

**HIT Policy Committee's
Meaningful Use Workgroup: Subgroup 4
Population Health
Transcript
May 1, 2013**

Presentation

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good morning everybody. This is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup's subgroup #4 on Population and Public Health. The call is public and it's also being recorded, so please make sure you identify yourself when speaking. And there's also a public comment period built right before the close of the agenda. I'll now go through the roll call. Art Davidson?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thanks Art. Marty Fattig? George Hripcsak?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thanks George. Charlene Underwood?

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

Here.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thanks Charlene. Amy Zimmerman? And Marty Rice? And if there are any of the ONC staff members on the line, if you could please identify yourself.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Michelle Consolazio Nelson.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Thanks Michelle. And any other Meaningful Use Workgroup members? Okay, with that, I will turn it back to you Art.

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

Thank you. Thank you MacKenzie, and thanks everybody for joining this morning. So our task this morning is to go over the comments that we received and maybe consider the items in the population and public health subgroup activities or measures and objectives, in light of some of the deeming and consolidation discussions that have gone on over the last maybe 6 weeks, in the Meaningful Use Workgroup and even some of it has gone back to be presented by George and Paul at the most recent

meeting that we had, earlier, actually it was last month. So, if everybody's okay with that, then I think what we would do is probably just start running through the slides and dealing with each of the topics that Michelle has prepared for us, based on the comments that were received. And there are two documents, one is the slide set and the other one is the word file. And I guess the slide set...they're both essentially the same, isn't that right Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Yeah. The slides summarize things a little bit more, but pretty much the same.

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

Okay. So if there's no objection to that, or George, if you have any other comments before we start, maybe we'll just pull that one up and then look at that and project it in the web session.

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University
Yup.

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

Okay. Great. So let's start with the first one, I think it might be the next slide. So here's the list of the items and we're going to spend more time on the items that actually affect Stage 3, spend a little time maybe just talking about the comments that came in on those that are future stages. And for those that haven't really changed, we won't spend much time on those at all. But I think the main point that we want to at least begin to address here are the ones that are highlighted in red here, because they are influenced by the recent conversations about consolidation and potentially even deeming as well. And just to note that we have our next meetings are on the 13th and the 30th, if necessary, but we at least have a meeting on the 13th, coming up in about 2 weeks.

So we can move on to the next slide please. So in this one here and I'm going to pull up my version, because it's just a little small for me to read. So, just a second here. On this 401A, the main point that I see is really on the next slide, you might move to that next slide, where we see the comments, and I'm just going to make sure you've advanced. So, this is the immunization one, capability to receive patient's immunization history supplied by an immunization registry or information system, and to enable healthcare professionals to use structured historical information in the clinical workflow, except where prohibited in accordance to applicable law and practice. And the documentation issue, did we all lose connectivity here?

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I still have it Art, its MacKenzie.

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

Okay, it may be my local. So let me just pull up this other one, I'll leave that one dead. So then, the measure is the documentation of timely and successful electronic receipt by the EHR and that the information is received for 30% of patients who receive an immunization. So, if we go down to the next slide, there were 93 comments, and I'm assuming that you're all going to be connected here and let me know if I'm wrong, but my connectivity is somehow not quite there. So, the concerns were that this objective requires the electronic health record and health department readiness, well, that's no different than what we have always been saying. It requires the EHR to be ready, of course, and we recognize that health departments that are not ready will give the proper excuse to an EH or EP, saying that this is not required in my jurisdiction. So, I don't know if that really is something for us to even discuss much at this point.

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

Agreed. You should go back one slide, I know Art, you can't see it, but go back one slide. There you go, now we're on the right slide. Go ahead Art.

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

Okay. So, yeah, and I'm just not going to be able to connect, something's gone...I'll try to work on that when we have a little break here. But the next item to discuss was readiness/maturity of bidirectional

information exchange capabilities, as well as data and interoperability standards. And again, I think that those jurisdictions that have this capability will be able to say that we were able to connect with the EP or EH and for those that it's not, this will not be an issue. I don't know that we should hold off because it's not at 100%. There are some early adopters of this and states that definitely will get into this game and be ready to do this sooner rather than later. So, I think that's also...except where, what is the wording again, except where prohibited and in accordance with applicable law and practice, would allow in those states where it's not applicable in practice, that that would not be required.

An excessive burden for providers with patients from different states, with different immunization requirements; this I think is a real issue. And this is an issue that Judy brought up during the last; I think it was the last HIT Policy Committee where she was making mention of how difficult it was for vendors to deal with multiple states. So, the ideal thing here would be that there was one standard, but we don't have that yet. And I was wondering, as I thought about this one, the rule as it might be promoted, as the recommendation is for Stage 3, would be for 30% of patients. And you could, I don't know how many providers or hospitals are dealing with more than 3 states. You George, live in the tri-state area, so you might have someone who has patients from 3 states, but you would...to get to 30%, it seems like you could pick one jurisdiction that you do it well with, and then the other states, we hope that you'd be able to do that with them. But it's not a requirement that you do it with all of them, it just says with 30%. So, I don't know whether we have a good answer to this issue and what Judy was raising in the last meeting. So, I'm going to ask for comments.

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

Yeah, I mean...well, I think that is the way to address that particular issue, is 30% then too high. I mean, I don't know if it makes a difference whether it's 30 or 20, I might leave it at 30 and let CMS drop it to 20 if they think that it needs to, for this reason.

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

Right. I mean, most of the time it's going to be 2 states and if they feel that that's too high a burden, let's say it was 50:50, that would be 60% of the patient's in one state were having the immunization registries searched, and you would receive information back. So, if it were a clean split. If it were 90:10, you would probably go with the state where it's 90; you'd go where you're able to achieve that 30%. Any other, I mean, what do you think Charlene, from a vendor's point of view. I mean, Judy is the one who really brought this up. Is Siemens dealing with this anywhere that you know of?

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

Again, I think...again, we haven't...this is where we need some...you know what Art, this is where we need feedback from Stage 2, because in Stage 1 it was just a test, right?

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

Right.

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

So we've got to be successful across all 3, so we will know a lot more in Stage 2. So I think this is one where getting some...we'll know more. I mean, again, it's really how far the public health departments proceed and all; there are a lot of open questions when we move through Stage 2. So, I think in term...I think we just need some more input from what happens in Stage 2 on this one.

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

So, needing feedback, so, are you suggesting that we go out and ask states...this is not a state issue...

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

Right.

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

...this is a vendor or provider issue.

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

Right.

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

So, how can we get this information? I don't know that we can.

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

Yeah, I can't tell you yet is all I'm saying. I don't know that answer yet, because we haven't really...we're just early stages of implementation of Stage 2. But I do think that having...like starting to create a readiness map across the country of the different states and their ability to be able to support these different types of transactions will be really valuable for us over time, from both ends. What the vendors can do as well as what the state readiness is on some of these. So that's just something that I think we should do because I think that will...this question it comes up every time, it'll start to add some transparency in terms of who's ready, and also transparency in who's not ready, which again, data will drive people to pay attention a little more, I think.

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

Okay. So maybe in follow up to this, what I'll do is contact AIRA, the American Immunization Registry Association...

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

Yes.

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

...and see if they have a readiness...

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

...a readiness map, yes, that would be great.

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

...okay. Okay, that's a good idea. So then this next...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Hey Art?

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Sorry, this is Michelle. I'll also follow up with Jim Daniel from ONC, just to see. He's our public health guy...

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

Sure, sure.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

...and see what he knows. Okay, thank you.

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

Yeah, actually I'm going to see him next week, so I was going to speak with him about this, while the AIRA people are in the room. Okay.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Perfect. I'll give him a heads up.

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

That'd be great. Because of course, all these different ones, this question comes up all the time, so, we need to start just making it transparent in terms of what the readiness state is, and then we'll have some information for decision-making and advocacy.

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

But it still doesn't get to what I thought; Judy had a legitimate concern...

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

Right.

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

...and I'm sure that you as well would have that same concern...

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

Yes.

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

...is, when I'm living in a multi-jurisdictional environment and the provider's dealing with 3 different messages, they're all just different flavors, but they are maintenance issues for the vendors.

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

Absolutely.

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

Okay. So, the next one about threshold, I think it...it says at the provider level or organization level, I think that's...I mean, isn't it always at the...it's either the EH or the EP. I'm not sure I understand what this means. Michelle...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

I think the concern was, so in the past, it was just ongoing submission. So, for example, at an organization level, you could just turn it on for that organization and it didn't matter at the provider level. Because that whole office, for example, had it turned on. But now, if we're going to do a threshold, it would be for each provider rather than...

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

Oh, that's tricky, yeah. For a hospital it's fine, but when you get to the EP, that attribution is really going to be a challenge.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

Yeah.

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

Ah ha. And how do we do that for the other subgroups? Do they have a similar sort of issue about whether it's at the provider level or the organization, other...can you give me maybe Michelle, do you have, or George, do you have some examples in other areas where we've dealt with this, or is this unique to...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

This one's kind of unique, I think, unless somebody can come up with something else. Because most of the things happen within the practice or at the patient encounter level, at least for the EP side. But this one is something that, a function that would have to be turned on for the organization. Just trying to think...I can't think of anything else, this is really unique, I think.

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

Well, so, I'm a clinician, and I order a shot for a kid or an adult, and I'm looking for the...whether there was a prior shot record for this child or adult, right? So should it...I mean, why shouldn't it be at the patient level?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

I think it's okay that it's at the patient level, it's just, I think, they're concern was is the threshold appropriate, is 30% going to be achievable at the provider level, with all of the other factors in place?

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

I don't know, it seems to me like this would be reasonable. I mean, there's some sort of audit trail that says, I gave a shot on this day and I searched the immunization information system for prior vaccine history.

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

Well you know I'm just sitting here changing my mind a little bit. I'm wondering how did we get 30% on this one?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

My guess is that we thought 10% was too low...so we...it was either 10, 30, 50, 80, that's what we had been using, and my assumption is we probably thought that 10% was too low.

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

I'm wondering whether, because this is the first time...sending the information is one thing, but getting information from the public health department, and then if you bring in the state issue and then the number of people who wouldn't have data centrally necessarily, 30% is now to me looking higher than I realized. Just on, this conversation right now, and I'm wondering if we should have gone for the lower number, but I don't know. Art, what do you think?

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

I think we want to promote its use and I'm okay with 10%. I think once they start getting it going, they'll...

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

Right, same thing.

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

...use it routinely. So, I don't think that 30% is hard and fast here, I'm okay with moving it down. I think we want to get them started. It'll get into a workflow and then they'll be using it more regularly. I mean, pediatrician needs this or a family doc, for any kid, you need this almost every time they're in. For an adult, well it's an annual flu vaccine, so you don't actually need to check, and you might check on a pneumococcal vaccine if it were in there, a lot of registries haven't got a lot of adult information in there yet, and hopefully with Stage 2, we would see more of that happening. So, I'm okay with making it 10% George.

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

Well I...

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

Yeah.

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

Yeah.

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

So that's the suggestion here, right. Okay. And some suggest we make this measure by attestation. We do want to record...there must be some sort of audit that allows us to record how many times this was done, isn't...don't we think that should be part of the...

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

So what's the functionality, it's a look up or is it inquiring, I mean, it's some action that the system does, right?

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

Yeah, it has to send a message to the state asking for the record and then has to receive a result.

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

And it's in the context of that patient and in that encounter, right.

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

Yes, right.

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

Yeah, I think they should be able to...I don't think it has to be...I think they should be able to count from the number of times you did the query.

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

Right. Right, so it should be a threshold then. Agreed?

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

So you would use the...

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

Yeah.

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

...denominator, your number of vaccinations, or what would you use? What's the denominator?

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

Right, the denominator is the number of vaccinations given...

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

Well, or, because then you're going to do the query for...you might not give it, because like I know my...in my dad's situation, they were just floundering around trying to figure if they'd given the pneumonia shot, no one could figure that out. So, it would be great to get this to work, but, then if they find it's given, then they don't give it.

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

Right.

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

So you lose some there, but that's okay, I think the metric was supposed to be of the ones where it was given, so hopefully you will be eliminating some immunizations, but it doesn't necessarily need to be the denominator just for the sake...

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

And I agree. If we keep it low, it could be rough, too. It could be rough. It's like if it's plus or minus, it's not perfect. I know we'll get feedback on that, but if they're doing inquiries, the more inquiries, that's all the better, right, that's what you're trying to get to have happen.

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

That's exactly what we're trying to get to happen, right. And then this...so, I think we're agreed on that, the provider level, denominator's the number of vaccines, the numerator's the number of lookups. It's a threshold. It should be from an audit trail. And we've gone down to 10%. The last thing here, I think doesn't really pertain, it's really out in the future, its vocabulary standard for adverse events, this is not something we need to discuss.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

I think that might have been a cut and paste issue. I've been looking for the original document and I can't find it, but if I do find it, I'll let you know what their comment was.

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

Yeah, I think this was...functionality, yeah.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Yeah, I think that was...

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

It was from an earlier version. We said, you should be able to say when someone has a contraindication so you wouldn't be...you'd be able to store that in the immunization registry and use that as part of the logic, but...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Oh.

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

...and then to report adverse events. We just said that's not ready and I think the Standards Committee's correct here. That's a gap. So, I'm going to move on to the next one, let's see if I can connect again. Let's see if I'm back with you or not. So the next slide is our...there's no change, and this is submitting the electronic laboratory report and I don't...there's some...let's run through the summary statement. They agreed with keeping this unchanged. The standards and implementation guide should be updated, I think we can take that back to the public health community, as that will be transmitted to them in the next week, Jim and I will both be at a meeting where we'll be seeing most of these leaders in the public health community. So I think that's something that's going to be worked on.

And the implementation guide should be developed to strictly enforce LOINC and SNOMED and I think that some places will be using the HIE to help them LOINC and SNOMED their idiosyncratic codes, so, I guess the implementation guide is just when it...it doesn't matter how it leaves the hospital, it matters how it's received at the state. Is that right?

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

What's that? Say that again.

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

So, it said to update the implementation guide to strictly enforce LOINC and SNOMED, and I just said that some hospitals will use their HIE to map from their idiosyncratic lab codes to LOINC and SNOMED. And the...actually the translation at the HIE. So, I don't know whether we have to force the hospital to adopt LOINC and SNOMED internally, we just need them to make sure that in the process of sending a lab result to the state that happens. And if the HIE is maintaining the mapping, then the hospital doesn't necessarily get involved in LOINC and SNOMED. I don't know whether we want to make that something mandatory for a hospital. Any comment?

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

Yeah, we want to set the clinical goals and not decide that anyway, right.

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

The clinical goals in what sense George?

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

I meant we're coming up with the objective; we're not going to say that they have to use LOINC.

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

Well, it should arrive...they don't have to use...but it should arrive at the state with LOINC I think is the goal.

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

Right. So these are not things that we need to...wait, what problem are we solving Art, sorry?

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

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

Okay, I'm hopefully going to be connected here, but on the slide that I have here, this is the 6 slide, and it said key points, an updated implementation guide needs to be developed with strict enforcement of LOINC and SNOMED. And so where is that strict enforcement? That enforcement, does it have to happen inside the lab or if...as long as the hospital is using an intermediary that can enfo...stick to this, we're not...we don't have to say the lab uses LOINC and SNOMED, it's that the report has to come with LOINC and SNOMED, and if the intermediary solves that problem, that's...

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

Yeah, but what I'm saying is that we just pass this information to ONC; we don't do implementation guides as the Meaningful Use Workgroup, we just...

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

I agree.

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

...this goes to the certification, it doesn't even go to our rules, it doesn't go to the Meaningful Use Rule, it goes to the Certification Rule.

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

Right, but the implementation guide is...who's developing that, I don't think ONC develops the implementation guide...

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

It's not the Meaningful Use Workgroup.

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

Yeah. So what happened with, and I don't know if it's pertinent to this case, but again, the S&I framework has these different workgroups, especially to work on some of this lab result stuff, and there were gaps in it this time. There were...they did a lot of great work, but they missed some stuff. So you prob...so I agree with George. This needs to be...there needs to be, well two things. One, we need to make sure that as tightly as we can align with standards, the better off we are and we've made a lot of progress there. And this feedback just needs to be clear in the process, that they need...to get this to work, we need robust implementation guides that are end-to-end. And I think that's the concern here.

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

Okay.

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

So, we can make it policy, but we just can't...so, we can't lose it, it should be in whatever column we put that stuff in.

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

So this is a recommendation back to the S&I framework is what you're saying.

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Yeah. So we can share it with the Standards Committee and hopefully it will get there.

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

Okay.

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

Yeah, and I'm sure you've heard this noise before; I've heard a lot of it on our end, so.

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

Yeah. Okay...

Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical
And I don't know if it's to this one...but it's just some of the other lab stuff.

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

Okay. Thank you. So this next one, some feel that laboratory function should not be part of Meaningful Use. I think that's not where we're at and I think we're...it's going to be included, it's been included in Stage 1, it's included in Stage 2 and it's going to be in Stage 3. And then, they mention, the other comment is mention that the capacity at the state level is an issue. And again, that's...you get excused if that is the truth, and it should not be a reason for us not to proceed with the early adopters and ones that are trying to make progress in this area. So, I think that's not a pertinent key point at this moment.

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

So, to that end though, just as a comment. When you mention early adopters and this is kind of philosophical, are these core or are they menu, in terms of what we're presenting?

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

Well these became core in Stage 2...

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

These are all core.

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

...so, and if your state cannot do this, you get a waiver.

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

Yeah, I see, you get a waiver.

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

You get a waiver. Right. Okay. So let's see, I think I might be, yes, okay, so we can move to the next slide, and I now can see your slides again. Hopefully this connectivity will last. So the next one is 402B. This is I think this is not something that we need to discuss, because this is for a future stage. We can briefly run through the summary. Once again about readiness, about mapping and the third thing, the second bullet down there is about why aren't hospitals included, it's because they're already included with electronic lab reporting. This is about case reports and most of the case are started from hospitals with a lab report, so, I didn't think...I don't think that there's a need for hospitals to be included. But, and there are some key points here as well that the recommendation isn't specific to reportable diseases. But I think that this was intended to be primarily around reportable diseases. So the comment there, someone may be thinking about using it in other ways. But I think our first step here would have just been to the anywhere between 58 and 65 reportable diseases by state, and a lot of that was embedded in the next key point below, which says Reportable Conditions Knowledge Management table for systems that's being developed. But I think the Meaningful Use Workgroup put this off in the future and I don't think we need to spend much more time on it. Any comments?

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

No.

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

So we'll move on to the next slide...oh, I lost my connectivity again. Sorry. So this is, yeah this is just a continuation of the same, of 402B. And we can, I think, pass over these. Right Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Yeah, I mean, I guess the only question is, are there any points that would make it possible for this to be moved into Stage 3, and if not, then...

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

Um...

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

Was this just certification for Stage 3 or as a future Stage or looked at as a Meaningful Use requirement?

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

So I think the certification piece would be that the EHR is able to access this external data to prompt an E...the end-user. And I think this whole idea about getting external data is I think that it permeates other areas besides population health...

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

Absolutely, it really does.

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

...and are we going to take this leap or not? And will we be ready...is there something to land on? I think that's the concern here. I know we're going to have to solve it for some areas, be able to access external data around clinical quality measures, isn't that true?

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

Yes. And the other piece that overlaps with this one, and again, I don't know where that's at, but there's a project that's looking at that, we've...around the DDI, you know, the drug-drug interaction...

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

Right.

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

...as well as the whole clinical decision support. I know there's eHealth Decisions Project; so just similarly, to how the National Library of Medicine now has the...it's the owner, if you will, of these value sets, right.

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

Yes.

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

We're looking...a lot of the projects across meaningful use are starting to look for homes for knowledge, right, so that's a consistent theme.

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

Right.

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

And so this is one of those categories of themes, and I think we're all struggling a little bit with what infrastructure we have. Now, people stepped up and created the infrastructure for quality, so, I think that's an important issue, because if we can get some of this stuff...we don't want to go to 15 different infrastructures, or maybe we do, maybe we have to go where it makes sense. But I think that concept, I think as a strategy and a direction, we should start to make that a little bit more overarching and see what we can push for, because that moves the market forward with that kind of strategy.

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

Right. So I think that what I'm hearing you say is that we could push this maybe at the level of the EHR being able to consume the data, if we could find a home for like the...

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

Yes.

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

...this Reportable Conditions Knowledge Management System, whether it's CDC or NLM, wherever, that EHRs were then able to consume.

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

Right. But if you get a lot of different sources and inconsistency, then it just...it won't scale.

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

Right. Well I think we do have one group, the CSTE is supporting this, so...and I think everybody's bought into them doing that and maintaining it. But I think maybe...so I hear what you're saying now Michelle, I think it may be possible for us to scale back to just certification, in this area, which would not be a meaningful use objective, it would be a certification criteria.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Okay.

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

Okay. So that's...thank you for pointing that out.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

I think that was Charlene, I don't want to take credit for it.

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

Okay. Well, thank you both then. So, let's see. The next one is syndromic surveillance is basically the same. Again, the same comments that we saw earlier, so I'm now on to slide 11, it should remain unchanged for most commenters, but states are not ready, you get a pass. Commenters want better standards and more efforts aimed at state readiness. Well, I think the standards have been worked on by the International Society for Disease Surveillance and states are getting as ready as they can. Again, you get...and the providers that the measure pertains to need to be clarified, including the addition of inpatient hospital reporting. Well, I think the eligible hospitals need to report, whether you have to report inpatient hospital data, I think that's up to the state, I don't know that the current system requires anything more than at least chief complaint for the ED.

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

Right.

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

So, I don't know whether that means that this is something for ONC to be aware of, should there be more clarity around the actual data that's required, whether it's just a chief complaint in the ED versus all hospital lab results, just going to the other extreme. And maybe that's something that ONC might want to consider in the rule. Now, it must be in the rule...I don't know what...Michelle, do you know what the Rule says now for Stage 2, does it...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Not off the top of my head.

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

Okay. So, I guess another thing would be to check the Rule for Stage 2. I'll jot that down.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Okay. Yes, I will.

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

Thanks. So the next item is, okay, this is the big one. This is what we'll probably spend most of our time on, and I don't know whether we'll get through this completely today, but we'll try our best. So this pertains to the recent discussion around consolidation...

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

Okay.

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

...and the merge registry objective, and I think after the group started the discussion around consolidation and deeming, Michelle asked for us to...or Paul had asked for us to refashion this, and that's what we have as a new objective. So, the comments that we're going to see, I think were from when it was not merged, but this is...our major task is to say should we try to merge this registry. And you'll see in the comments below, especially when we start talking about this and the cancer registry folks who have established their presence in Stage 2, are concerned that cancer registry reporting might be decreased if we give options to participate in different registries rather than saying the cancer registry is one that you shall participate in.

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

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

So, the capability to electronically submit standardized, and that's data elements and transport mechanisms, commonly formatted reports to two registries at the local or state health department, professional or other aggregating sources, from your EHR, except where prohibited in accordance with applicable law and practice. And it doesn't replace the immunization registry. So I'm going to give some examples below, of the mandated jurisdictional registry, and that could be the cancer registry, children with special needs registries, early hearing detection and intervention. Those are just some, there could be others as well, depending on the state, but those are just some examples.

But then these additional community registries for other aggregating sources might include participating in a registry supported by an ACO, or a specialty, like we heard the testimony from the cardiology association and I think the thoracic surgeons early on presented about their registry work, and someone should be able to get credit for that. So, it doesn't say that it has to be a jurisdictional registry, because many of those specialties probably would have less of interest to the jurisdiction and more of interest to their specialty community in looking for benchmarking. So, and some examples of these are activities going on now, like in New York City, they have registries for diabetes and hypertension. We're working on a registry around body mass index. There are other registries that people could participate in, in a healthcare-associated infections, which are reporting to the CDC. So, these are just some examples here.

We will probably get some pushback again because a registry that established itself with the hard work that the people at the CDC did, they may feel that cancer is somehow now being relegated to lesser importance. I don't think that, I think it's now offering opportunities for providers who see very few cancer patients to participate in a registry that is more meaningful to them, rather than saying I didn't have any cancer patients this year, which probably happens in many practices, where you're not seeing cancer patients.

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

So where was it posed to merge this one...because I mean, what we're seeing happen again kind of in our market is again, providers are coming together to try and reduce readmission, so the first thing they need to do is understand the data. So you could see where some of these registries, those people who have a lot of readmissions, start to be shared in a community, right, so you're going to have that kind of functionality, so...request it...

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

So that's where it might be the ACO coming together, trying to inform providers who are sharing patients, about how to reduce readmits.

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

Yeah, yeah, yeah. So, what...how would we merge this? Where would we merge this at?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

This is...sorry.

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

So what the merge part is, is that so 404 is the cancer registry...

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

Oh, you want to merge them into one, okay, okay, I'm fine...I think I'm fine with that because again, I think we want to support the development of these different kinds of registries that are starting to emerge to manage populations, because that's kind of a new space, right.

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

Right. So maybe we want to call that out...I'll just make a note here, we may do a little modifying here, but managing high-risk populations or those at risk for readmit.

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

Or, I mean, they'll be a lot of different ones, like you've got BMI, and so, I mean, but I think people are...depending on what's in their area, will be trying to manage those populations, right.

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

Now, one of the problems is that the beauty of the cancer work is that they went to great lengths to create a standard. And the work in New York City that I referred to earlier about hypertension is not necessarily on a standard. No the query health work that is going on at ONC is trying to help us establish that standard, but I don't think that it's yet baked. So, that's where we're probably going to get the same sort of argument we got about immunization registries, we'll probably get here about a lot of these other registries. Parenthetically, at this point, in the Stage 2, it talks about the specialized registries and the whole process of getting your certification...is it called a letter of certification, I can't remember, when you onboard, Michelle, do you know what that's called? The eligible hospital will get a letter from its public health agency saying, they are certified and met the criteria for that jurisdiction, do you know what that term is, I think it's a letter...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

I think it's a letter, but I'll go to the Rule and get the exact words.

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

So how...I know how I can do that for the immunization registry, and any other registries that I maintain, but how, when I give a letter for someone meeting that with the cardiology association, where do they get that letter from? So, this is something we may want to bring back as an operational issue for even just Stage 2. Do you understand what I'm saying Michelle?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

So are you saying where does the letter come from?

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

Yeah...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

Okay.

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

Because I write a letter for electronic lab reporting and immunizations and syndromic surveillance, but the cardiologist says well, I don't do syndromic surveillance, I don't have...I have to do one of these registries and it's not one that you, the public health department, are responsible for, it's my specialty society.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

Yeah.

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

And there's no sort of onboarding process for specialty societies, at least not that I've heard.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Okay.

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

So I don't know where that goes in the...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Yeah, I'll have to bring it back, I'm not sure where it goes either, but I'll find out.

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

Okay. Thank you.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Yup.

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

Okay. So that's the ideas that we would be merging these, health care associated infections or specialized additional registries and the cancer registry all into one merged registry objective with two registries that you need to report to. So let's...that's just...we will have to come back to that, I think. We should maybe run through these 3 topic areas and look through the comments there. So, on cancer registry, and again, I'm sorry, if you go to the next slide, that would be...yeah, that's the next slide, which is...and in Stage 3 its capability to electronically participate and send standardized data elements and transport mechanisms, commonly formatted reports to a mandated jurisdictional registry, cancer. So this is...the cancer became this mandated reporting jurisdictional registry. So, what was in Stage 2 was cancer, now it got lumped with children with special needs and...as an example, and if we go to the next slide. You can see that the cancer registry community, and those that participate in that, including the hospitals and the registries and all the advocates out there, was concerned about expansion beyond the cancer registry. They didn't want to include others. What would be the impact on the registry from expansion, so that hospitals may not be reporting cancer data anymore or...well I think that's unlikely. Most states have a rule that that's required, so it's not likely that hospitals would violate a state rule.

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

No.

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

Uniform reporting needs to be adopted prior to including other registries. So this is a...I think this is a concern, that we don't have uniform reporting, as I mentioned, maybe query health might do that. But we do have examples, for instance the work that the FDA supports in the Mini-Sentinel about creating an environment to do post-marketing surveillance. There are ways to do federated queries across institutions. And is it about cancer or is it about increasing the queriability of the data? To me the cancer registry is one method of reporting, but it could be that we're also trying to promote types of registries that enhance the ability to operationalize the learning health system. And I think that if we keep looking at it as it's a push, all registries must be pushes, where we're pushing the cancer report to the collecting organization rather than what the Mini-Sentinel Study does in other registries or other ways to generate registries is to do it by querying the data in its home environment. So I know that the HIT Standards Committee is probably going to say, there are no standards for this. But I think that we should be, as Farzad said, more bold about this in promoting new ideas in jurisdictions. So, I don't know whether we've made progress here or not. George, any comments?

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

Right here. Let me look ba...so, I'm trying to apply these comments on slide 14 to slide 12.

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

So I...okay, so the comment I think from 14...

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

Yeah, they were meant for the original 404, I realize that, but now I'm going back to 12 and say, okay, now given this new comment, how do I apply that to 12 instead of 13, so it becomes jurisdictional and additional, your comment being that we need to push this forward and not just limit it to cancer. What is this one doing? So this says one mandated jurisdictional...

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

So this one...I think the early hearing detection and intervention, I think that actually is a standard that's been vetted by HL7. So cancer had a leg up in that it really had an established standard. I think that EDHI now...EHDI, rather, has now, I think, achieved that same level. I don't know about the children with special needs, I don't know whether that registry, if there is a standard there or not, so that might be something for us to...is there a standard. So, that's in the mandated area...

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

Well, but your conclusion is, let's not limit it to cancer only, right.

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

Well that's...

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

So there's a lot more advice we're going to get, so mainly your saying, we don't think it's the time for Stage 3 to limit totally to cancer.

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

Correct. Well, so one way was to leave it as...yes, I am saying we should not limit the mandated registry to cancer alone. Yes, that is what slide 13 was saying, even though it's labeled cancer registry, it should be mandated registry.

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

Right. Okay.

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

And the cancer community obviously was concerned about that, but I don't know what percent of physicians actually see cancer every year. And some might see very, very few, and they may never report to cancer registries and they get captured on a referral to an oncologist. But they may see many kids with special needs or many kids with hearing problems, or many obese kids. So...but I take the admonishment of the Standards Committee seriously, there are poorly developed standards for registries and I don't know whether we can expect all of these to be standardized across the country. I think we need places that are doing some innovative work to kind of step up and show us through these query health pilots, what might be possible. And our timeline is what? We need to have these finished by when George?

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

You mean all our changes to the recommend...to the objectives?

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

Yeah.

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

By what is it, the end of May, right.

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

Right. And then the timeline for ONC to put out the proposed rule with CMS is...is it the end of the year?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

It's a little uncertain.

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

So we're keeping...they may slow down what they do, so that's up in the air, but we're trying to get this iteration done, since we have the information from the public it's relevant now, try to get this done over the next set of meetings.

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

Right. So I think that...I think query health is doing some pilots now, around the country, and I think there's one...may be one or two in New York, and in Massachusetts, other places. And the way that we might proceed here is being better informed by those query health pilots. So...

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

Okay, well the process has plenty of time for steering it; we should just do what we can do, given our best evidence so far.

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

Right.

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

Right.

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

So I don't know that there's much here that we would change. It's an attestation of 10% who meet registry inclusion criteria.

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

Right, I mean the only thing I see on slide 14 is, what do we mean by mandated?

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

So, and again that is what...so this whole onboarding process is allowing the public health agency to declare what it can and can't do. And I think that would be declared whatever is the capability of a jurisdiction to say, I do have...okay, so, I do have a registry capable of receiving this and I'm asking my providers to send this. So, do you think we need to define mandated as...

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

Well, we may not even need to use the word mandated, there's what we mandate, you don't mean that, like make it core is a mandate. What you mean is that in the jurisdiction the public health agency, or whoever has authority, says these are things that need to be reported to, and then we're piggybacking on that to say, okay, well it's got to be sent directly from the EHR. Is that what's going on?

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

Yes. Okay, I think I can work on that. Thank you for pointing that out. So, we'll change that mandated definition to something that is clearer here.

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

Now the standards problem will be if each neighborhood...if there are a thousand different possible registries and each jurisdiction...

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

Right.

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

...picks one, a different one of that thousand, then what is the EHR vendor supposed to do? That's why cancer ended up being a focus, but then cancer may not be mandated by the jurisdiction, in which case it's not one of the mandated jurisdictional registries. So we've got to work that out.

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

Right. Right, I think not all states do have...almost all of them do, I think it's 49, I'm not entirely sure.

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

Oh, okay, well that's good.

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

It's pretty good. Yeah, it's pretty good there. Let's see, we'll go to the next slide, cancer registry, this is the slide 15, cancer registry concerns lumping with other registry reporting could diminish the cancer cases reported. Again, I think this is the states require this; I don't think they can back off, I think the states will mandate this and there should be no decrease.

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

Right, you're separating the fact that a provider has to do something from whether they did it with their EHR or not.

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

Right.

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

Right.

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

And if their EHR does it, why wouldn't they want to use the EHR? Keeping a separate item for cancer is preferable, this allows cancer registry to be moved to core while other registries are added as menu. So, this is an interesting point. I think there is a bit of value in this is that, we would be separating out the thing that is most advanced in its messaging structure and content, from the others that are a bit nebulous at this time, or less structured and less defined. So, that makes a point, but that goes contrary to our recent discussions about consolidation. And, we have to kind of balance what I think is a pretty positive effort by the Meaningful Use Workgroup and the Policy Committee to say, consolidation and deeming is a new way for us to think about and get us farther along on this path to better outcomes in Stage 3. And by consolidating these registries together, we're sharing information to get it to the point of measuring better out...better measuring outcomes.

So, there's a tension here in this second bullet on slide 16 and I don't know...I don't really know the answer to this, but I know that we as a group have made a commitment to the ide...we have made a commitment to better understand the opportunity of consolidation. And I think this is the one area, this whole idea about registries, is the one area where population and public health could contribute to that.

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

From the vendor perspective, I...like it makes my head spin trying to respond to all these different registries. So again, I think a call for...yet we know if we want to get to where the vision is, we've got to get the infrastructure in place. So I think we've got to push for...I push for the consolidation of it because then maybe at least they can drive the standards to consolidate as much as possible, but if we have to break them back out, we have to break them back out. So, support for population based registries kind of capability is what we want, and we want standards underpinning that. Now it may not happen that they can make them, because again, there's different data that's required for the different registries and there are different reporting requirements, but, if we can start to get some sweet spots there, maybe we can make progress.

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

Right.

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

And there can be de novo registries and all sorts of stuff. Or maybe the future state is which I don't see that happening for a while, all the ACOs own their own registries and then it's just part of the vendor product and it doesn't matter. But I don't think that's going to get us where we need to go either.

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

But, I mean if the ACOs owned their registries that to me seems like a valuable resource for the community.

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

But I think the market will drive that.

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

Yeah, well right. I'm not...

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

But where...what will help is, this is where the registries are more a public good, and that's I think...so where the registries are really a public good, which some of these are, then a drive toward increasing...making that infrastructure as common as we can to support them will just help us accelerate getting to that capability. I just don't know if it can happen, but the Standards Committee has to look at that.

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

Right.

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

Which I think you've been saying a long time.

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

Or maybe the S&I framework, through the query health work, might be able to come up with some ideas. Do you know Michelle, how that's proceeding? I know this is not your immediate area, but do you hear anything about that?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Sorry Art, I don't know. But, I mean this is an area where we can certainly, if we have specific questions, we can send them over to the Standards Committee.

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

Okay. Okay, maybe that's what we might want to do is...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

I think it might be worthwhile to, and the Standards Committee has actually asked that of the Policy Committee, to if we have specific questions to be more specific about what they are and maybe even provide use cases where we have areas of need. So maybe we just provide more detail then could send them over to them to get better informed.

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

Right. Okay. So then the other two bullets that follow this, the cancer registry may not be prepared to change the current reporting systems, I don't think we're asking anybody to change the current reporting systems. In Stage 2 they're using the reporting systems that they...that the cancer community has proposed. Maybe I'm not reading this right. Are they say...this seems like it should have been a comment back in Stage 2. I use my paper system to report, I don't want to use the cancer registry proposed standards, see, I don't get that third bullet there. And the fourth bullet is one that we've acknowledged, and I think it is true that they have a set of national standards and the others are less defined, so that's the same discussion we've been having.

So, let's go down to the next slide, again, more cancer, standardized format of state registries, so all about standards, it's just about standards here. But, I guess we're kind of caught here that without the standard, we can't be bold, and without trying to establish a standard, we'll never be bold.

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

Yes, I think that could...so I mean, the discussion is, if we do this, it probably needs to be a certification criter...I don't think we're there yet, but we need to continue having this discussion.

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

Yeah, if we could get it boiled down to a certification criteria that would be helpful.

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

So I know on my workgroup we're going to have the S&I folks, I don't know if this is really important, and I think it is, do we have as one of the sessions where, and Michelle, you tell me who are the best people to pull in, a representative from S&I or whoever the appropriate person is, come to the table to give us a recommendation.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Yeah, maybe on the next call we can get somebody to help inform us. I don't know who it is over there, but I will find out.

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

I mean when they say...if we're just...if it's totally impossible, they've looked at it and we can't come to a common standard to support this consolidated registry capability. I mean we can kind of talk about how to approach this because from policy, we think it's important to expand the registry's capability in support of population health by whomever.

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

Okay so we may actually be setting up some agenda items for the next call, that's...this, is going to be helpful Michelle, for us to kind of talk this through and come up with maybe invite specific people to the next call. So, moving on to the next slide, which is 17. This is the additional registry, and so that was the one where in the first slide we went through, 404, 405 and 407, in our original comments we had one called an additional registry. And that could be, as I described earlier, the hypertension, diabetes registries, the BMI registries or devices such as those that might be important to specialists who are following something like an intra-cardiac defibrillator or something else, or a heart valve or something that would be pertinent to a specific specialty.

And let's look at the comments for this additional registry. They're looking for more specificity. Should this be menu or core? Need a standard format, we talked about this earlier, we need a standard format. And then, which registries qualify? And this would again require that somebody, either in the jurisdiction or at an organizational level be empowered to say, I maintain a registry and this person's participating in that registry. The same way that for Stage 2, the public health entity will give that letter, whatever that's called, that letter of certification or something like that, for immunization...sending immunizations, for electronic lab reporting and syndromic surveillance. So, I think the details of that, I don't think we really need to get specific here because the rule will take care of that. We didn't deal with that as a Policy Committee; the rule took care of that when Stage 2 Meaningful Use Rules discussed onboarding. So, that's probably knocks out the third one, which registries qualify, that would be something that comes out in the Rule, but I guess we could give some suggestions about which registries might qualify and those suggestions I thought were in this above here. I don't know what more detail we could provide. You know, whether the HIE supports a registry, the ACO, these are all just newly forming. I don't know if we have more definition or specificity to offer at this moment. Any thoughts?

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

No...the ACOs, public health agency, hypertension, diabetes, body mass index...well, healthcare associated infections we'll talk about in a minute, but...

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

Yeah, that's 407, so we'll get back to that in a minute. Now, I guess one thing we could say, since this is pretty new, is that it could be that this is menu.

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

Yes.

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

That 405 is menu.

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

Yeah...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

But 405 is merged with the others and so we can't...

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

Right, so then that gets us...we need two, so it doesn't become menu. Because we were looking at comments when it was separate and now we're looking at the consoled...so if we wind up consolidating, menu versus core is moot, you select two, whichever two.

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

Well we can offer a mini-menu, which is you have to do the mandated, then you have to do either the additional...based on the healthcare associated infections, that kind of thing. So it's not officially a menu objective but within there, there are choices.

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

Right. So that is...you must do one juris...

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

In fact, that's how it's written now.

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

Pardon?

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

That's how it's written now, in effect right, because healthcare associated infection, on slide 12 is one of the choices in the second bullet, therefore it's as if you have a menu, hypertension, diabetes, body mass index, devices or HIE...HAI, sorry.

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

I don't know if HAI is in 405.

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

No, it's not in 405, but it's in slide 12, under bullet 2.

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

Yes. Right. Yes, thank you George. That's the merged one, that's correct.

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

Yes, yes, yes. So the menu-ness of it is just that you can pick which registry, but the core-ness is that you have to pick at least one of those second ones.

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

Right. Yeah. So in creating that slide 12, we've addressed this issue about menu and core is what you're saying, because...

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

Well not completely, they would like to be able to do zero of them.

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

I hear that. I hear that. But the world has not really seen slide 12 yet, I don't think, right.

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

Right.

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

They maybe have been posted to a site from our meeting in...the policy meeting, but it's not been something that's been sent out and asked for comment.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Right.

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

Yeah, yeah, okay. So...and I think we discussed already that at the bottom of slide 18, the non-mandated...we need better definitions. So, that we can work on, as we discussed earlier.

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

Right. That's the main thing to fix.

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

Yeah. Okay. So now let's move to 19, which is the 407, HAI reports. So that's the capacity to electronically send standardized HAI reports to the National Healthcare Safety Network using a common format from the certified EHR and there will be...the measure is documentation of electronic submission, and that would be 10% of all reports that were sent by the EHR during the reporting period. And, this is a certification criteria is enable sending the standard HAI message. Now, if we go to the next slide, so they were split between those supported and those who did not. And one said that it's something already in place and operating within some EHRs and I went to look and I think this is now mandated reporting in about 28 states. And, I think that NHSN has some EHRs reporting directly to it, so, I couldn't get the exact number. So I do think that this is...the last comment on this page, it's premature as a pilot is currently only conceptualized. And I think we need to really find out if that's true, if it's only conceptual, I understood it to be farther along than that. So again, I will contact the person at NHSN to find out the real state of this.

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

And then also remember the consolidated one leaves it as one of several options, so...

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

Right. And, I mean most states probably are going to push toward more and more reporting to NHSN, so, there are going to be state mandates for them to report, so, an eligible hospital would be foolish to buy into using a certified EHR functionality. And it doesn't mean that you just...it automatically sends all the data, it requires human intervention. But, most of the record it accumulated from the electronic health record, because an HAI needs data that won't be routinely collected during the course of care. And some of that happens from infection control investigation. But the whole basis of the record would be created from the EHR and then additional elements added to send it on to NHSN.

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

Okay.

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

So, this feels like...it may not be...it's not a simple function, but it's creating the base data to report and I'm not sure that...it's true in the second bullet, the sub-bullet underneath that that it involves manual review of data and chart audit. But I think we really need to find out how it's being used in the sites where it's being piloted, and if indeed, there are completed pilots or not, of it's just still in some conceptualized state. It was described to me as beyond concept, by the folks from NHSN at CDC. So I will contact them.

So, the next one, unless there's more comment on slide 20, we're going to move on to slide 21, adverse event reports. This is a future item. I think that going back to what Michelle or Charlene pointed to earlier, is there some way that even though we couldn't necessarily make this a meaningful use objective could this be something in as a certification criteria. And I don't know if this is sufficiently developed yet for us to do that...

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

Right.

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

...and I don't think it's ready. So this probably would not be something we would want to push forward at this point.

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

So Art, it strikes me, again, there's a lot of...some of the decision-making around is like where we really want to push the envelope. So I think we need to come back maybe at some point in the conversation and kind of summarize and say, if we had to prioritize the most important policies that we can drive are...because we've talked about a couple of them, being able to gain knowledge from public sources, being able to advance the proliferation of registries for population health, establishing two-way communication. So somehow...I think at some point we're going to have to step back a little, because I lose track in terms of who's on first, if you will.

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

Right. Right. So again, you had the gain knowledge from public sources, what were the others that you had, that you just mentioned?

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

Summarization step, so as we were talking about immunization registries, there was two-way communication, but what we really we got talking about there was the ability to be able to go to a public source to access knowledge, right. So we said, that seems to be really important, and we start to consolidate that. The other one was advancement of registry, right...

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

Right.

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

...to support population and public health as a core concept, right, and the standards around that.

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

And then you had a third one which...

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

Oh...

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

Establish...you went so quickly, you just kind of blurted it out.

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

It was on the top of my head, now the top of my head fell off. Don't put that in the record. No, I was just thinking through the top...what we had talked about today, that was all, so, strategically a little bit.

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

Okay, we at least got two of them, I can probably get them off the...

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

The transcripts, right.

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

...the transcripts right. Okay. Thank you. So then this one I think we can...and given what you just said, here are major areas, do they fit in any of these and does advance...adverse event reporting help us gain knowledge from public sources, advance registries in support of population and public health. So we can look at it in that context and say, eh, maybe not, maybe this is a stretch and this is maybe one that's farthest away in its current maturity for standards. So, and this is on the 23rd slide, this is what the Standards Committee said is that, it's not clear that EHRs could support this functionality. So I think we'll move on to the last one, which is this decision support one, that...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Sorry George, I mean, I'm sorry Art. Can I just interrupt real quickly?

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

Yes.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Can somebody, Amy Helwig from ONC is trying to make a comment but she's not on a live line. Could the operator put her on a live line so she can comment?

Caitlin Collins – Project Coordinator, Altarum Institute

We're working on that now. Thanks.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Thank you Caitlin.

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

Okay, well when she joins, we'll just go back to that topic. So thank you Amy, if you're listening, we look forward to speaking to you. If we can go on to slide 24, this is the one about the clinical decision support for immunizations and here it's the capability to receive, generate or access appropriate age, gender and immunization history-based recommendations including immunization events from the registry or immunization system, as applicable by law or state policy. So this is what the immunization community calls forecasting, telling us what should be used, what should be given for someone trying to catch up or trying to now maintain up-to-date status for their immunization schedule and it's...the measure would be to establish baseline recommendations based on the advisory committee, the ACIP, the immunization practices committee. And then allow for local and state variations, but then also this should be for 20% of patients receiving an immunization and that would be that the practice receives the recommendation, this forecast, before giving an immunization.

So, going back to 401A, you first received the prior shot and then at the same time, you would receive or somehow calculate from those shots what to do, what to be forecast, what should be given at that time with this clinical decision support. And I think that we were going...I don't have that slide, let me just look and see if I had this nice slide that Michelle worked on, the consolidation view. So, the...where, I'm just looking back to clinical decision support moved...which was in area 1 of the...all the subgroups, it now has embedded in it this CDS for immunization on a slide that Michelle prepared for our Meaningful Use Workgroup...rather our Policy Committee or one of those earlier presentations. So, this is now embedded in the clinical decision support area, it's not maintained by us any more, I don't believe. Is that correct Michelle? How do we look at this?

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

Hello. Okay.

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

Michelle, are you on mute? Maybe she's not there.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

I think we just lost her; she'll be dialing back in.

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

So, umm, this is George. Let's see, that's right. I mean the difference is that we may be getting the...yeah, because of consolidation I'd like to put it under decision support. This is different because we may actually just get the recommendation from the state, right.

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

Well you could get the recommendation from the state, you could get that recommendation from...you could pass all your immunization history for that child or adult to a service at NLM. I don't know where...we wrote it broadly so that it didn't say where it came from. You could embed it...

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

Right, that's what we did.

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

...in your EHR as well.

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

I definitely agree with that, that's how we wrote 401B.

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

Right.

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

And then whether CDS, does CDS include that. So, it seems to me that this would get consolidated, yes.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

Sorry, this is Michelle. I hung up instead of unmuting.

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

Right. We know how that goes.

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

Yeah.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

I think when I left you were asking what happened to the immunization one, are you still talking about that?

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

Yeah.

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

Yeah, we're still talking about that.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

So it got moved to the CDS objective, which is 113, and in David's group, they talked about making...so one of the areas is for prevention and it says immunizations, and so they've talked about making that a requirement because this objective got moved up there. So they're trying to make sure that it doesn't get lost.

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

Right. So...and then...and David's group is anticipating that CDS would be a knowledge base external to the EHR that the EHR consumes real-time or downloads every week or whatever. Is that right or are they thinking differently about this?

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

I think they are thinking a little bit differently. So they are thinking about how you could use CDS for preventative care, so I think they're thinking about more a clinical decision support for a reminder for an immunization perhaps, or an intervention I should say, for an immunization. So, we may want to add to their objective, maybe its certification criteria, I'm not sure, but...

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

So the certification criteria would be the...this gets back to that general, that higher-level goal that Charlene was talking about before which was gain knowledge from public sources. And is David's group talking about that or are they down...they're not at that level; they're in the level of...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information

Technology

Correct.

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

...you need to do clinical decision support.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Correct. Yes.

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

Okay. So, we probably need to bring this back to the larger Meaningful Use Workgroup at some point, about this gain knowledge from public sources.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Agreed, but maybe Art on the next call I can make sure that all the details of the CDS objective are available and we can perhaps add certification criteria or whatever we think might be necessary to tighten it up a little bit, so that when we go to bring it forward, we have a better objective. Does that work?

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

Yes, that works.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Okay, thanks.

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

Yes, thank you.

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer - Office of the National Coordinator for Health Information Technology

Hi Michelle, this is Amy Helwig; I'm on the line now for any other questions.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Thanks Amy. I don't know were you able to speak before, when I hung up.

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

No, we haven't heard from Amy yet. So please, if you have some comments Amy, feel free.

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yeah, my comments are back on the adverse event reports, which is number 408, and one of my colleagues from AHRQ, Bill Munier, I think he's working to get his line unmuted as well. I just wanted to provide any background information, or if any questions you had, because I lead the effort on the S&I for structured data capture, which is currently working on developing standards for this function.

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

So this is the CDISC approach.

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yeah, you can just say it's a CDISC style approach, we haven't definitely decided on what the standard will be, but I know that that one is in consideration.

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

Right.

William B. Munier, MD, MBA – Director, Center for Quality Improvement and Patient Safety – Agency for Healthcare Research and Quality

Hello, hello. Can anybody hear me?

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Is that you Bill?

William B. Munier, MD, MBA – Director, Center for Quality Improvement and Patient Safety – Agency for Healthcare Research and Quality

Yeah, good.

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

Yeah, we just switched you over.

William B. Munier, MD, MBA – Director, Center for Quality Improvement and Patient Safety – Agency for Healthcare Research and Quality

I don't have anything to say now, but...yet. But I wanted to have the capability. Thanks.

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

So I...so we were just talking about this CDISC-like approach for adverse event reporting. Do we think that would be a certification criteria, is that what we're hoping for at this point, or are we talking about this being a meaningful use objective?

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

My understanding is that it most likely would be a certification criteria on the electronic health record being able to send out a standardized adverse event report. And that could go to whoever the requestor is, it may just be being sent out of the EHR, even to the hospitals incident reporting system, and then it could be completed after initial information is put into the report out of the electronic health record, the management at the incident reporting system within the hospital could add content. Or it may get sent to an external entity, so the Structured Data Capture S&I Initiative doesn't specify which organization it would be or entity, it's just building the structure so that you'd have that flexibility to be able to send any type of adverse event report or patient safety report to whoever the needed organization is...

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

Okay...

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

...I don't want to say it's similar to one approach that you were looking at with registries, earlier, where you were saying there are many, many registries out there, but it's all one function to be able to submit to a registry.

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

Right, right. So, we're not saying that there's...the trigger needs to be manual, right, we're not saying that there's a list of...like when we spoke a little bit earlier that Charlene brought up about the DDIs.

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Right.

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

We're not saying that there's a list of triggers for adverse events, we're just saying that when you want to do a...report an event, you can quickly get to a way to do that from the EHR.

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Correct. So whoever the individual healthcare provider is, they would be able to bring up that function, bring up the form, whatever template or form is needed, from a library. And then the electronic health record would auto populate it with whatever fields they knew, knowing that they're going to need more information that's not necessarily in the electronic health record, but they could at least initiate it or start it and then export that out of the electronic health record to whatever organization or entity. So that might be, like I said, hospital incident reporting system, that might be FDA, that might be CDC. This same functionality is being looked at by NLM for case reports, but it would have to be verified by that individual provider before it is sent anywhere. And likely they'd have to add content as well.

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

Right. Now when you say case reports, case reports of what?

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Umm, National Library of Medicine is looking at it, they are following it and sponsoring within the S&I as well, their case reports for clinical research studies.

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

Okay.

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

As opposed to public health case reports.

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

Okay. So does this...

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

The same function could be used for public health case reports with the same standards that would be built with structured data capture.

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

Right. Right. And this is...I know that the S&I framework is working on this, do they...is there anticipated time when they would...are there some pilots that we would learn from in the next several...

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yes.

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

...months, or is it a year away. What timeframe to you think that is?

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

The S&I will be sponsoring pilots that start in the fall. The FDA did this function, getting reports to MedWatch several years ago and they've published on their early pilot studies or concept studies. And then I am aware...my understanding is that there are some electronic health records that currently have this function in place, just speaking to one of my colleagues in the private sector and he may be able to provide more comment at a future meeting.

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

Okay. So it sounds like we have a little more learning to do about this, and whether this might be a certification criteria.

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

Yeah, but essentially just to know that the efforts are under way to build the standards for this and that they'd be very...they could be broadly applied. The certification criteria, as it states now in the draft was, being able to send adverse event reports, and it notes using the common format. Those are AHRQ's common formats for patient safety event reporting that can be used to report any type of patient safety event report.

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

And is the S&I framework adopting the AHRQ common format?

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

There is a track on patient safety that will be using the AHRQs common formats. Different parties want to add content to that, and that's fine. So in the example of the FDA, for their Device Group, there are a couple of data elements or pieces of information that they would like beyond what is in the common format, and they'll just be adding on for their use cases.

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

So are these all trying to use the CCDA?

Amy Helwig, MD, MS – Medical Officer, Office of the Chief Medical Officer – Office of the National Coordinator for Health Information Technology

For AHRQ...well, that one I'm not sure. We have an implementation guide that's been developed for the common format, but it is for sending information from PSOs to the tactical assistance center using CDA.

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

CDA, okay. Thank you. That's helpful, I'm glad you joined us. Any comments from George or Charlene on this?

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

George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics - Columbia University
Nope.

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

And Bill, if you had anything to add there, please feel free to speak up.

William B. Munier, MD, MBA – Director, Center for Quality Improvement and Patient Safety – Agency for Healthcare Research and Quality

No, thanks very much. I think Amy covered it perfectly.

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

Okay, great. So I think we've gone through...we...on this last...the last 2 slides, we were just talking about how this is part of the CDS objectives. We need to see those and what would be the certification criteria for CDS activities and this idea about how we might actually...or how certification criteria might include gaining knowledge from public sources. So, that's something that Michelle said that she would take this back to the CDS group with David, is that right? I think that's how we left that discussion.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

I'm sorry Art, I actually thought we...I would make sure we have all the information available to discuss it again on the next call...

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

Right, yeah. But...yes...

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Okay.

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

...and then, well, go back to that group and bring to our May 13 discussion the pertinent information.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Right. Okay.

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

Yeah, so we'll get that in that context next time.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

So Art, there are a few follow up things that I'm going to follow up with Jim and I think you have...you're going to follow up with Jim and a few others, so maybe offline we can work to make sure we're prepared for the next meeting.

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

I think so.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Thank you.

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

That sounds fine. So, I believe we have a little time here for public comment and then we can adjourn.

Public Comment

MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator for Health Information Technology

All right. Operator, can you please open the lines for public comment?

Rebecca Armendariz – Project Coordinator, Altarum Institute

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

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

Okay. Well everybody, thank you for joining us this morning, we'll be back in touch on May 13, and is that again at 10 o'clock East time Michelle? I haven't got my calendar open.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Sorry, I'm checking.

Caitlin Collins – Project Coordinator, Altarum Institute

The next subgroup #4 meeting is May 13 at 3 p.m.

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

At 3 p.m., okay.

Michelle Consolazio Nelson – Office of the National Coordinator for Health Information Technology

Thank you.

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

Thank you all.

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

Thank you Art.

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

Bye, George. Bye, Charlene. Thank you.

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

Bye, bye.