

**HIT Standards Committee  
Standards Task Force  
Transcript  
March 7, 2014**

**Presentation**

**Operator**

All lines are bridged with the public.

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

Good afternoon everyone. This is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Standards Committee's Standards Task Force, a newly formed Task Force at the last Standards Committee meeting. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. John Halamka?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Here.

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

Hi, John. Ann LeMaistre?

**Anne LeMaistre, MD – Senior Director Clinical Information Systems and CMIO – Ascension Health**  
Present.

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

Hi, Anne. Arien Malec? Cris Ross? Liz Johnson?

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

Here.

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

Hi, Liz. Floyd Eisenberg? Kim Nolen?

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

Hey, Michelle, I'm here.

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

Hi, Kim. Leslie Kelly Hall?

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Leslie's –

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

Hi, Leslie. Lisa Gallagher?

**Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy and Security – Healthcare Information & Management Systems Society**

Here.

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

And I think that's everyone. John, it's you and a bunch of ladies today, this is new.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay.

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

So I first want to thank you John for volunteering to be Chair of this newly formed Task Force and thank you in advance for your help in leading this effort.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well thanks and so folks, if you look at the work that ONC has so diligently done over the course of the last couple of months with the Meaningful Use Workgroup presenting its potential Meaningful Use Stage 3 recommendations, you also look at the 2015 NPRM, what you see is that both efforts would really benefit from a reality check. A Standards Committee sense of what is implementation difficulty, standards maturity and so over the course of our couple of phone calls with Michelle's guidance and creating wonderful frameworks for us, we're going to have the opportunity to take a look at those Meaningful Use recommendations and be able to, we hope, create a consensus assessment on several dimensions.

Because we know we want to move forward the policy goals of ONC and those that were enunciated in HITECH, but we also want to do it in a way that the industry can absorb, that workflow can tolerate, that standards will support. Because although it's wonderful to say, here is an idealized future state workflow, you have three months to come up with the standards that'll support it. I think we all know that there's typically an 18-month to 3-year timeframe between a standards idea being proposed and a standard actually being implemented in the real world. So that's the sort of thing that our colleagues on the Meaningful Use Workgroup don't know, and so we're going to be, with Michelle's help, looking through some 19 different Meaningful Use Workgroup recommendations and, among other things, talking about difficulty, impact on workflow, standards maturity, that sort of thing.

Similar thing, I think, Michelle for the NPRM because ONC of course would like to come forward with a voluntary certification program that will reduce burden. And it's important as you look through that NPRM document to realize many of the suggestions are simplifying language or taking lessons learned from the 2014 edition and applying them to 2015 to cleanup. But there are novel recommendations, and we, I think, have to be a bit careful when we look at those novel recommendations that we aren't creating more burden while getting the benefit of less burden, at least we want to achieve something that is deemed by the industry as generally a positive balance. So that's our agenda for our next several meetings and Michelle, fair to say that you are going to ask us as we go through this review, not on today's call to do all the work, but we'll sort of get a sense of what is the scope of work, what are the Meaningful Use recommendations. You're going to ask for us to generate a deliverable of recommendations back to you, we'll review those as a group and the hope is that by the end of the month that we are going to have something that ONC can use as a product that we could openly review. Is that a fair summary?

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

That is a great summary. Thank you, John.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And so I presume, Michelle, that in today's call, that – did you want to start with the PowerPoint and then use the document as reference, or what would be easiest for you.

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

So I was thinking today that I would run through the PowerPoint and today's call would be more of a getting everyone oriented, understanding what the work effort is and we probably won't go through the Word Document that has much detail, but I'm happy to do that as well, based upon time and questions that people have.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And maybe Michelle, one of the things that would be good to do, we'll go through your PowerPoint and we open up the Word Document and maybe together as a group, just go through one, and that way we sort of get a flavor of what are the criteria in the framework that you're looking for us to address.

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

Exactly. So I was hoping to do that with clinical decision support, I probably should have picked an easier one to start, but I thought that that could get to some of the complexities as well. So, that's why I chose that one.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And I'm happy to discuss that and describe the two methods Jacob has proposed for offering global nationally curated decision support. So, can we attack that PowerPoint?

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

Let's do it. Next slide. So again, these are our Task Force Members. I think we're only missing a few folks today, so we don't have Floyd, Arien or Cris, and thank you all for agreeing to join this group. Next slide. So, as John mentioned, our goals are really, the first stream of work that we'll be focused on is the Meaningful Use Workgroup recommendations. And they are actually being brought to the Policy Committee next Tuesday, so they aren't finalized yet, they're still a bit of a work in progress.

Just as background, Leslie Kelly Hall was also on the Meaningful Use Workgroup so, I'm sure that she can help fill in things that I forget from the perspective of the Meaningful Use Workgroup. And then once we go through the recommendations coming out of the Policy Committee, we're also hoping to kind of pivot to the 2015 NPRM, as John mentioned. I will mention that some of the other workgroup on the Standards Committee are also looking at the NPRM, so, Liz Johnson, who's on this group, leads the Implementation Workgroup. And they are going to be taking on a bulk of the work effort for the NPRM, but I think that they might be looking at the NPRM from a different perspective than this group, I'm hoping for. So I think we're going to ask the Implementation Workgroup to really be the reality checkers, if you will, and then this group will focus more on some of the 2017 criteria, because it relates very nicely with the MU3 criteria, which we'll first review. So hopefully it will all make sense as we get there, and I'm happy to provide additional context as we go through things. Next slide.

So this is our work plan, so we're trying to do things a bit quickly, so that we can bring back information to the Standards Committee in March, which is March 26. And also help inform the Meaningful Use Workgroup, and as I mentioned, they are bringing recommendations to the Policy Committee next week. I know the timing isn't perfect, but even once the Policy Committee approves their recommendations, there's still time. The Meaningful Use Workgroup is planning to have listening sessions to hear from the public, they're going to take feedback obviously from the Standards Committee and just continue to refine recommendations so that they can better inform an NPRM coming from ONC and CMS.

So our work will be – during today’s meeting, my hope is to give you some background on where we are with the Meaningful Use Workgroup recommendations, go through things in detail if you need me to. Discuss the criteria that I am hoping that you all can use when you evaluate the Meaningful Use Workgroup recommendations, because we are going to be giving a work assignment, as John mentioned. And then walk through an example of CDS, which we discussed earlier, as a group, so that you have a good idea of how to look at the objectives. And then the feedback that – of the work that will be assigned will be due on March 13 and then we’ll discuss – so I will consolidate and consen – and try to get a good consensus from my perspective, from what everyone shares with me. And we’ll discuss that during the March 13 and 17 meetings.

So, next slide. So, just to give you a bit of background, at the February Policy Committee meeting, the Meaningful Use Workgroup brought draft recommendations to the Committee. They had a few more objectives included and the Meaningful Use Workgroup, based upon feedback that they heard, did some work to poll the group – they did some refining of their recommendations and have narrowed it down to these 19. Next slide.

So these are the action steps that that Meaningful Use Workgroup took after the Policy Committee. So they wanted to make sure that each and every objective was relevant and related to the focus areas, which they had determined for Stage 3. So as we all might remember, Stage 3 is really supposed to be focused on outcomes, but then what are the things that are going help us focus on outcomes. And so that’s where these focus areas came from, so clinical decision support, patient engagement, care coordination and then population management.

So they looked at each objective and made sure that there was alignment with one of those focus areas. They also wanted to make sure that the objectives helped advance payment models. And they also wanted to make sure that the type of provider was beyond just primary care providers. They also were asked to look at each objective and get a better understanding of how much effort it would take for a provider to implement that objective and then look at standards maturity for those objectives and also development effort. So we took a stab at the standards maturity and development effort, but that, I think, is the area especially that we could use help of the Standards Committee, to make sure that we hav – are better informed, have the most up-to-date information and aren’t just stabbing in the dark. Next slide.

And can you just click through on this slide. So, as I mentioned, this is the clinical decision support objective, and so it’s really the standards maturity and the development effort that we’re going to be asking all of you to take a look at. This is included in the matrix in the Word document, so you’ll see it looks a little bit different, but the same. And so what we’ll be asking all of you to do is to track changes and make any updates that you feel appropriate to the standards maturity and development that is included in that matrix in the Word document. Next slide.

So, and these are the different criteria that were used for evaluating the standards maturity and development effort. So for standards maturity, there are four different categories, immature, emerging, approved and adopted. And then for development effort, there was low, medium and high. And so I wanted to first just take a step back and ask the group to make sure that we all have the same definitions for these items, so that when you’re doing your evaluation, that everyone is kind of using the same criteria and that we’re all on the same page, I guess. So John, I think I’ll take a step back, I don’t know if there’s much room for disagreement or questioning, but I just wanted to make sure that everyone was in agreement, if we should change the criteria, if there are any thoughts behind this.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well, so let's actually – I wonder if Michelle, Doug, for example, might be able to actually hang some definitions, because I could take a stab at standards maturity. Immature is no consensus standard has been proposed. Emerging, a consensus standard has been proposed, but is not yet balloted. Approved is a ballot has succeeded and adopted, it's in production. And you could probably have gradations of adoption, like widespread adoption and those sorts of things. But I mean so as you think, for example, we'll talk in a moment about CDS, Health eDecisions has proposed a set of standards for a series of decision support models, but those standards have neither been adopted by anybody nor, to my knowledge, passed in final form an HL7 ballot. And I could be wrong about that, but – so that would make them more – I mean, they're not immature, something has been proposed, but they are certainly not approved. And I'd certainly welcome input on others behalf on standards maturity based on the four terms and the simple definitions I just gave.

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

John, the only comment I would say is kind of what you just said which is, if we were working against the stated criteria, so that as we have the discussion, we consistently went back to a definition that was in front of us. I think it will make our work go faster and we won't get off into this debate.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So Michelle, I wonder, would you like me to email say Doug those four sentences that I just articulated and see if we might get, as Liz just said, some wording on these so that we aren't – we're all grading using the same criteria.

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

Yeah.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

John, this is Leslie and I just had one other comment and that's when a standard is maybe mature but – for providers, but new for patients, because we have so much coming up in the patient engagement area, we should probably have a definition that states when it's new for a patient, but mature for a provider is that emerging? Is that approved? What are we going to do with that information?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right, and so I think Leslie's got an important point, which is, when Dixie came up with our matrix of standards maturity, it was suitable for purpose. So –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Right.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

– you could have a mature standard that is emerging for purpose.

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

Right.

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

Well yeah –

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

This is Arien, sorry, I –

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So hey Arien, you've joined us, welcome. Please.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

I have, sorry for attending late. I would point out that when we reviewed the criteria, we did explicitly note that standards maturity is environment dependent and we specifically called out the patient engagement case as one that would be warranting use of less mature standards because it's inherently an emerging area.

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

This is Kim. I would almost recommend adding a third dimension, because you could have a standard and it could have a floor and a ceiling. And they may only be using the floor of the standard and there's other capabilities within it that aren't being utilized, that would help with what we're trying to do, just a suggestion.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Sure, I mean one example, Leslie and I have had several calls around the use of CDA and it is I think we would argue that a CDA is adopted, but its use, let's say for structured care plans, would be emerging, or something like that. There are pieces or parts of the standard that might have varying levels of maturity.

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

And coming back to Arien's and Leslie your comment as well, and I guess we'll get into this when we get into actually looking at the measures themselves, but the recognition that – and so, I'm gasping for, is there a definition around adopted. Because if someone in a very progressive, unusual circumstances has adopted a standard, but it's not widespread by any stretch of anyone's imagination, is there some place in this that we make that notation? Not to pass a judgment, but simply to notate so that we go back and this is my reality since Implementation Workgroup orientation, but it does really matter. Because sometimes we jump ahead of ourselves, we feed back to ONC there's a standard out there it is adopted. But because there's no qualifier, and I am not going to take any of our time to talk about some of the things we're dealing with today, related to Stage 2 that are absolutely out there. But the adoption has been very – is very, very low and now, because of the way the measures are being – we have to now report on or do attestation, we're being forced to take a very, very low adoption and try to create mechanisms to use it, because we're not required to use it. I don't know if that makes sense, but I think you understand what – the example I'm thinking of, obviously, ToC, but regardless.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

And Liz, I'm going to build on that a little bit, and that is we're looking at three years out from now and as we might have something that's being adopted by an early adopter, it might have huge momentum, with an expectation that, hey, that's going to be pretty good in three years. Or something that might be – not have momentum, and I don't know whether that's too gray for us to get into, but think of how long it takes to get something done, and if we have something that's building in momentum, we could do damage by cutting it off at the knees. So –

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

Don't know how to resolve it –

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

You will have the half glass half-empty thing with Leslie and I because I agree with her, so let's just get that on the table, because both you and I have been accused of not being as supportive as we might be of patient engagement. But the reality of it is I agree with you Leslie, but what goes in now, we will be living with and so if we make the wrong guess, if we're not relatively convinced it will take off, then we will be compelling our EHs and EPs to meet standards whether that doesn't happen. And you know what, I think it'll be decision we'll make as we go through the measures.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Yeah –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

I agree with that.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

This is Arien, it cuts both ways. I would note that a year ago we thought that Green CDA was pretty promising and now I think FHIR is pretty promising. I have a little more confidence in FHIR than I had in Green CDA. But we would have been – I think we would have been – there's a point at which you jump in and double down and a point at which you need to let the market evolve and see – we could take some twists and turns before we get there.

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

Yup.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right, so what I wonder is, I mean Michelle, I'll forward you this email I wrote to Doug, but basically it says standards maturity is a function of purpose, environment and stakeholders so for a given purpose and a given environment by a given stakeholder, a standard is immature, no consensus has been proposed. Emerging, a consensus standard has been proposed. Approved, successfully balloted by an SDO and here's where it gets very controversial, adopted; in production by greater than 20% of stakeholder sites or you guys decide what the threshold is, it's some – number.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

I would argue for using the framework that we already created, because it does have many of those attributes.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay.

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

So Arien, help us remember, does it have a threshold for usage?

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

It does.

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

Okay, I don't remember what it is.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Well, I have to admit, I have to go back and look at it, but I do remember making David and Dixie and I made all these same points in that process.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And so I forwarded that email to Michelle and to Doug, could you also, Arien, forward whatever you have from historical materials, and by consensus –

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Yup.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

– we will put them together.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Amen, will do that.

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

Absolutely. Great.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So I think we have an approach on standards maturity. Development effort is another one of those things that's a bit hard to quantitate. So before I go forward, hey Arien, did you even have a rubric for development effort?

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

We did. We had implementation – development and implementation complexity.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay, well, I'm all for using whatever has been done in the past because I was talking to a major vendor at HIMSS and this major vendor CEO told me, the Meaningful Use Stage 2 implementation cost that vendor 17,000 man/weeks.

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

Yeah.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Now I don't know, by any metric, I would call that high.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Many of us would have the same experience.

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

Yup.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And so, is there a way to quantitate it in some fashion. I mean, I don't know what rubric you had in the past.

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

That would be really helpful though, Arien, and I agree with John. If we could have again that sort of look to the set of criteria routinely, then I think we'll be able move quic – in a more structured fashion and particularly given the timeline we have.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And so, to the extent that every vendor is going to be different and their architectures are going to vary and the ease of deployment is quite different, but there's a difference, I think we would all argue, between one developer spending an afternoon and 17,000 man/weeks.

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

I think you're right.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So Arien, yeah, we will certainly look forward to any recommendations you might make, so that when we evaluate complexity and degree of deployment difficulty, I mean I certainly – I have five developers, so it took us 200 man/weeks to get through certain aspects of the Meaningful Use Stage 2 criteria. And I'll tell you, for us, 200 man/weeks among five guys, that's high.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Yup.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Okay, well I think – Michelle, I'll summarize that by saying that the criteria of judging based on standards maturity and development effort and highlighting the concerns we might have seems good. But we better, in the next day to two, try to get folks definitions, hopefully the ones Arien has said we've used in the past, but if necessary, I'll work with you to amend those based on this discussion.

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

Great, thank you John. And I will add, so all we're hoping for is in the Word document that was sent out, once we come to consensus on what the appropriate criteria is, if you could track any changes and make any updates that you have based upon your perspective. But then we've also added an additional column for overarching comments or concerns about a particular objective. And then we're going to consolidate those and discuss those, as we review all of the objectives during the next meeting. Next slide.

So all that being said, we thought it would be good to walk through the clinical decision support objective and discuss the standards maturity and development effort, and then discuss any overarching comments that you all may have. And just to review the objective a bit, so this – the chan – there are a few changes from Stage 2. The workgroup is recommending, and so again, this hasn't been approved by the Policy Committee, these are draft recommendations, but they are recommending that there be CDS interventions that apply to clinical quality measures in at least four of the six National Quality Strategy priorities.

And they recommend that those interventions be in one of those six different categories so, preventative care, chronic condition management, appropriateness of lab and rad orders, advanced medication related decision support, improving problem, medication and med allergy list, and drug-drug/drug-allergy interaction checks. They are also proposing some additional certification criteria to enable the intervention tools so that there's the ability to track CDS interventions and user responses. And there are a few more details included in the matrix; we tried to make it a little bit higher level for the PowerPoint. And also to perform age-appropriate maximum daily dose weight-based calculations. So, any questions first of all, about the objective itself?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So one of the things would love clinical input from Liz or others on the call. The way our EHR works is it absolutely for every order written examines the appropriateness of that order for a dose and weight and age and other stuff, creatinine clearance.

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

Right.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

But outside of chemotherapeutic dosing, we don't actually attempt to cross-orders that may have been written on a substance to try to evaluate that a category of a substance of accumulated nature over the course of a period of time is appropriate or not.

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

So John, we do, to some extent. It depen – I mean, there are some other drugs that fall into the same category because there are lifetime doses because there are that kind of cross-reference. But still, I think that we are very similar to you and we certainly do it for chemo for all the reasons you can imagine.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

And I will represent a perspective of ambulatory electronic prescribing. We built an electronic prescribing application that was designed for speed and efficiency for ambulatory adult prescribing. And we never saw a market need to put in dose calculations, understanding that it was not fit-for-purpose for pediatrics, it was not fit-for-purpose for chemo, and there were certain medications that you would need to go with a separate process to do the calculation, for example, warfarin therapy.

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

Yeah.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

But there is a market niche for people who are looking for block and tackle electric prescribing behavior where this – we need to recognize this would limit the market availability for electronic prescribing, to make those things non-marketable.

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

Yeah, and I was going to say, that is the one thing we do a lot – or much more – is in our pediatric hospitals and our pediatric units. And so John, when you asked that though, are you – I read the intervention – the certification criteria intervention, those were examples, not requirements? Did I miss – am I mis-reading that? What are you thinking?

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

No, this is Michelle. So that's exactly right, they are recommended interventions, but the workgroup tried to not be overly prescriptive, which is feedback that they had received earlier on.

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

The other question that I had is when I look – when I think about what we have to do for Stage 2 today, I believe its five records in a – pardon me, five CDS interventions related to four more of the quality measures within certain domains. So this doesn't seem radically different to me, is it?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So I guess the two – I mean, Michelle, let's ask – this is sort of maybe a Steve Posnack question, or maybe a Paul Tang question. But as I read the materials, what I took it to be actually you must record every user response to every intervention –

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

Yeah. That's different

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

– made and if they accepted it or didn't accept it, be able to run a report that shows you all decision support that was not accepted –

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

Wow.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

– for the notion that you might identify errors caused by lack of an individual to accept decision support. There wasn't a choice in doing that.

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

No. So, this is Michelle. Actually to that certification criteria, the ability to track CDS interventions and user responses, all the workgroup is asking for there – not all. But, what the workgroup is asking for there is that the functionality be available within the electronic health record so that the provider is able to go back and track and see how they – basically how many interventions were ignored or – to see how well it's working.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

So one of –

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

But it is only a functionality criteria, not a reporting criteria for Meaningful Use.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

One of the complexities here is that from previous experience, I implemented a drug-drug intervention checking system that provided contextual clues, very prominent contextual clues that there might be an intervention, but did not put alerts that needed to be dismissed. And I will tell you that solving for user experience and solving for tracking of what was done with regard to a particular intervention, it's difficult to do both at the same time. It is easiest to track the outcome of an intervention if you destroy user experience by putting hard alerts in and require definitive action to dismiss them. It's easiest to solve for user experience if you allow for soft alerts in some context where you need to give contextual clues but again, you're not tracking the information required to track the status of an intervention.

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

So one of my curiosity questions about this one is today, we go back and look at where alerts have fired and whether action was taken or not. I think the – if it's an appropriate action is a different kind of a discussion. So from that perspective, the functionality exists, because what it sounds like Michelle to me, and others please chime in, is this requirement is heavily reliant on the vendor and becomes an opportunity for the provider to take advantage of the functionality. Is that a fair assessment?

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

Yes, exactly Liz.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Yes, this is Leslie that is exactly right on. And the other part of this was that didn't imply that these CDS functionality had to be within what we used to call the full EHR, but could be a component or a module or an external system. So that was also part of this discussion.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And one of the things we want to be very careful of, and hopefully provide ONC feedback, is sometimes in the past we've suggested, oh, don't worry, it's not an attestation criteria –

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

Right.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

– it's just some complex thing that the vendors, who have lots of free time, have to implement as part of a certification step. And so to say, oh, we're not going to put a burden on doctors, that's okay, that's one dimension.

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

Right.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

But as I had to go through my EHR and at every single point that we offer a hard or a soft reminder, track a reaction to it, the development effort involved would be enormous.

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

You're absolutely right, John.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Absolutely right.

**W**

Yes, I agree.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

And I am highly suspicious of activities where ONC or CMS is making product decisions without also holding providers to the resulting behavior. It is far too easy to believe that providers won't do it but they need that functionality. And that really is or in many cases, should be a market decision and a market selection decision that should be made by the end users of the technology, who may well trade off, for example, user experience over tracking as a valuable trade off to make. And unless it is compromising the programmatic outcomes, likely should be able to make those tradeoffs.

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

It – this is Michelle. And so part of the intent of having the tracking was to improve the user experience. So, I think that's exactly the feedback that the Meaningful Use Workgroup needs, that they're kind of – they may possibly be looking at it from the wrong direction, and there could be a better way to do it.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And so yes, to the point, if we could even adopt a general principle that the intent of this entire federal program should be that we are going to ensure the functionality is in the EHR when a provider is mandated to use it. As opposed to, oh, let's just decouple what the Meaningful Use regulation says and what the Standards and Certification Rule says.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

So John, this is Les and I have a question about that because when this was discussed, part of the goal was to align the requirements in the quality measures to be able to have reports that would actually track that these things would be done. So, part of this goal was to have the reporting capabilities for quality measure requirements aligned. And so is there a way to look at that differently as a result of that information or are we simply stating that certification criteria should only apply to the actual intervention versus the requirement today, where reporting is necessary, but there isn't any certification requirement to support that reporting. Does that make sense?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right. And so one of the things we also wonder, and this is probably Michelle beyond the Standards Committee input, but if – instead of being completely prescriptive like saying, you must for every intervention record whether it was accepted or not, the notion that in some domain that you have the capacity to track whether intervention was accepted or not. Like, it is probably true that in e Prescribing, if I have an alert that says, don't do this, the patient is going to die of anaphylactic shock, I actually do track such stuff. But if you are recommended to get a colonoscopy this year and you ignore it, I don't track that one, that's sort of a soft reminder kind of thing. So it's I guess maybe a gradation of what is the scope and intent of this one, capability exists to do it somewhere, sometime or for every time decision support is offered, it must be trackable.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**  
(Indiscernible)

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

So John are we saying we should give back the feedback that's here in the table below. But we should also query back to MU Workgroup to say – and we did this before as we were going through the process, is we would send a query back to say, we understand your intent to be this, we'd like validation before we comment.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well, I mean I think – Michelle, you tell me the process that'll work best for you, but I think we can synthesize this one by saying, as we look through this slide, we do have some questions in the certification criteria, are they exemplars or are they mandates, because if they're mandates, then we need to clarify intent. But we would certainly offer a recommendation something like, language less prescriptive that in a given domain to be chosen by the provider, this is going to be something desirable to have and it will be linked to an attestation criteria.

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

Therefore we wouldn't just create vendor development costs without measure requirement, is that sort of the end game, John?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

That's right.

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

Okay.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

And that would account for both provider use as well as the quality measure reporting that's required, when you say attestation, you'd say both or one or the other?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Right. I mean so if we're going to mandate in Stage 3, let's say, that a physician be able to document a reason for overriding a critical drug-drug interaction alert, a report should be available of some variety, documenting how many they overrode. The only problem with that is I'm not quite sure what the quality measure would be, because the EHR is unlikely going to be able to quantitate the adverse event that resulted as that might have been ignored in a quality measure, or some such thing.

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

This is the –

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

This is, by the way, is really important and this is an area of emerging science. I am not aware of any great way to tell you, besides having the mind of a clinician, that if you prescribe this, the patient will die. All you can do is to say, there are conditions where this is a bad idea.

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

This is Kim. I have a question. I'm trying to put this into a real-world example with the definition that they have on there, that apply to CQMs. So if you take something like the diabetic foot exam and a physician wanted to set up a clinical decision support to alert him of his diabetics who hadn't had a foot exam in the past year. And then they wanted to track that in their practice site for a Quality Improvement Initiative, then having these alerts and being able to run that report would be beneficial for them or am I looking at this the wrong way?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Yeah, I mean I think of this as two issues.

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

Right.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

One issue would be care management, which is I want to identify in my cohort of 5000 diabetics, how many have not had a foot exam and get alerts or reminders of some variety and then track at the end of the year how many had foot exams as a quality measure. I mean that actually sort of seems reasonable and we're doing that in many ways. As opposed to, I was told that if you eat this drug with grapefruit juice, you could develop agitation and then somehow as a quality measure, say, so you ignored the grapefruit juice warning, how many agitated patients did you have. I think that's – to Arien's point, clinically impossible to evaluate and certainly the care measure's impossible to produce.

So we have to be careful and I'm not sure there's always going to be a linkage between clinical decision support and quality. I mean, I think – at least again, as I sort of understood the intent, Leslie, maybe I'm wrong, that this was more of an adverse event patient safety rather than quality issue.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

It was –

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

That's correct, John.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

– yeah. The primary is clinical quality, but we have always been asked to harmonize for the measures, too. So – but the primary issue is always about quality in care.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Got it. Well, so Michelle, I think you're getting lots of input on these and we're jus – this is an exemplar –

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

Right and I knew this would be a good exemplar because I know that this one has lots of discussion around it and I wanted one that we could have a discussion around.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

But let me ask, Michelle, because as I understood Jacob's vision on this and maybe this is in a different criteria, that there was the intent that the CDS itself would be importable from external sources –

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

Um hmm.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

– or calling an external source. Is that a different criteria?

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

No, so before the Meaningful Use Workgroup brought this to the Policy Committee in February, under the certification criteria, there actually was a third recommendation, to be able to do just that, possibly using Health eDecisions as an exemplar. But based upon the feedback received at the Policy Committee meeting in February, and additional feedback, the workgroup has removed that piece from the objective.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

But my understanding is that it is included in the 2015 certification criteria –

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

Exactly. There is a question about it, specifically in the NPRM and there are questions about including it, so there'll be an opportunity to respond in that way within the 2015 NPRM comments.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Very good. And so you aren't asking us as part of our evaluation to comment on the technical difficulty of being able to consume externally supported rules or a Web service that offers knowledge services.

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

Not for this, but – I mean, it's all related so if there is feedback, it's certainly something as we go – as we pivot to the NPRM response, we could probably put that – keep that information and add that as we work on the response. Does that make sense?

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Sure, and so we will probably address that area instead in the 2015 NPRM and Arien did circulate a set of maturity guidelines and Michelle, there are actually a number of items that he circulated. It's slide 18-25 in Dixie Baker's presentation.

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

Thank you.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And they are –

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

I do have a clarifying question, because in the workgroup there was discussion, Michelle, about when rules are ingested into an HER. And those rules on clinical decision support would be under the guise of more of an FDA type of rule or algorithm, that there was a sense of where does this take place and when does it cross that line? And so was there further discussion about that –

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

Yeah, so Leslie, I just want to be careful not to confuse everyone because I know we are pretty deep in the discussion, but yeah. So number 3, which was here, is now gone. Pieces of that were moved to the immunization objective, which we haven't spoken about, but it's not in the same format that it was originally discussed.

**Leslie Kelly Hall – Senior Vice President of Policy – Healthwise**

Thank you.

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

Yup.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

So I guess let me just – before we move on to the NPRM, just a few words there, that from a process standpoint, Michelle. What you'd like us to do is go through the Word document and for the 19 recommendations, each of the people on this call will propose, based on a set of criteria that involve where are the standards maturity and what's the degree of difficulty of implementation using a rubric, which is the one that Dixie Baker had used in the past. And I looked at it and every actual element of it is quantitated, so that certainly is something that should be comparable across observers. Get back to you within one week a sense of for the 19 a score of standards maturity and a score of implementation difficulty, as well as comments that might be made of the kind that we've just described. For the certification criteria proposed, here are some concerns that we would like to feedback to the Meaningful Use Workgroup to seek clarification.

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

Exactly. Thank you, John. And I'm sure, because we didn't review every objective, I wasn't sure what we'd have for time, I'm sure there will be questions that come up. But clarifying those questions will also help the Meaningful Use Workgroup, because if this group has trouble interpreting the objective, then we probably need to further refine the objective.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And then, of course, we're going to do this individually, but then there will be two meetings where we have the opportunity to review the collective responses and then hopefully come up with a consensus recommendation on standards maturity and degree of difficulty in implementation.

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

Exactly. And so what I will do is pull out the criteria from what Arien sends and share that with the group, with a reminder of the due date of when we're hoping to get all of this back.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And then – so, given that we have just a few minutes left, I mean it sounds like a good process. Anybody on the phone want to comment on the process of emailing 19 x 2 scores, within a week, to Michelle for correlation – collation and discussion.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

As long as Michelle – sounds hard.

**Lisa Gallagher, BSEE, CISM, CPHIMS – Senior Director of Privacy and Security – Healthcare Information & Management Systems Society**

Yeah, this is Lisa, I think that's fine and I think the examples of the ratings will help as well.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Great and so again – actually, Dixie – I mean Michelle, all of Dixie's Appendix A, which is actually slide 18-34, provides a whole body of evaluation criteria in detail that I think people would find useful. It does really well align with what you had proposed in your slide, it just provides – what does high, medium and low really mean?

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

Great, I think that will be very helpful for everyone.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And then – so on the NPRM, what are your thoughts on timeline and scope of that? I did write that – the longest blog piece I have ever written on evaluating those 242 pages and identifying exactly what was new and what was old and what was changed and that sort of stuff.

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

So the response to the NPRM I did leave a bit ambiguous. We are still working to refine all of the work for the different workgroups on the Standards Committee. So, as I mentioned, most of the work is going to the Implementation Workgroup, thank you, Liz. But we do think, as I mentioned, that the Implementation Workgroup will be looking at things from a realistic point of view, but there might be a perspective missing.

So we've been discussing do we invite folks such as Arien or others, who might have a different perspective, to the meeting when we discuss transitions of care, for example, or do we do that in another meeting. So, we're still figuring that out, but my proposal was, if we decide to do it in another meeting, that this might be the right group of folks to do that with. But I do definitely want to review the 2017 criteria with this group, because it relates really well to the Meaningful Use Workgroup recommendations that you'll have just reviewed.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Are we –

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

So there's a little bit of process that we need to refine – sorry, go ahead.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Are we held to the response, the public – the comment response timeline? Because my understanding is those are pretty tight turn-around.

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

They are pretty tight turn-around so what we're hoping for is that anything related to the 2015 Rule, that we do try and get that as close as possible to the April 28 deadline. But, we are going to give more time related to the 2017 item, because those are a little bit future, not a little bit, a lot.

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

Arien, I was going to tell you that what we were planning to do on the implementation side is really focused between now and April 24 on the 2015 portion of it, with the intent to bring back something to the Standards Committee that day, knowing that April 28 is the deadline, and then move to the 2017 stuff.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

Okay. I'm just worried about whether we get enough comment in for 2015 and I'm frankly worried the 2015 will be left as a precedent for 2017.

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

Agreed.

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

And that will leave ONC in a strange position to pull things in and then have to pull them back out.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

(Indiscernible)

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

Yeah, true.

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

So, speaking of time, that's – so this group, we're hoping this first set of work will be done by the March 26 Standards Committee meeting, which then leaves a month to do additional comments for the NPRM, if we decide that this is the right group and you all are willing. It sounds like Arien might be.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Yeah, no, no I'm –

**Arien Malec – Vice President Strategy & Product Marketing – RelayHealth Corporation**

I'm always up for it.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Yea but I – so, I did this long analysis in my blog post, there were about five areas in the NPRM that had the risk of being very burdensome, I mean, and this is to the discussion we had earlier. That to say that in an EHR there has to be at least one place where decision support answers are tracked, that's not burdensome, to say everywhere, that's really burdensome.

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

Yeah.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

And so I think it's important that in the sort of four or five areas that I, or Arien or others might highlight, we just are very careful to say, this could either be good for the country or disastrous for the country, depending on how you scope it.

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

Okay. So I think, just to summarize it, ONC still has a little bit of work to do to identify what this group will respond to, but it sounds like you all are willing to respond to the 2015 pieces. So I am going to work out a few additional meetings between the March 26 Standards Committee meeting and the April Standards Committee meeting for this group. I know Liz that that might be too much for you, because you also will be working in the Implementation Workgroup, but hopefully you'll be able to attend as much as possible.

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

I will. Thanks.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Well good. I – so I think you have our full support and I think we, at this call, basically Michelle we will await maybe from you a circulation of the Dixie Baker criteria, which we will then apply to the Word document and then get back to you within a week with our scores.

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

Great. Thank you, John. And so I think with that, if there aren't any other comments, maybe we can open up to public comment.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Other comments? Well, let us open to public comment.

**Public Comment**

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

Operator, can you please open the lines?

**Ashley Griffin – Management Assistant – Altarum Institute**

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

**David Tao – Technical Advisor - ICSA Labs**

Hi, thanks. Its David Tao from ICSA Labs. Thanks for the opportunity and for the first meeting, I think you're off to a great start. Regarding the development effort or degree of difficulty assessments, which you have to focus on, I wonder, it seems very hard to independently estimate those things from scratch in about a week. So I wanted to mention that I had listened to the Meaningful Use Workgroup calls, a couple of them in the past 2-4 months, where they came up with their assessment in the matrix and those were done based on input from the EHR Association, which is the vendor association. And at that time, it was Sasha TerMaat of EPIC who was the Chair and was the representative to the MU Workgroup, so they had consolidated the input from the members and produced the low, medium, high and I think they also had an estimate called jumbo. So in – to supplement your work, I would suggest contacting Paul Tang or Sasha TerMaat directly to figure how they came up with it, because I think that there was probably a lot of work that might help you out, it wasn't just a one-way flow. But there was some give and take like trying to understand what the intent was and if it was – if they intended X, then it was going to make it jumbo, but if they intended some simpler approach, then it could only be a medium. So I think that would be helpful and I just wanted to disclose that I used to participate regularly in that group in EHRA, but have not for the past 18 months, since I'm no longer working for a vendor. Thanks a lot.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Thank you.

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

Thank you, David. This is Michelle, I will comment that EHRA is looking at the Meaningful Use Workgroup's criteria and is going to be giving us an update on their development effort as the Meaningful Use Workgroup has been refining their recommendations. With that, thank you everybody. John, I appreciate all your support and everyone else for agreeing to join this group today.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Sure, were there any –

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

Have a nice weekend. Sorry.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Any other public comments before we break?

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

No, there are no more.

**John Halamka, MD, MS – Chief Informatics Officer – Harvard Medical School/Beth Israel Deaconess Medical Center**

Very good. Well thank you so much everybody, I hope you have a wonderful weekend and I look forward to our scoring sessions ahead.

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

Thank you.