and again we're prolonging this, but we measure it both ways.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Because for example when we choose the rules that we choose we then went out and audited all of our six hubs to say, how often is this used and then actually what we're doing, but it's not required by Meaningful Use, is to try and see if it was used what was the output of it.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah, yes.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

But that's a different exercise altogether. Cris, kind of bringing us back –

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Yeah.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

When do we – first of all Scott and Michelle, when are we to get this information back to Meaningful Use?

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

So this is –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

They were hoping to have it by –

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

They're expecting to have comments by –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Sorry. They were hoping to have it by December 10th it's during the December 10th meeting that they will be talking about clinical decision support maybe you could give them an initial round of feedback and if you have more they certainly would welcome it. They're giving their final recommendations to the Policy Committee in January and they have a meeting on December 10th and another one on the 20th. So, if you have additional comments perhaps you could provide them in time for the meeting on the 20th.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

So, I would suggest, based on our conversation, we just have a couple of minutes before at least Liz and I need to go, and others can develop more, I would propose a couple of recommendations. One would be the more that the NQS standards and domains are harmonized across a variety of sectors the way that we're paid, the way that NQS measures are used across Meaningful Use and so on, the more that they are harmonized the more sophisticated we could be with respect to the Stage 3 objectives on CDS.

And there is probably a way to simplify that, but I don't think we all know – Michelle you mentioned that there had been some input to the Meaningful Use Group around harmonization, around the NQS domains, but I can say that if that doesn't happen an already difficult task I think will be nearly impossible for purposes of certification.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

I would propose a second area for us to look at which is when I look at these Stage – former Stage 3 and updated Stage 3 I get the point that the updated is in response to overly prescriptive concerns in the former, but when I look at the pieces there isn't anything listed as certification criteria but I assume it's the bottom paragraph where it says CEHRT should have the functionality to enable.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Correct.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

We've run into problems in the past with the phrase "should have."

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Right.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Does that mean optionality or does that mean everything and we've run into places where "or" means "and" so I guess the question is, when I've gone through this list of seven things just speaking from my organization some of these are hard and I don't know what six – I think I know what six is, I think it's a broad overreach.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yes.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

The idea of trying to consume external CDS interventions, you know, we're just making baby steps, if someone wants to do it more power to them, but to mandate the ability to consume external CDS I think is out of bounds and I don't know what the phrase "use info in systems to support maintenance of lists" means. I have no idea what that sentence means. So, I have a hard time understanding what a certification rule could be around it.

So, I'd say one just try to be a little bit action oriented, I think number one through number five are hard, some of them may be impossible. I think six should be out of bounds because it's just not feasible and I don't know what seven is.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

Yeah and I –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

So, this is Michelle, can I just speak, so six is related to the Health eDecision work and the Clinical Quality Workgroup is actually going to be answering that question, will the work being done within Health eDecision be ready in time.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Well, I will say from an Implementation Workgroup perspective I would – I believe and I'd love to hear from other Workgroups the Health eDecision stuff will not be ready and not in a way that's feasible.

Elizabeth Johnson, MS, FHIMS, CPHIMS, RN-BC – Vice President, Applied Clinical Informatics – Tenet Healthcare Corporation

So, Cris I'm going to run to my next meeting, but I just – so just to add mine and then Michelle, we're going to need either at minimum a follow-up with you and Scott and Cris and I so that we can get something out to the Workgroup to review and give feedback on prior to giving it to the Meaningful Use Group and Cris the six and seven were the two that I circled as should be omitted.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Can I describe seven? I know you both have to go, but seven the thought was for example if you're thinking about medication lists, if for example a patient was put on an antibiotic for a short period of time maybe there is a prompt to say to them, you know, this has been on their medication list for over a year is this something that they're still on or if they're a diabetic patient and they clearly are diabetic but it's not in their problem list prompting the provider that perhaps that could be added to their problem list. So, that was the intention of that and maybe it's not very clear.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

So it's maintenance of problem lists?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

All lists, so medication lists, problem lists, you know, medication allergy lists.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Well, I think it goes without saying that lists should be up-to-date if that's what the standard is, we'll see. I agree, I also need to go and sorry, I think just a few of us have dominated this conversation I feel bad because I want to make sure we get input from others and maybe we can do that when our loud mouths get off the phone, but I think we should have a follow-up call.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, so we'll work to schedule a follow-up call hopefully next week I think, I think it's going to be really difficult, but we'll try. So, thank you Liz and Cris we really appreciate it and Scott and I will follow-up with you off line. Perhaps for the other members of the group we can continue looking at those seven items that Liz and Cris had mentioned and see if you all concur with their recommendations.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Thanks so much, see you all.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thank you Cris.

Christopher Ross, MBA – Chief Information Officer – Mayo Clinic

Bye.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Thanks, so hey it's Dave Kates, the – I can appreciate Cris's perspective and probably everybody that's on the implementation side given the terms of the feasibility of being able to consume external clinical decision support and I'll defer to others in terms of readiness.

But I know, you know, there is a lot of discussion and a lot of activity going on related to being able to provide guidelines and decision support from external systems that either have a broader perspective that know activity that's going outside of the care settings that can incorporate that level of – that breadth of understanding of the care that's being delivered to an individual patient as well as have deeper, you know, decision support capabilities and content management and the like.

So over time having the capability that, you know, a decision support system in the cloud, if you will, might be triggered and might also render guidance and alerts through the workflow system namely the EHR as something that I think we should be moving towards, but I recognize that that may be premature for Stage 3 but I would just put in a vote for at least keeping that on the horizon as something that we want to move toward albeit timing-wise we'll have to see what the readiness of the industry is.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Thanks Dave. Any others on the phone?

David Kates – Senior Vice President, Clinical Strategy – NaviNet

I mean, I think the next step will be if we have some specific language that we want to review, you know, in a follow-up discussion next week when Cris and Liz, and the rest of the group can reconvene that's probably the next actionable thing unless there is further discussion.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

So, I mean, this is Scott, I was – our plan is to try to take some of the notes in this conversation and try to combine them as best we can with some, you know, summary actions and circulate that back to the group ideally either tomorrow or Thursday. Our initial timeline was that the comments were due back to the group by Friday, but with the extension of time we do have a little bit more flexibility to circulate it and kind of get some additional feedback received.

So the goal would be to get the initial comments together so that we all can kind of review them and then kind of talk like Michelle and I will talk to Liz and Cris next week to figure out what the final comments need to be and then we can refine it as we move forward.

I mean, I think a lot of this conversation was really centered upon what Stage 2 looked like as opposed to what we can try to drive towards Stage 3. So we will need to try to continue that conversation to try to kind of push the needle forward to get to answering the questions that were posed.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah and if there is stuff that you want us to react to via e-mail or whatnot even if we can't together as a group for a meeting that would be useful to circulate.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

Okay.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah this is John Travis and we probably don't have time to go through it today, one that we didn't speak about that some of my colleagues here have a very strong opinion about is structured SIG, so the 5th one I think on the list. And Dave I know you probably have some perspective on this as well, but two things, number one unless you're prepared to address structured SIG as an aspect of the NCPDP standards that are adopted for messaging about prescriptions it's going to be – if we're only talking about that in isolation of an EHR vendor system supporting it we need clarity around it.

We're very strongly in favor of having structured SIG supported as an aspect of an interoperability requirement for electronic prescribing to convey with the prescription because it's killing the utility of that kind of capability for a lot of EHR vendors to perhaps support it for themselves but not have it be able to be supported by any recipient system or sent to it by, you know, any other system, because essentially you're receiving it as a narrative text and that's not very useful for clinical decision support.

So, my suggestion would be if we're going to consider it as something that should be supported as a factor in CDS we need to consider addressing it as a factor, as a messaging standard as well wherever it gets attached for perhaps a Stage 3 in 2016 ePrescribing requirement if it's – and if it's not ready for that, you know, maybe have the discussion about what's the barrier to it. It's been a long festering point I think for the industry.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yes and I'd agree John that it's related to CDS and the ability for a CDS system to operate on discrete data elements down at the SIG level. I sort of – I had the same reaction when I saw it here that it's not really a CDS capability it's a dependency that we'd like to see promulgated elsewhere but it doesn't seem like it doesn't belong in this section.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah and one thing that may be beyond Meaningful Use's ability to push and it's kind of like the issue we have with reference labs sending LOINC codes, if pharmacies aren't sending structured SIG with renewals we still are going to wind up limited, but maybe at least there's a place for structured SIG in the messaging standard requirements to support ePrescribing and maybe there is a renewal transaction we have to prove –

David Kates – Senior Vice President, Clinical Strategy – NaviNet

Yeah and even in – I mean, I think in 10.x it is another option.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

I definitely support it, I don't know to what extent it's required.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

It's been a couple of years since I've been dealing with that.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

So, that maybe feedback to, you know, a peer Workgroup in the Standards Committee to consider whoever has the ePrescribing area of responsibility to take that up. I don't know what discussion they've had there but that caught our eye and we're very much supportive to it. I think a lot of vendors would be supportive to it because it enhances the utility of what we can do and right now it's narrative text if it's anything at all.

I don't know that I have any other – I think otherwise I agree with Cris and Liz on what was it six and seven being pretty hard to do or maybe aspirational right now. Well, seven is "what is that" and six is aspirational.

David Kates – Senior Vice President, Clinical Strategy – NaviNet

So are the ONC folks still on the line?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yes, we are still here. So, for seven I just – after I explained it did it make more sense and do you have suggestions for fixing that language to make it clearer of what they're asking for?

So, for seven the intention was that, again, if there is a patient that seems to be diabetic but diabetes is not on their problem list they would be prompted and asked in some way, you know, should this be added to the problem list or if there is a medication that is typically a short-term medication and they've been on it for a long time or it's still listed on the medication list they're prompted and asked should this be taken off of your medication list for that patient.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

It – yeah, no that makes sense Michelle, thank you, this is John, I think that maybe a restatement because it's almost a flavor of a decision support intervention I think that's the point of what you're representing to prove a capability to – you know, it begs something more and maybe it isn't going to be everything but it's kind of – where my mind goes is would a better way to say that is to use information kind of like the concept of the required data elements that we had for – and this maybe beyond where all our systems can go, it may provoke a lot of comment, but it's almost like use problems, medications and, you know, the lab results in at least one combination or something of that nature to suggest maintenance of lists.

I guess where I'm headed is the example you gave was really the systems acting on knowledge that is circumstantially it suspects the patient's got diabetes so why not say so, you know, maybe there is construction of an example that is proof of capability –

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

For the system to be able to do that without prescribing that it must do it on, you know, the way that we certified CDS in Stage 2 because I'm not sure it makes sense to certify on things individually. I think out of list proof maybe the ability to do at least one combination where it could be true, that's a very sloppy statement on my part, but that seems like maybe an improvement on it.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, no that is very helpful, thank you, I appreciate that.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Okay.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

And I think one question that we really didn't get to today was, so what the Meaningful Use Workgroup is afraid of is stifling innovation that, you know, vendors have come up with ways to do clinical decision support which is why they didn't want to be overly prescriptive but at the same point for different systems they want to push them further to do things that they aren't currently doing.

So, they're having trouble, which is part of the reason why they reached out to this group, you know, making sure that they're pushing things further for some but not stifling innovation for others and that's where their concern comes in regards to certification, you know, how do we do this in a way without causing too much havoc in the industry.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

So, I think that's kind of an overarching question for not just clinical decision support but all of the objectives. So, I think maybe that's a discussion that we can have in a future meeting but I know its feedback the Meaningful Use Workgroup would appreciate.

John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance – Cerner Corporation

Yeah and maybe, you know, I'm thinking about some things that I'm familiar with what some systems do as to, you know, that the intervention provides for a suggested next course of action. Maybe number seven could be made more generic that it's not just the maintenance of lists but it's to take an appropriate additional clinical action based on the intervention that the intervention actually suggests.

You know, so it may be that the suggestion is taking other actions and simply adding something to a list, it might be to go cancel an order, it might be to place an order, it might be to order additional laboratory testing, confirmatory testing or things like that. So maybe they'll accept that the concept could be broadened that it's not just maintenance of lists it could be taking the next appropriate intervention based on a suggestion that the intervention actually makes subject to an end user, you know, confirmation or concurrence.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

I think that's great feedback thank you. Any other feedback from the group? Okay so hearing silence, so I think next steps, and Scott please confirm that I have this right, that Scott is going to write up the notes that he took from today and we'll work to distribute those. We'll also work to set up a meeting with Liz and Cris to figure out next steps and we'll likely try and schedule another meeting so that we can follow-up on some of the things that weren't quite finished during today's discussion. Scott, do I have that right?

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

That is correct. I mean, I think, the – so the timeline is that the meeting is on the 10th, correct?

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Yes so as long as there is something prior to that meeting that I can put together for them.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

Got it that's fine.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

That would be great.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

That's fine. So, we will circulate some of these. I mean, ideally by close of business tomorrow if not, you know, if we needed a little bit extra time I'll let you guys know to kind of get those out and circulated and then if we can get some reactions by Friday we can turn that around to get it back to you next Monday.

Public Comment

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay. Thank you everyone and with that we'll open for public comment. Operator can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute

If you are on the phone and you would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We have no public comments at this time.

Michelle Consolazio – Federal Advisory Committee Act Program Lead – Office of the National Coordinator

Okay, thank you and thank you everyone for joining it was a great discussion today and we'll follow-up.

John F. Derr, RPh – Health Information Technology Strategy Consultant – Golden Living, LLC

Thank you, bye.

Scott Purnell-Saunders – Program Analyst – Office of the National Coordinator

Thanks everybody.

**John Travis, FHFMA, CPA – Senior Director & Solution Strategist, Regulatory Compliance –
Cerner Corporation**

Bye-bye.