



## HIT Standards Committee Content Standards Workgroup Final Transcript May 4, 2015

### Presentation

#### Operator

All lines are bridged with the public.

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

Thank you. Good afternoon everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Standards Committee's Content Standards Workgroup. This is a public call and there will be time for public comment at the end of the meeting.

As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Also, as a reminder if you are following along via the webinar and you use the public comment we may share those public comments during the public comment period at the end of the meeting. And with that I will take roll. Andy Wiesenthal? Rich Elmore?

#### Richard Elmore, MA – President, Strategic Initiatives – Allscripts

Here.

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

Hi, Rich. Calvin Beebe? Charles Jaffe?

#### Charles Jaffe, MD, PhD – Chief Executive Officer – Health Level 7 International

Here.

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

Hi, Charles. Clem McDonald? David Dinhofer? Dianne Reeves or Larry Wright? Floyd Eisenberg?

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

Here.

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

Hi, Floyd. Grahame Grieve? Jamie Ferguson? John Klimek? Joyce Sensmeier?

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Here.

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

Hi, Joyce. Kelly Aldrich? Kevin Kirr? Kim Nolen?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Hi, Michelle I'm here.

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

Hi, Kim. Kin Wah Fung?

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Hi, I'm here.

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

Hi, Kin Wah.

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Hi.

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

Marjorie Rallins?

**Marjorie Rallins, DPM – Director of Measures, Standards and Informatics for the Performance Improvement Division – American Medical Association**

Here.

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

Hi, Marjorie. Becky Kush? And Susy Hull?

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

Good morning, I'm here.

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

Hi, Susy. And from ONC do we have Matt Rahn?

**Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology**

Here.

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

Hi, Matt. Mazen Yacoub?

**Mazen Yacoub, MBA – Healthcare Management Consultant**

Here.

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

Hi, Mazen. Anyone else from ONC on the line?

**Dianne Reeves, RN, MSN – Associate Director for Biomedical Data Standards, National Cancer Institute – National Institutes of Health**

Dianne Reeves.

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

Hi, Dianne.

**Dianne Reeves, RN, MSN – Associate Director for Biomedical Data Standards, National Cancer Institute – National Institutes of Health**

Hi.

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

Okay, just a reminder if you could please mute your line if you aren't speaking, we're getting a little bit of feedback, that would be appreciated and with that I'll turn it to you Rich.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Thanks, Michelle. Today we're going to be focusing on the subgroup work on the NPRM, certification NRPM, targeting eventually feedback to the HIT Standards Committee scheduled for, Michelle or Matt do you know the date?

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

Sorry, it's May 20<sup>th</sup>.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

May 20<sup>th</sup> okay so not that far from now, you know, there's some good work that's been done. This is an opportunity for Workgroup and then public comment on the work to date and after this, you know, we'll begin the process of stitching it all together. So with that we're going to have group one comments, Kim Nolen will be leading that, and then after that Floyd Eisenberg will be reporting out on group two. You may recall that group three, Calvin Beebe, reported out at our last meeting. So, take it away Kim.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, great. Michelle will you be...or who will be advancing the slides?

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

Altatum will be advancing the slides.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

There we go.

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

Yes.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, thanks. So, I want to thank our group one members who helped come up with kind of our consensus statements. We had 11 areas that we needed to look at and we have gotten to eight of them so we're going to present those out and I believe we have a call this week to finish up the last three. And the next slide, Michelle.

The first one that we were looking at were the medication allergy list and we actually had a lot of discussion around this one and I'll give a little bit of a background before I go into what our consensus was on the standards.

We felt like that regardless of the substance if you have an allergic reaction the end result is the same like your body responds in the same way, so we think it's important to start trying to figure out how to incorporate this into our Health IT system, but we did feel that the standards were not mature enough, but maybe we could allow the users to start entering in some of the food allergies or something by text.

And we also thought that we should start considering what are the main food allergens out there and that maybe a good place to start. So, we had found a reference and we put that in there, and then how could we link...start building a vocabulary around those so that we could not only have it in a structured discrete field but then it would have...or a discrete field but then it would have structure around it with a vocabulary.

So, those were the comments that we came up with for the medication allergy list. So, I'll pause and let the group add in any discussion around that.

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

So, this is Kin Wah Fung...

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Kim...

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Sorry.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Go ahead.

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

So just to add to what Kim said and we also noted that right now the food and environmental allergens they don't play an important part in clinical decision support systems because a lot of the ordering side of things are still not covering like food ordering that might be able to feed off a list of food allergens. So that is another piece of information that the group had discussed.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

This is Clem, I'm sorry, I got on late and I've got to leave a little bit early too.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Kim, this is Rich, I had a question for you. The NPRM I think conflicts with the 2015 standards advisory where RxNorm is listed. Now I'm sure that might be a mistake, but, you know, I think to the point that was just made identifying substance reactions and intolerances is really important and we might be able to use the guidance of Consolidated CDA Release 1.1 if that might be helpful.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

There was a lot of discussion of that. I think there are a few like...maybe even latex in RxNorm, do you know Kin Wah?

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Only a very limited number of things so definitely not enough to cover all the food or environmental allergens.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

I...I mean, this is kind of farfetched thought, but with RxNorm and what I know about the medications they have different term types. So, it almost...I wonder and maybe John, Kin Wah or somebody can help us with this, but could you just have a term type that was for food and start with these first eight or 10 that we have listed so that you could get a vocabulary around it, but it was just a thought we had kind of tossed around when we had spoken.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

We should explore that but I still bring up the fact that when you get beyond that it's really hard to do anything with any of it, you know, that is if you get to say the Unicode you're talking about unique chemicals and people don't know the names of chemicals and, you know, so...and if you get into foods you have the cooking and all the stuff they throw into it that isn't recorded anywhere necessarily at a restaurant or whatever. So, I mean, I like your idea, we should explore that with John if he'd take that on. He may be hesitant because that you could actually do.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay and then we can loop in maybe like Elaine or Lindsey that's from the dietician society they may have some comments.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Well the other part of it is that the dietary orders really are sort of two steps, you know, so the provider would say that, you know, a 1500 calorie diabetic diet and that's it, and then dieticians talk to the patients and collect additional information about...it's just as important what they don't like, you know, I can't eat...I can't swallow, whatever, you know, and probably more frequent. And I don't know how you do a vocabulary with that except, you know, maybe...so it's a very complicated space and there are really two levels to it. And for provider ordering I don't think they're going to get into a lot of that extra detail.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yeah, well, with you saying that comment about I can't swallow it makes me think too with even medication allergies there are people who have the true allergies and it's an immunologic reaction versus...

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Right.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

People who just, you know, had an adverse reaction that then is labeled as an allergy. So, to me there is...that's beyond just the standards there's another issue with people's knowledge level...

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Right.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

And how they understand what an allergy is. So, I feel like the same thing concept could fall over into food.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Well, I think the big eight is something we could actually accomplish. I mean and we should see if RxNorm would do it, but...

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Yeah, but maybe we should not name a specific vocabulary, I don't know whether RxNorm is...because it's...when you go deeper it's kind of complicated because it's not just representing the type of food allergen and then you may need to drill down into specific food types.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Well that's...

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

And then also you have to link to different types of dietary choices and so on, and then it gets kind of complicated.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Oh, yeah, yeah, I don't think it's even...I don't think we're up to it.

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Yeah.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Really.

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

So, I think maybe at this point we can just acknowledge that the standards are not mature and then there are things that are more important than others in terms of food allergens and then work should be continued to make sure that eventually we can have a good enough standard.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, so do you think the two bullets we have captures what you just said or do we need to add more to it? And then...

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Yeah, I think it pretty much captures the recommendations right now. What do you think Clem?

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

I'm not sure of the bullets, I see, I'm not seeing bullets. Are they showing on the screen right now?

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Yeah, yeah they are on the screen now. The first one...

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Oh.

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

The first box, yes.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Oh, I see, I'm sorry, I thought...yeah, standards are not mature enough to require...yeah. Yeah, all right. Yeah, in fact I thought we decided this at the last meeting.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yeah, we did, this is for the full group now to get comments from others...

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Oh.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

That weren't in our small group.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Okay.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

And then Rich you mentioned something about getting guidance from the Consolidated CDA. Should we add a new bullet around that?

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Well, I think Rich said there was a contradiction did you Rich between the NPRM and the Consolidated?

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Yeah it looks like there is a contradiction so maybe we can get some clarity from ONC Matt or Michelle, maybe we can just follow-up on getting clarification there.

**Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology**

Yeah, that's fine, I'll follow-up.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

You know another thought on Uni might be if we were able to create some meaningful value sets, you know, might create a useful subset of Uni for future use, it may not fit into this NPRM but it may be a...it may be helpful.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

And Kim this is Joyce Sensmeier, one suggestion I think at the beginning of this discussion for this section there was a comment about clinical decision support systems not necessarily including this information today. I don't see that on the bullets on the screen or on our slides, but maybe it's somewhere else. I do think it's an important thing to capture because that just shows that the industry might not be ready yet.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay. Mazen can you and I like set up a call and work on adding these in afterwards, is that how it would work?

**Mazen Yacoub, MBA – Healthcare Management Consultant**

Yeah, we can that.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Or Michelle you're going to do it? Okay.

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

And this is Susy Hull, just one final comment, this is a great place where these documents get often pushed out into patient portals and this is where patients often want to have a chance to correct or amend the information. So, there are future implications for being able to do that perhaps not in this round but in setting these up as a standard way to look at it and then allowing patients to correct or edit.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

I'm not sure what you mean? You mean our statements here or some future invention that we haven't described?

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

Well, thank you I haven't fully read page 57 Clem, but what I'm saying is that this is an example where you said you should allow users to enter information as text.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Oh.

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

I was unclear if you meant that would also be consumers to correct or edit...

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Right.

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

Through their patient portal.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Right, right, because then you can say what want, whatever you know.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

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

And this is Floyd I just want to echo Joyce's comment about CDS so make sure that we do address that. Thanks.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay. I've got it written down so Mazen and I will work to incorporate all of these comments in here and then I guess we can send it back out to the group is that how we'll do it Michelle?

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

Yeah, I think that makes sense.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, perfect. Can we move to the next one? Are we ready to move to the next one? And it's actually labeled incorrectly it should be computerized provider order entry-medications, page 38, it says medication allergy list again, so we just need to get that corrected. I wanted everybody on the phone when I started making the comments to understand where the comments were coming from.

There was a section in the beginning of the CPOE that asked for additional elements for the medications such as diagnosis, it was mainly...it was for all of them for imaging, medications, labs like what should go along with it, are there any other elements that should go along with that, reason for order, diagnosis codes, etcetera.

So, we were in agreement that it would be helpful to have additional elements to go along with the medication ordering especially or more so for the diagnostic imaging and less so for the medication ordering.

And when we were reviewing everything in the certification criteria we didn't see a message standard specified for CPOE and inpatient and we just said they should consider specifying HL7 v2, maybe we missed it, but we just wanted to put that out there since that's what the inpatient uses and that was our comment around the CPOE for medications. Any comments from the group?

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Those of us who wrote it think it's pretty good.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yeah, I know, so we'll move to the next one then. If somebody wants to come back just let us know. Then next one was for CPOE laboratory which is also located on page 38. And Clem actually and Kin Wah actually helped us a lot with this one. So, we said that the LOI...we had some concerns because we weren't sure with how it was stated in the NPRM what the hierarchy was and so we just wanted to make sure that the LOI defines the requirement for lab order entry whether or not there is an eDOS available, so that was the directory of service for the labs and it was unclear regarding whose cardinality is being referred to, the LOI should hold sway if there's a conflict between the eDOS and the LOI standards.

And then we would also support in using LOINC as the vocabulary to promote interoperability and those were our comments. Clem did you have anything else on that one? That may have...Mazen was that the one we lost our comment...

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

No.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

In a technical glitch and we tried to recreate.

**Mazen Yacoub, MBA – Healthcare Management Consultant**

Yeah, I think it might have been that one, I'm actually in the process of doubling checking.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

But that one, the page isn't showing anymore for the test ordering on my screen. Did somebody...

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yeah, it...

**Mazen Yacoub, MBA – Healthcare Management Consultant**

No, I think it should be the...

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Can we go back one slide?

**Mazen Yacoub, MBA – Healthcare Management Consultant**

Yeah, yes, that's the one.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

There we go, it's at the bottom now.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Yeah, now that I read it it's even better.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

And did your group feel that the standards or the implementation guides or not the standards but the implementation guides are mature enough or will be mature enough in the timeline required?

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

For the lab?

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Yeah, the CPOE one, yeah.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

They're going to have to get out of this business completely and totally because it's only been eight years or so they've been working on it and we're dead if we can't do it in lab.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Rich are you talking about like the eDOS stuff in some of them...I think some of them were like a different version was still ballot is that what you're speaking to or is it something else?

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Yeah, it was the implementation guides that were still in ballot I believe. It was question, I mean, I just don't know.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Well the S&I Framework has been worked really heavily for a lot of years by the big laboratory companies and it's based on what looked like plain old v7 for about 20 years and that's what's used in all hospitals and commercial labs anyway.

And the one big missing thing and it may not work well, there were no codes required. So, I don't know how they can do better than that. And they're using it now. So, I mean, if you have some specific questions or places where people are finding problems we should hear them.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

So, Rich, do you think we should stick with the current version that's not in ballot versus the one...

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

No, I was...I don't want to slow you down Kim, I was just interested in feedback from the group if that had been...

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

A consideration.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

This has been the most cautious evolution that you could ever imagine so I can't see how it could go wrong.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Any other comments from the group? Okay, we can move to the next slide. This is a collection of CPOE diagnostic imaging and it's on page 41. And in this one the main comment that we had, because there was a question up in kind of the preface of the CPOE, which I mentioned in the medication that for diagnostic imaging we did feel to have an additional data elements available such as diagnosis, reason for order available with that transaction would be very helpful because typically they need that information to be able to process and do the diagnostic imaging. So, we thought it would be very helpful to add that information.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

I think it's also required for billing. I mean, I believe that everybody has to do it now already, but it doesn't matter we still say what we said.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Any comments from the group? We have a quiet group today. Okay, so we'll move forward to the drug-drug, drug-allergy interaction check for CPOE which was on page 41. And what we came up with this...there was a lot of information in this section about actually being able to capture what the end user had done with this specific alert or message that came to them about the drug-drug interaction or drug-allergy interaction, and so what we discussed as a group and came up with is that we didn't feel like the user should be required to enter any additional information beyond their normal workflow to satisfy this requirement that the system should be able just to capture it that they saw it and they clicked and moved on and that could capture it.

And then we were also in agreement...like a lot of these drug-drug interactions and drug-disease state interactions have different levels of severity and a lot of organizations like to choose which ones that they activate in their system and that their healthcare professionals have to review and look at. So, we felt that it was important to have them placed, that each organization has their ability to choose the level of severity with the alert.

We did have a concern that if they did add that you had to respond "I saw this, I made a change to this, I changed the medication" you know if they had to do something with the alert how that would affect the alert and if people would look at them more, if they would just start clicking to get through them. So, that was one of our concerns.

And then we also thought how could we incorporate it better into some type of clinical decision support strategy to try to minimize that alert fatigue. So, those were the comments that we came up with from our group so we'll open it up.

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

This is Floyd Eisenberg with a comment. I think you're right about the approach. I think the question is stressing usability for providing the decision support because there are different ways of providing the information perhaps without a pop up alert that says "there might be danger here." But by presenting it differently which vendors can certainly work on in their interface. So, you might want to address, needs to be addressed for usability to avoid excess pop up fatigue.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Well, I think we all agree with usability but are you disagreeing with saying the user shouldn't have to enter...

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

Oh, no I don't disagree with it I'm just thinking to add to that about an usability factor should be considered to help avoid this as well.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

To make it easier, yeah.

**Kin Wah Fung, MD, MS, MA – Staff Scientist, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Yeah, this is Kin Wah, I think the usability aspect is important too and of course in terms of alert I mean they're usually incremented in two ways one is called interruptive and the other is non-interruptive. So, any pop up that requires the user to do something even just clicking "okay" or clicking "override" that would be interruptive and to minimize alert fatigue and unnecessary interruptions I think that has to be reserved to things that are really more important clinically.

And so when we discussed this recommendation one thing we worry about is if the system is required to capture everything that is considered an alert, so the users might be forced to do something in order for the system to capture his or her action. So, we don't want this to be the force of driving more alerts to become interruptive unnecessarily. So, that's how I think we came up with this.

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

I agree with that I was just making the comment that adding that suggestion so not to prevent giving useful information if it's done in a non-interruptive way.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Well could...

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

The main problem with these alerts is unspecificity, you know, the crying wolf actually most of the time and it has to do with the logic not being sophisticated enough and maybe we could say something about that, they should work toward higher specificity in the alerts.

You know if someone is on a drug for two years and you get a reminder they're allergic to it, you know, something is off, if they were...they're probably not allergic to it. So, there are all kinds of things like that or, you know, if they're telling you about a warfarin and some interaction in your pro-time is dead on perfect the last three visits there is nothing to be alerted by, you know what I mean?

So, if we could get them to be more specific so the reminders usually are something they wanted to see life would be easier across the board.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Hello, this is David Dinhofer, my comment is sort of a little bit more general. Do we want to be this specific at this time, is this also in the scope of this particular...this Workgroup? Because as content standards we're kind of really grinding down to the nuts and bolts when we talk about how we're going to be doing the pop ups and the details.

I would certainly want to allow for a little bit of freedom in that between one group or another because different areas may have more or different physicians may have a need for different alerts and if we sort of say we have to do it this way for everybody then I would certainly want to allow more leeway and then put in my...as we discussed in our group meeting just process improvement should be like a key issue that's my comment.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Well, are you applying that to what we just said or the things that are on the screen?

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

To what was just said.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Oh, okay.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

To what we're talking, because I hear everybody kind of getting down into nuts and bolts of how we want to do these alerts.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Yeah, I could back off yeah.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Yeah.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

All right.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

I guess for me though, you know, there was a specific question about whether you could record the client ignored overrides, you know, have that action captured. So, if they're asking to capture that...also like from what I've heard with what we talked about in our group and what we were talking about here with usability, the non-interruptive and the specificity that if they do want to capture that information then we should say, you know, this is a best practice to make sure that it's usable, it's not interruptive to end user, there is a level of specificity so that it doesn't alert if the patient's been on the medication, you know, for a period of time, you know, different things like that. Like we're not telling them how to do it but just the concept of what the end result could be if they are capturing this information.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

What page are we on, I'm sorry I'm missing the page that you said we were supposed to be on? I'm on the PowerPoint.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

It was...yeah, yeah, that's what page we're on but in the NPRM they said we solicit comment in the voluntary edition proposed rule dah, dah, dah, dah, dah which means record and will be referred to as record, provider referred to as user for the purposes for actions of drug-drug, drug-allergy interactions including recording if and when the user viewed, accepted, declined, ignored, override or otherwise commented on the drug-drug, drug-allergy interventions.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Yeah, that's...

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

So, they specifically...

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

That's page 10 you said?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

What?

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

You said page...slide 10 is that, what page...

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Oh, it's not on the slides it's in the NPRM somewhere around page 41.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Forty-one and forty-two. Hey, Kim, just a time check, I mean, you still have some time left but if you could just kind of keep track of it as you guide us through this.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Thanks.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Thank you.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

So, that's why we made those comments because there was a specific question soliciting that information. Does that help with your comment?

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

You mean David, you mean me?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yes.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Yes, I mean, what we did is we just want to make sure that when we moved forward that these words were just helping us think about this as a...not to make too much of a mandate and so if that's what you're...if that's what you're doing here that's good, but we also added that there should be the idea of process improvement built into this and that would help, you know, just...like I think collecting the data is really important so I'm not saying no to that of course that's...so, yeah, I mean that's where we were going.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Does that explain that?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

All right.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

I may have to excuse myself, I wish I could stay on but I've got another obligation.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, thanks, Clem.

**Clement J. McDonald, MD, FACMI – Director, Lister Hill National Center for Biomedical Communications – National Library of Medicine**

Thank you.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

So, we'll capture all of that information Mazen and I will and we'll send it back out to the group for a double check.

So, we'll move forward the with drug formulary and preferred drug list. And what our high-level comments for this one was that the drug information the physician receives needs to be consistent with what other care settings such as the pharmacy received so there won't be inconsistencies with the information, because today there are inconsistencies with that information it's two different sets of data that people get.

And then we should consider excluding this requirement for the NCPDP formulary and benefit standard and instead wait for the real-time prescription benefit inquiry that has an active group to develop that standard because that standard is supposed to capture the same information that the pharmacies receive. So, we're saying hold off let's wait until we get the information right before we implement it instead of feeding information that may not be complete or accurate.

And then we should explore the Telecom standard which providers...which provides I shouldn't say providers, patient out of pocket cost and formulary information to the pharmacist. So, today like half of the industry does get that information but the providers don't get that same information and that's provided by the Telecom standard. So, I'll open up for discussion. Okay, I'll go quicker with the pause because we're running out of time.

Electronic prescribing which was on page 113. For this one we said we should consider prioritizing the additional transactions or segments. There was a chart in the NPRM with change prescription, refill prescription, cancel prescription, bill status and medication history these are all transactions within the script standard but they haven't been named in the final in Stage 1 or Stage 2.

So, they had opened up questions like, should we add these transactions into this and what we said is we should consider prioritizing these transactions that we in agreement with adding the cancel prescription and refill prescription as a transaction segment from the NCPDP Script standard in order to better facilitate prescriber/pharmacy communication.

With the RXCHG we are aware that several pharmacy software vendors and large pharmacy systems are in development of this transaction today so if the EHR vendor were to get this capability within this year to next year a majority of the pharmacy systems would have this to be able to do that information. So, we were in favor of that one also.

The ones that we had questions around was the RXFILL or the fill status and we felt like we needed...we were not sure how this information was presented to the physician. Is he going to get, you know, an abnormal number of e-mails that has this information saying, hey, so and so got their prescription filled or did not get their prescription filled or is it incorporated into the ePrescribing module and it's automatically there.

And we felt like we needed to get some input from some healthcare professional societies with those that would be involved in this process and I'm actually at NCPDP right now and I've talked to a couple of people about this and one of the things that did come up is, you know, if a physician does get this information, you know, what will they do with it, they have to look at it and then that creates something that they have to take an action on at that point. So, I think it would be good after hearing that to get more input from the healthcare professionals to see how they would want to use this information.

So, I'm going to pause right there on that little section with all of those transactions before I go into the medication dosing, because that is a lot of information, to get feedback from the group.

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

Kim, this is Susy Hull, just thank you for getting more information on this fill status and the benefit to providers it seems like an important loop in trying to bring this standard to fruition just from the safety aspect of getting that feedback to know about fill status.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, thank you. Any other comments?

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

This is David Dinhofer.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

No great job and I like the way you presented it.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, thank you. Okay, I will move forward to the medication dosing. There was a comment in the NPRM, where still on the slide before, that we should use the metric system versus the imperial standard and the imperial standard is using something like teaspoon, tablespoon and we were in agreement that we should move forward with the metric unit standard, however, the way it was worded in the NPRM it almost looked like the provider would be prescribing by the volume versus the strength of the medication. So we just wanted to be clear that we think it's important that it's prescribe by the strength and then it's converted into the volume that's needed from there and not necessarily prescribed by the volume.

And we were in agreement with the dosing numbers to include both dose strength and dose quantity having leading zeros before the decimal point on amounts less than 1, so that would be something like 0.5 mg and should not be used in trailing or terminal zeros after the decimal point so an example of that would be 5.0 mg. Any comments on that?

Okay, going to the next slide and the structured and codified sig is one we're going to take up this week. We did get to incorporate laboratory test value results which is on page 120 of the NPRM. And what we came up with our group was the functional requirements should not trump implementation guides where there are inconsistencies between the two and that we were in agreement with adding the certification criteria to the inpatient setting, also it should utilize the same message standard which was HL7 v2.5.1.

And the laboratory NPRM already specifies which LOINC codes should be used, value sets have answer lists but...okay, this was the one that we lost the information and we've lost Clem, so we may have to come back to this one. What he was saying was the value sets are like the answers and they haven't been formally enumerated with the codes and so like there needs to be a way to do that and I'm probably not articulating this 100% so if it's okay with the group I would like to come back to this one unless other people have comments on it when Clem is on the phone. Is that okay with the group?

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

That seems reasonable.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, thank you.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Kim?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Yes?

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Kim, this is Joyce, just a quick thing on the first bullet, I'm not clear on what the phrase "should not trump implementation guides" means. So, when you do revisit could you just explain that a little bit more, I might agree, I just am not clear on what that means.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, yeah, we can clarify that.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Thank you.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Let me just make a note. Okay, perfect, so we'll go to the next one. And I think we're almost done, oh, well our next two are ones that we're doing on the next call. So, that is all of ours that we have gotten done, so that's really, instead of eight we did seven and then we'll come back to that laboratory one. Any comments or overall comments?

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

I was pretty impressed with the comments.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Thank you.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Thank you very much Kim and to the entire Workgroup. Should we turn it over to Floyd?

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

Sure, thank you. So, we start on slide eight and we have a lot of slides and not a lot of time so I'll try to hopefully get through this quickly and thanks to Marjorie, Susan, Kelly and David for all the comments.

So, why don't we start on slide nine this is the decision support knowledge artifact, so in going through this we clearly support the use of CDS knowledge in electronic health systems, feel that it's important to promote use of standards and use structured data to support CQMs and clinical decision support.

The next is basically highlighting what's out there today and what EHRs...what's existing in standards. The first issue is EHRs really have not adopted the knowledge artifact Health eDecisions. The artifact that's out there requires a virtual medical record, VMR, which does not have commercial EHR support and there is no compilation engine at this point to create EHR specific formats for implementation and no automated method to author them.

I'm going to go to the next slide because it continues on, so in other words the ecosystem, this is slide 10, ecosystem adoption is still early, evolution is in progress and it is working well but it's not mature and it seems premature to address standards that are outdated for instance the HeD implementation guides that reference vMR.

So, currently much of the HL7 work supported by the clinical quality framework addresses metadata, the data model and expression language, the metadata and expression language have successfully been evaluated but the data model is still in development, the name of it QUICK won't actually be re-balloted, it was only informational before, but won't be balloted until September of this year and the FHIR profile related to it is in ballot now.

So, I think the main answer that we're concerned about is prematurity and our recommendations for this are on slide 11 and that is basically support the effort to harmonize standards and keep it as standards for those used for routine data capture and interoperability, so CDA and moving forward FHIR, encourage adopting a framework that moves standards at the forefront while we move ahead, CDS standards are however now insufficiently mature and not sufficiently tested to include in this round.

The other comment which was important is that clinicians...from the whole group was clinicians should not be the only focus for decision support and the focus should include patients and consumers. So, I'll stop there. I went through rather quickly to try to summarize but I'll look for input. Okay, any others from our group, is there something we may have left out?

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Floyd, this is Rich, I would just second the subgroup's recommendations I think they're very solid. There is need for a certain level of maturity before it can get into standards.

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

The discussion was really things are on a good path, they're moving forward nicely, they're getting defined, but we're not ready yet and we'd all like to be ready. It wasn't a matter of lack of desire it was lack of readiness that's all.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Yeah. Did the...right now the NPRM is silent as it relates to FHIR. You mentioned FHIR as kind of one of the standards that is progressing in this area. Is there any reason for...did the subgroup think that we should be specifically calling our FHIR as part of the way forward whether it fits into this particular NPRM.

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

Well, I'll make a statement and if someone else from the group thinks that they want to add to that feel free to do so. But in general there was agreement that we're not ready for FHIR yet but things are developing and at some point we may see things move to FHIR. So, whatever is being developed needs to have that in scope that at some point...it's kind of a longer transition but still needs to be in the scope of standards development. Anyone else on our group have additional comments on that?

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Yeah, this is David, no I just support what you're saying. I think...Rich is that you who was speaking? FHIR is not ready yet and we're anticipating that we're going to want to move to FHIR at some point but not at this time. So, we're not really calling out FHIR.

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

Yeah, essentially we're saying...

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

What...

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

Nothing is ready yet but as we develop these...some of these are interim prior to FHIR assuming that we all go there, but...so all of these need to be developed in a logical sequence is I think what we should be saying.

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

This is Susy Hull, I think the other comment we made is that FHIR will coexist with existing standards and so the evolution of that may move quicker or quickly but we're not going to be replacing existing work with FHIR. FHIR will really be add-on work at least that appears how the market is moving. I think it's...I do think it's worth though calling out a comment specifically about our encouragement of FHIR and monitoring of that given the timeline from this response to when these standards will be accepted.

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

Does that help Rich?

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Thanks.

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

So, if we move then to the next element we commented on, this is slide 12, this was the decision support service. So, this is slide 12, my screen...there it is. So, we again, support this. We reiterate the need for using standards to build cross platform capabilities which will aid in development of tools to make it easier to share and standardize measures.

We support process improvement through standard clinical quality improvement techniques to evolve the standards and decision support services so similar to what we said before. We did say that there are significant evolutionary changes and again we support FHIR and with the statements just made it certainly makes sense to set structural standards, content standards but needs a dictionary like SNOMED or RadLex was one of the comments that came through.

Structure data capture effort is working on sending its own standards and should be included in setting vocabulary standards. The requirement of course to have a service requires maturing of CDS as a service and maturing of standards and the ecosystem is still in development for the CDS knowledge artifact supplier and CDS knowledge artifact integrator. So, it's more a matter of timing the requirement rather than using existing standards that are moving to others such as vMR to QUICK and FHIR quality. And that pretty much covers, that one actually made it all into one slide. So, comments on decision support service?

Okay, I'd note that most of these maintain the same theme because they're all related to basically the same set of standards.

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

I think, Floyd this is Susy, we were really curious about the CDS knowledge artifact suppliers and integrators and we didn't really see these called out in the industry yet or really working in practice although it was a novel idea.

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

Thanks for adding that.

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

I think of deploying the decision support as a service, maybe others on the call are familiar with the suppliers and the integrators.

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

Yeah, so Susy just for others...we actually have some more written with some detail like you just said in order to fit things on the slide we summarized all that here, but we did actually come to the conclusion it didn't seem like there was anything out there today as far as the ecosystem. Comments?

Okay, given that we'll move onto slide 13, the next one, which actually covers two slides it's the clinical quality measures record and export. And we do support the direction to use standards requiring functionality and including it in a rule though could be premature and we recommend a phased approach.

So, with respect to exporting data at a time the user chooses the concern is while that would be nice it's really unclear that a user should be able to export data for analysis whenever they choose but exporting it to the receiver, say CMS, depends on specific rules and so QRDA is expected for transmitting data to CMS which is a different use case than exporting for your own use to see how you're doing and it wasn't clear that the NPRM separated those.

So, exporting more often may...QRDA may not be the right solution for that. We're not saying it is or it isn't but needs consideration. And exporting may include sending all data to another analysis engine rather than expecting that all of this is captured within the EHR and calculated within the EHR. So, it seems like there needs to be more analysis of the statement we propose to require a system to be able to export data at any time.

The NPRM also refers to the S&I Framework clinical quality framework initiative as a standard and the question is while that is a consensus organization that fits the requirements of the National Technology Transfer Act the standards currently used are run through a more traditional standard development organization, HL7, which does have input from additional stakeholders some are US domain, some are international but the question is coming from CQF, the S&I Framework, since there are standards through a more standard SDO the NPRM should address those in the SDO.

And another recommendation, the QRDA that's listed is 2012 version with 2014 errata as of mid-May 2015, possibly this Friday, the next balloted version will be approved for publication and we recommend that version, it was a version balloted January 2015.

There is another slide still dealing with this so I'll just finish this one as far as import CQM data, standards are still being stabilized. HQMF is now being balloted to include the QDM that it did before the implementation guide but also to include the new clinical quality language and depending on that ballot that might be...that needs to be implemented and to date since it hasn't been officially balloted EHRs aren't implementing that yet.

So, the issue also that an analytic engine might be expected to import a CQM if it is based on feasible and valid, and reliable data normally found in clinical settings. The question is, do the CQMs currently used...a number of them seem to expect excessive and non-feasible data. So, we feel some of this is premature. I'll leave it open for comment now that's related to the record and export for quality measures.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Hey, Floyd, this is Joyce, on the previous slide at the bottom it says the most recent QRDA should be adopted not earlier imperfect ones, it's not that I disagree with that in premise but I'm wondering if that's something we should specifically call out or maybe we shouldn't, could we...

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

Well perhaps the word "imperfect" is a little...

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Yeah, yeah.

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

Yeah, we can change the word easily.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

That would be good.

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

But the changes are based on findings from implementation that cause challenges to providers and to EHRs and even though it is implemented it still causes workflow challenges so we would recommend that although still not perfect the newer version addresses some of those issues and that would be the one to adopt.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Yes.

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

But we can certainly leave out the word “imperfect.”

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Yeah and maybe even just adding some of the...briefly the language that you just said, so learnings from implementation challenges I think that’s an important point to make because that’s really where we want to head to incorporate those learnings and to really get standards implemented and to be able to learn from that. So, I think that’s an important point, maybe it’s just kind of twisting it to that different phrasing.

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

Well, excellent feedback, that was one of the challenges trying to summarize things onto a slide that had more language and we’ll certainly make sure we address that.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Yes, thank you.

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

Other comments? Thanks, Joyce. Okay, so the next one we looked at was import and calculate for clinical quality measures and this one actually goes through three slides starting with 15. So, the first issue was we really needed clarification on what does import data mean, what data from where, is it import of a specification into the Health IT system, import of results.

So, we really felt we needed a definition of what do they mean by CQM data and perhaps CQM data that IT systems currently are able to import would be a good start, because once it says import and calculate that assumes you can import any kind of data that a measure will potentially need and we don’t necessarily have structured data in all those areas at this point. So, we also thought it should say import and understand if we were to use that data.

So, the other issue and I’ll try to not read every line here, but there are other sources of data and some of them are not appropriate in their original source for the EHR but the original source is more appropriate for the measure, for instance sometimes labs are usually fairly straightforward by not always, radiology results, especially if we’re including results from monitors, blood pressure monitors, etcetera, that actually have more information about the time that it occurred and the kind of device it came from.

So, some of the information needed in measures may not necessarily exist in the EHR and that should not make the measure in a sense infeasible if it could address a warehouse that could obtain measures or data from different sources. So, we felt that might need to be addressed, and vendors shouldn't have to support any and all kinds of data, classes of data that might be considered.

So, next slide 16, to go a little bit further on this, test of import and calculate functions, the ability to test a larger number of cases is likely useful, sorry, this got reworded I'm trying to make sure I describe correctly what we said, but the calculation should consider the complexity of the CQM and the number of elements needed to adequately cover the measure. So, we really need a formula to determine the minimum number of test cases that would be required to meet the requirement.

We also need to know more about...we also had some comments on technology to calculate each and every clinical quality measure presented for certification some include data not captured routinely, that's kind of a repeat of what we said, feasibility remains an issue, we have to make sure the measures address feasible data and deal with analytic engines in addition to EHRs.

And on slide 17 we talk about supporting the concept of clinicians importing data on request, we said that on the last one as well. We feel as data are structured they should be accessible as published in the 2015 interoperability standards advisory and made available without requiring developer assistance. To make it work though all sources need to support the same standards for data sharing and structured content.

There is also an issue of evaluating longitudinal data over time that requires standards and expressing and maintaining provenance. And we're concerned about the independence from small practices, so while at the beginning...while it would be nice if all practices could upload Apps for example that automatically connect data from different sources they're not quite available yet. So, we still may need some support but hopefully without significant extra cost to the provider to be able to manage the kinds of data that are needed.

So ONC should support development of capabilities for importing data. For example a large organization might have a staff that can pull data from different devices and sources but a small office does not and expecting a vendor to support every possible source of data out there without defining what kinds of data we're talking about seems excessive.

So, that was kind of the whirlwind tour of that discussion. I open it up for others who want to make clarifying comments from our group or comments from the rest.

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Hello, this is David, I just...one comment, when we were talking about those data sources we were thinking of things like iPhones and home pressure cuffs, and we didn't know how that data was going to be brought into an EHR because it could overwhelm the system. So, that was kind of covered by Floyd but just wanted to add that comment.

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

Right and that was part of the issue of decision support data that's almost what data and from where. And the NPRM was not clear so it kind of leaves it open to anything you might want.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Hey, Floyd, this is Rich, did the group two deal with the question of what the intended value is of this proposal?

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

I think there was...we didn't say that specifically, I think had they felt there was no value we would have heard that. So, my impression is that there is value to being able to import data and use it it's a matter of we have to in some way constrain what we're talking about because it was really very expensive.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Yeah.

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

Any comments from our group that would add to that?

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

This is Susy, I work with a lot of mobile health development and I don't think that this construct is at all on their radar screen. So, you know, we're going to continue to grow an ecosystem with a lot of interesting data that has no standards behind it. So, I do think this is really a helpful one to query more the intention and how we see this growing. There was a lot of dense work here, thank you, Floyd for summarizing it so well.

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

Yeah, there was a lot of good content in our discussion and you can see it here, but there is the issue of how do we actually get all of this together and the industry is not there yet. So, that was the concern.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Yeah, this is Joyce, I think that's an excellent point, you know, as they expand this NPRM to be about Health IT rather than just EHRs it really opens up a lot of considerations, a lot of opportunity but a lot of challenges as well and I think you're pointing to a really, really good one that everybody is going to need to be using the same standards to make this happen and all of these input devices aren't even necessarily standards ready at this point.

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

Right.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

So, it's a big consideration, great to point out. The only other kind of quasi-comment I have is about the standards advisory and at the point where it was published it was draft so I don't know if we want to mention that there will be another version of that or if that's too much detail, but just a comment.

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

Oh, good feedback though, thank you. Okay, well, let me move to...we still have three more, well four more slides, but they get, the comments get a little shorter. So, next slide, 17, is about report and export. So, this is the issue of...we support the direction to use standards for recording and exporting CQM data, however, requiring it includes...in this rule may be premature, it's really referring to what we talked about before with some of the standards.

And so one question came up that QRDA categories 1 and 3 have been balloted and 3 may actually move toward normative soon, but there also seems to be interim implementation guides, there are guides in HL7 and interim ones in CMS to assure that some additional changes could be made or sometimes because of a specific need sometimes it's a need of CDS receiving systems and it seems as if there are a lot of comment periods for the CMS versions of the standards, the HL7 version and it seems a little confusing as to which one should be used and needs to be a mechanism to standardize the standards process that was the first item here around standards for CQMs.

The ability to import data is in a sense some of the discussion we've just had but one thing that...did we move to 17, yeah, I'm sorry...so pretty much we wanted to talk again about data that might come from other devices, monitors and EHRs so dealing with data sharing, it's a similar issue we just talked about with other sources of data that needs to define them. And, oh, I'm sorry, I'm on slide 18, you're still on 17, that's why I was having trouble reading.

So, this is on the user ability to import data. There are efforts about reporting patient generated health data that include mobile devices that extends a little more of what we talked about with device information coming in on potentially non-standard devices and in order to deal with that we want to allow innovation without restricting data elements, but we need some standards if we're going to import that.

And if we go to slide 19 we support, again, this is pretty much a copy of what we had before. So, you're seeing it again because it applies to this element as well. There is nothing different here than we talked about in the last set but does anyone have any specific comments?

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

I have...

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

Okay, yes?

**Susan Hull, MSN, RN – Chief Executive Officer – Wellspring Consulting**

This is Susy, I was just thinking that on our comments in the interoperability roadmap we did make some interesting comments about the standard development organizations continuing to collaborate and network, so we sort of continued to keep things in pace that comment maybe helpful here.

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

Great, okay, all right, well let's move to the next one, this should go fairly quickly, this is the quality measures filter supporting the ability to report a practice, this is slide 20, yeah, at organizational levels. It seemed that most of these requirements were about how to...the security and the issues about doing the reporting which seemed a little out of scope for the Clinical Quality Workgroup, I'm sorry, the Clinical Content Workgroup.

The question we did have is the scope for structured data in decision support and quality measures is potentially everything and it needs to be somehow constrained similar to what we said before and we may also...in order to evaluate the care given or to be given, we often need more provenance than is available in the CDA at the data level.

And there was also a comment that was in the NPRM that EHRs should time out within 10 minutes to manage security and we had some concern that 10 minutes could be too short, so we have that in here as well. Most of these were about time out for the EHR, access to the EHR which seemed much more privacy and security related than the content that we're actually addressing. Any comments?

Okay, we did say that if we had Dixie Baker in the group we'd have much better comments on this one. That's the extent of what we looked at. So, thank you.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Great, Floyd, thank you so much and general comments or feedback on either of the two groups presentations today?

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Hey, Rich, this is Kim, there was one observation our group made because we were trying to go through and take what was in the NPRM and match it to the interoperability roadmap and Floyd made me think of it when he said that RadLex was a vocabulary for the...on one of his slides. When you look at what's in the NPRM and the interoperability roadmap there are some inconsistencies like they named a vocabulary for diagnostic imaging and so we weren't sure, you know, how that got in there and then also for the formulary and benefit like they had named a standard in the interoperability roadmap but yet at this point in time it's not named like in Stage 1 or Stage 2. So, we didn't know if that needed to be corrected or if there was a rationale behind it so we just wanted to throw it out to the group.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Where would that feedback...where would we take that feedback do you think Michelle?

**Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology**

So, this is Matt, I would just leave it as a comment.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Put it in as a comment in the NPRM comments?

**Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology**

Yeah, yeah.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

That it's inconsistent with the interoperability roadmap?

**Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology**

Yeah, that's totally fine.

**Kim Nolen, PharmD – Medical Outcomes Specialist – Pfizer, Inc.**

Okay, all right that's what we'll do.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Thanks, Kim, any other feedback or comments? Hearing none, Matt or Michelle, could you apprise the group of how you see the next steps leading up to the Standards Committee presentation?

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

So, I was just looking to see when you're in the...

**Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology**

So, this is...

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

I'm sorry, Matt.

**Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology**

No, go ahead, I'll add anything if I need to.

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

So, I was looking to see...so there is a meeting on the 18<sup>th</sup> which is two days before the May 20<sup>th</sup> meeting. So our hope is that we can use that meeting to wrap up anything that was left open. So, I know that Kim has a few items to still walk through. If there was anything that we needed to do research on and come back with that would be the meeting to wrap everything up, get it finalized, and put it together before the meeting on May 20<sup>th</sup>.

**Matthew Rahn – Program Analyst, Implementation & Testing Division, Office of Standards & Technology – Office of National Coordinator for Health Information Technology**

Yeah, so this is Matt, it would be good also if there are some things that need to be wrapped up we do that like well in advance so that, you know, Andy and Rich are ready to rock for the May 20<sup>th</sup> meeting, the HIT Standards Committee meeting.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Is there a time by which you want comments back from the group on what's been presented thus far over the last two sessions?

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

Yeah, so maybe we could give people until May 13<sup>th</sup> so that will give ONC staff some time to prepare for the meeting on the 18<sup>th</sup>. So, we'll send a follow-up e-mail with, you know, everything cleaned up, remind everyone that we would like feedback by the 13<sup>th</sup> and hopefully we'll be as efficient as possible walking through anything that comes up and have Kim finish up her work, her group's work I should say, on the 18<sup>th</sup>.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

Just like you said...

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

Does that work for everyone?

**David Dinhofer, MD, MS – Chief Medical Information Officer – Infotek Solutions and Services**

Yes, it's me, David, yes.

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

I'm sorry...

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

Well, hopefully by then we'll already have resolved the ballots in HL7 and we can give you new numbers but don't ask.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**

There's the voice of optimism. Okay, so well listen thank you Matt and Michelle for that and before Michelle opens it up for public comment I just want to say thank you to both groups who presented today and to the group that presented last week there are just some really good thoughtful work that's been done that I think will really contribute to a much better finalized rule. So, thanks all for your work thus far.

**Public Comment**

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

Yeah, thank you again, Floyd and Kim and with that Caitlin, can you please open the lines?

**Caitlin Chastain – Junior Project Manager – Altarum Institute**

If you are listening via your computer speakers you may dial 1-877-705-2976 and press \*1 to be placed in the comment queue. If you are on the phone and would like to make a public comment, please press \*1 at this time.

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

So, it looks like we have no public comment, so we will send a follow-up e-mail just reminding everyone to send us any feedback that you have and we look forward to the meeting on the 18<sup>th</sup>. Thank you everyone.

**Joyce Sensmeier, MS, RN-BC, CPHIMS, FHIMSS, FAAN – Vice President, Informatics – Health Information Management Systems Society**

Thank you.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**  
Thank you too.

**Richard Elmore, MA – President, Strategic Initiatives – Allscripts**  
Thanks, everybody.

**Floyd Eisenberg, MD, MPH, FACP – President – iParsimony, LLC**  
Bye-bye.