

**HIT Standards Committee
Standards Task Force
Transcript
March 17, 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

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

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

Present.

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?

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

I'm here.

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

Hi, Arien. 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? Leslie Kelly Hall? 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 with that, I will turn it back to you, John.

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

Well great. So thanks everybody for joining and our process is actually going along very well. If you recall, our last meeting we agreed on a set of formal constructs to evaluate standards maturity and difficulty of deployment using the Dixie Baker Protocol. And, oh, by the way, Dixie and Jon Perlin and I have submitted to JAMIA last night, a paper, which I'll circulate just in draft form to you, which is a way of describing the Dixie Baker Protocol with specific enumerated high, medium and low templates and other things. So we should hopefully see that published in a few months.

As we go through our 19 areas, it's interesting, I have reviewed every vote from every party on this Task Force, as well as I had sought opinions from some external entities. A medical record vendor that is known for say servicing very large academic medical centers, a medical record vendor that is known for servicing Community Hospitals and smaller community organizations and the EHRA, just to get some, not votes per se, but to get some validation of what we thought. And I think what you'll see is that as we look at the standard deviation across the voting of high, medium and low, as we go through a set of categories today, that you will, I think, see that we actually have pretty good clustering and agreement on many of these as to their standards maturity and the difficulty of implementation. So that's good news.

I did ask Michelle how many calls exactly we had scheduled, she said, two. So, we'll try to work through these in a workman like way, and believe me, I want ample discussion, don't want to bias the jury. But as we go through each slide, what I will say is, here are the votes, here's the count, here's the high, mediums and lows and here is a strawman based on consensus, and then get discussion on that strawman. So with that, Michelle, shall we kick off the slides?

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

Yeah, Altarum, I think you can click through one more. I think John's covered this, the next slide. One more click. So today we're just going to go through the first 12 objectives, or at least try to get through the first 12 objectives. Next slide. So the first one is clinical decision support, and we started to talk about this during the last meeting. And just a note, when we first distributed this, there have been a couple of changes, so the Meaningful Use Workgroup presented their recommendations to the Policy Committee last Tuesday. They were approved, but there are just a few minor tweaks and changes that have been made, so some of the changes won't – were not reflected in what you had reviewed. So, just keep that in mind. Most of them are pretty small, but I will let you know if there is something significant.

So for example, the one language tweak was made for the certification criteria element, for the ability to track CDS interventions and user responses, they just tried to clarify that a little bit more. And in the Word document matrix, there was more detail about what that actually meant, which I think that item did cause some confusion. So, just want to make people aware. So John, I just want to check should I walk through the results?

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

Well – so let me just

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

And then – how do you want to –

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

Sure, so as we look at this slide, we know that CDS is exceedingly important and desirable. But as it is currently stated, that we are going to be tracking CDS interventions and user responses, we will perform age-appropriate maximum daily dose, weight-based calculations and the specific nature of the CDS is to apply to the clinical quality measures in four of the six National Quality Priorities. And so what you see is the sense of the group that the standards maturity – I mean, you've got five lows and one medium, and it's really three of us who said low and two vendors that said low. And on development, you've got six highs, two mediums and one low.

And so, I guess, just to open it up for discussion, the strawman on this one would be, for CDS, as it is articulated in this specific Meaningful Use Workgroup recommendation, it appears that the standards maturity is low and the development effort is high. But, comments, especially around things like tracking every single user response.

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

So John, this is Liz. I'm in concurrence with what you just said. I mean I think you described well what the challenge is, again, in full accord with the criticality of CDS, but trying to track every response and then appropriately move from there is a long way from where we are today.

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

And – this is Arien, I would add, my comment was that implementing crappy CDS is easy –

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

– implementing excellent CDS is exceedingly hard. And this is an area where I would much rather lean on the changes in the payment system and allow flexibility in how IT is deployed to support those, rather than constrain an artificial set of criteria, that if it'll lead us towards probably the easiest thing to do, which is crappy and ineffective CDS.

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

That's very, very well said. I mean, I think we all can agree that as we see fee-for-service moving to global capitated risk, we are seeing economic incentives align in new ways. So that new IT tools and techniques, prospective and retrospective, and new workflows are being deployed as opposed to we're going to put a bunch of rules in to an EHR, I am not absolutely certain that alone will be effective. So, other comments before we declare this one "low" and "high?" Well, Michelle, I think we actually have a group consensus on this one.

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

Thanks, John. I actually have one additional question, if there are specific comments that we want to make sure get tossed back over. So I think Arien's comment would be something that we'd want to make sure goes along with the consensus, but I just want to confirm. So for each one, as we go through, maybe we could agree upon any additional comments.

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

Sure. So I think Liz summarized it well that the nature of tracking every user response is a very substantive development effort. And then just the philosophical point Arien made which is, if CDS is going to achieve an outcome, the – maybe this is one where we actually through payment reform, align incentives to an outcome as opposed to have prescriptive CDS, which can be done very badly. I actually chatted with somebody the other day who spent millions of dollars buying CDS rules from a third-party vendor, only to find that they were actually quite ineffective in their workflows.

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

Yup.

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

Thanks, John.

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

Okay.

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

It strikes –

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

So John, this is Anne LeMaistre, can I just ask one question, though?

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

Deaconess Medical Center

Sure.

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

In the slide deck that was sent out that was Dixie's methodology or on the group's methodology, on development, low to high, "low" actually said there were a few off the shelf, indicating there was a high level of development. And "high" indicated that there was a lot of supporting infrastructure. So I just wanted to make sure when we say "high" we're going to say that that means significant development is needed.

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

Deaconess Medical Center

That is correct.

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

So we might want to correct our methodology, just so it reflects what we're actually saying.

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

Yeah, just to be clear, the methodology that the NwHIN Power Team proposed, the Dixie methodology, was a standards readiness or a standards maturity model. And so that was intended to be the development effort with regard to implementing the standard, not the development effort with regard to incorporating the standard into EHR-based workflow.

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

Deaconess Medical Center

So, yes. So to clarify, the standards are very early in their development and would require substantial effort to bring them to maturity, whereas what we're saying is to code actual change in an EHR would be very, very significant to implement this one. So you're right. Arien, good clarification on the difference between the EHR level of effort versus the standards development effort.

Okay Michelle, I think we're ready to move on to slide number 11, which is taking us to demographic and patient information. And specifically, preferred method of communication, ability to capture occupation and history code, sexual orientation, gender identity, disability status, and then the general application of communication preferences to visit summary, reminders and patient education.

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

John, I think we skipped on, we skipped order tracking.

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

Deaconess Medical Center

Oh, sorry. My mouse slipped, sorry about that. So –

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

Can we go back to slide 7?

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

Deaconess Medical Center

So slide 7, yes, that is correct. Sorry. So –

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

Oh, the slide numbers are off, sorry.

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

Or is it slide 6, slide 7, what is it in your –

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

Slide 12.

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

The slides are off from what was sent out though, I think. It's slide 7 in the deck that was distributed.

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

Yeah, okay. So sorry Arien, I slipped. Slide 7, improving quality of care and safety, order tracking. And this is specifically follow up orders to improve the management of results, results of specialty consults, return to ordering providers. In effect, this is closed loop management to ensure that orders and referrals are actually done, and if not done, then escalated. And here, very similar kinds of votes, that the maturity of the standards 5 lows, 1 medium, and development effort 4 highs, 2 mediums. So comments from the group on a proposal, this as well is low/high in terms of closed loop ordering and consult workflow implementation.

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

And my comment here was that there's actually three completely different certification criteria, each of which has very different implications in terms of standards maturity and development effort. So, displaying abnormal flags for test results as they are sent by the lab is a very different kind of certification criterion with regard to standards maturity and development effort than order matching to results and full closed loop referral tracking.

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

So Arien or John, based on that, since this is a menu item, would – when you get to the what would we recommend, could we recommend maybe something that – a piece of this that's better developed, therefore not blowing the whole measure out? But instead saying, here's a part that does have potential to be a menu for the 2017 edition.

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

So Arien, would love your input on this, but at BIDMC, we have an ability to display lab results and their abnormalities and then offer a sign – basically a physician who views it and takes accountability for dealing with that abnormal. So it's a lab workflow that actually works pretty well. Whereas close loop referral tracking across multiple organizations, although it has been done by one group in our – in Boston, it's unbelievably hard and expensive to do right.

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

Right.

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

Agreed and I'd also add that tracking an electronic order through to completion at the lab and then back to its result sometimes can be done on the basis of an order number an ascension number, but there is a lot of art that is not very well explored there. So I'd agree on bo – on that and I'd add that one more.

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

So Michelle, maybe the comment being that we think this one is low/high, but the problem is it conflates a variety of different concepts of varying difficulties, and therefore, maybe a scaled back menu item that focuses just on lab abnormal display and sign off or something like that might be a reasonable starting point.

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

Okay, well if no other comments, then we will move on to – slide 11, for real this time. So, that's demographics, patient information with preferred method of communication, occupation, industry, sexual orientation, gender identity and disability status. So, interestingly enough, we do have quite a series of split votes on this and I have a feeling that's a result of, for the – just like the last one, there are multiple different domains being referenced here. So we have 1 high, 3 mediums and 3 lows. Development effort, 2 highs, 4 mediums, 1 low.

And let me just quickly comment on what I think are some of the gotchas on this one. The preferred method of communication, the challenge is, is there a vocabulary for that, phone, fax, email, PHR, smoke signals, Morse code, etcetera. And the fact that you then, based on offering that series of choices, would retrofit your visit summary, reminders and patient education materials to follow whatever vocabulary. And Michelle, is there a stated intent by the Policy Committee that you must offer a Twitter feed or that you can declare that you only offer two options, a paper-based, regular old mail or PHR and nothing more?

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

The intent was whatever technology is available to the provider. And I think there's more details in the matrix, we just made it higher level for the slide, so it's missing that piece here.

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

So that's sort of one area, just of general concern. Occupation and industry codes, certainly we can talk about constrained vocabularies there. Sexual orientation and gender identity, I actually have a paper which I can circulate to the group, if you're interested, about early attempts to enumerate how to gather such information. It's a fascinating paper because what it suggests is it's very difficult to categorically state sexual orientation and gender identity, it is better captured by asking the patient a series of questions, the answers to which then create a constellation sexual orientation and gender identity information. So that's one issue is the immaturity of that standard and the fact it's a good and novel concept, but not widely deployed.

The other is do you, and again Michelle, standards – or Policy Committee question, suppose that gender identity is suggesting that the patient has more female characteristics than male characteristics, how does that apply to patient education materials or decision support, which today are expecting binary administrative fields based on phenotype? Was that discussed, to your knowledge?

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

Umm, no. There was discussion that it should be – the SOGI information should be entered by the clinician or the provider, not something entered by front-desk staff, so that it's coming from a clinical perspective, but that was really the only discussion item.

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

I'm reminded that –

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

One –

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

Sorry, go ahead.

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

Please, go ahead.

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

No, I'm –

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

So just one more note, they did discuss at the Policy Committee that they wanted to add a note about a report coming out from the Institute of Medicine and that they should be using HHS's demographic data collection standards. So, I just want to make sure that that's an additional note that has been made to this criteria.

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

So Arien, please go ahead.

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

Yeah, I'm reminded, John, per your discussion that the CDC ultimately went to a men who have sex with men designation with regard to HIV risk, because of the inherent difficulty of capturing meaningful sexual orientation in a way that worked across different – people of different cultural backgrounds. The people contextualized behavior in very different ways, in ways that were not culturally stable. And I also note that I looked at Facebook for this one, it's probably the vanguard for how to do this for gender identity and discovered that Facebook codes gender as male/female/other specified.

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

Interesting.

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

So Michelle, I've just forwarded the two papers to you and so feel free to circulate. So, the question then, if we were to take into account that input, the standards maturity, although probably high on occupation and industry and maybe there are disability codes that are reasonably mature. Sexual orientation, gender identity is sort of a – it's a work in progress and preferred method of communication I think at the moment, would have to be made up. And so the question is, do we set this one as low or do we set this one as medium, given that we have a tie?

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

I would lean toward medium given the – medium – standards maturity I would lean toward low, given the constellation of issues, with the comment that occupation and industry is likely high, disability status I'm not aware and trying to lean on your assessment there, and that the others are likely low.

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

Yeah, and so that is a strawman then that if what we say is – we actually break this up and say, it's kind of – we worry that these are evolving and therefore low, although pieces of them, such as the industry and occupation codes and potentially disability status may be higher. Does that sound reasonable Michelle?

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

Yup. Thank you.

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

And then on development effort, now this one again, we see 2 high, 4 mediums, 1 low. And I mean, taking into account – we actually don't quite know the intent of the Policy Committee here to modify decision support or patient educational materials based on these items. So, I mean the strawman I would offer is it's probably medium, but could be high, if you intended the consequences of these demographics to flow into other areas.

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

John, this is Michelle, I think I misinterpreted your question earlier. So the intent of the communication preference piece was that when you're giving the patient their reminder, you're giving it to them in the format that they requested, not that some of these – so, and part of the discussion again at the Policy Committee was that these things should be separated because they don't necessarily go together.

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

Right.

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

So that's part of the confusion, but – it's really that those things should be given in the preference that the patient asks for them, but not that the demographics or any of the other information discussed should inform that.

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

Right. But, I just – I mean completely understood, but you can imagine that if a person is phenotypically male, and I give them educational materials for a male, but that their gender identity is female, that that could create an awkward moment.

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

Yes, it could.

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

So, I don't know, I'm – is it fair to say to the group, this is medium but also could extend to high depending upon the scope of the change that might apply to education materials or decision support based on the answers to these questions.

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

John, this is Anne, I would agree with you.

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

I also think I worry that the – again, intent of the Policy Committee, but if I prefer secure messaging, but I happen to phone the office and get a reminder on the phone, does that – what’s the intent there regarding to always following the preferred method of communication? That may be a default, but not the only way that the patient prefers to receive that information.

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

Right. So, the challenge with all these is there are workflow implications, so, medium for now, but potentially high as we clarify language.

Okay, so let’s now move on to 14, I think that’s the next one, care planning - advance directive. And so this one, in scope its core for hospitals, menu for EPs, record whether a patient 65 years or older has advance directive and the ability to store a document or a pointer to the document. And the standards maturity is 2 highs, 2 mediums and 2 lows. Well, that’s helpful. And development effort is 1 medium, 6 lows. And so I think the reason for this is that it’s sort of a question of how is it that we think an advance directive should be represented?

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

Should it be represented as codified data in a structured data elements in a C-CDA document? Should it be a yes/no question with a pointer to a URL? And I think the answer is, those are two very different standards maturity and development effort questions. So what I might hypothesize is that if all we’re doing is answering yes/no and having a URL that actually standards maturity is high. If what we want is structured information in a C-CDA, standards maturity is low. But, other’s comment on that?

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

Yeah, I would say I assumed simple storage of a document and/or a text box in my assessment, so I gave them the function.

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

This is Michelle, I just want to confirm that the intent is the former, so, it really is just a “yes” or a “no” and a link to a URL.

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

Okay, so I have one question. When you all were discussing this in MU, I happened to be part of a particular discussion and there was a lot of discussion about whether or not – what our responsibilities as providers were around ensuring it was the current advance directive and how we manage that. Was that – and the reason I’m asking the question now is, is there anything else that’s in the longer version of this than what’s represented on this PowerPoint? Is it strictly storing an advance directive and that’s the end of the requirement?

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

Umm, it’s not even storing it, it’s just “yes” or “no” did they have it and then a link to a URL or the ability to store it, but –

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

Okay. Okay.

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

Very good, so, if we re-scope this one as yes/no with link, do we say that standards maturity is high and development effort is low, is that reasonable?

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

With the assumptions clearly stated.

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

Yes.

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

Right.

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

Right. Agree.

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

Okay. Good. Hey, Michelle, we are working through these in a work – in a pretty reasonable way – so are we – let's see. So next we will move on to 16, electronic notes. So EPs record an electronic note authored by the eligible professional, electronic progress notes excluding discharge summaries, should be authored by an authorized provider and the notes must be text-searchable. And so, Michelle, could you clarify this one for me, because I've seen it go both ways, searchable across all notes or searchable within a note?

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

Searchable within a note, I believe. It's – that piece has not changed since Stage 2.

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

Ah, okay.

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

So they just were really using the langu – same language that was in Stage 2, the only change is that they want to make it as core for EPs and a higher threshold.

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

Well and it wasn't core for EHs either, last time, and now it says core, so it –

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

It's core for both, I should have clarified, core for both.

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

And does this mean that if you have electronic progress notes they should be authored, or does it mean you must have electronic progress notes?

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

So, it means you must have the functionality, presumably it's certification 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

And that is the reason we look at the scores and we've got standards maturity 1 high, 1 medium, 3 low and then development effort, 2 high, 2 – 4 high, 2 medium. I think it's assuming that robust functionality for the creation of notes, which might say include structured documentation would be required.

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

And just as an additional note on the note, the term discharge summary I commented, if you – is a poorly defined term, because there is a discharge summary Consolidated CDA template that includes structured data as well as textual data. And so I wondered if the intent of discharge summary as being course of acute stay and discharge instructions. And if the intent was that that data, that textual data, also be included in the Consolidated CDA.

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

Yeah, and, so that's – so again, kind of interesting question would be, just like with advance directives, if this is just a BLOB and it doesn't have any particular structure and that BLOB goes into an EHR, is editable at an EHR and then goes in a transition of care summary, for example. That's quite different than a structured note, which has pieces and parts that becomes compartmental – in a CDA, it fills out a template of some variety.

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

So I wonder on this one why though the votes are so all over the place, because if it's imputing a text BLOB, I'm not sure what standards are exactly involved, I mean, it's exporting a text BLOB, as long as there is a CDA template for free text, I don't see that that's specifically requiring much standards heavy lifting. So –

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

Yeah. So again, my comments, and I don't remember how I scored this was, assuming that text searchable meant within a patient as opposed to within a note, so that would drive down the development effort there. And then I assumed a text BLOB, but I also assumed a semi-structured text BLOB in the sense that it would populate the appropriate sections of a structured Consolidated CDA, including the discharge summary Consolidated CDA. So I assumed a little more of a granularity in terms of the text that was captured, than perhaps your comment would have suggested.

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

Got it. And so one of the things you could say is, well, if this is in fact just the capture of text, which may have semi-structured nature to it, and its incorporation into a C-CDA. Well then the maturity of the standards is medium to high, but the development effort could be high to create de novo clinical documentation functionality and export capabilities.

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

And so, do we want to declare standards maturity, do you think, medium and then development effort high?

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

Yeah, can I ask one question, and I don't know if this will change those ratings or not, but when I read electronic progress notes, I am assuming that is indeed the course of the episode of care and does not include admit note, H&P, surgical note. Is that a fair assumption on my part or is that a – ?

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

Yeah, I don't know if it is or isn't, that's the problem.

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

Yeah.

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

This is Michelle, yes, that's a fair assessment.

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

So it is simply and use the word "simply" carefully, is simply a note that I make on a daily basis or bi-daily or whatever is appropriate given the patient's condition, that's documenting the progress. It's none of those other documents and you're saying, Michelle, that is correct.

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

That's correct.

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

Okay.

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

Good. So the strawman, standards maturity medium, development effort high and I think also the assumption, Michelle, I keep reading in various documents coming out of the Meaningful Use Workgroup that the intent is to search all documents within a single patient and not just the Meaningful Use Stage 2 within a note thing. So, I don't know –

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

So, we'll ask for clarity on that, but that wasn't the intent.

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

So you're sure, because –

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

Yes.

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

Because that's what was in a couple of PowerPoints, so –

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

We've changed this a lot, the language has changed quite a bit.

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

And Michelle, must remind us, what percent of patients – discharged patients have to have progress notes?

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

In Stage 2 I believe it's just one.

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

Yeah, I knew what it was for Stage 2, I was wondering what was proposed for Stage 3?

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

So they didn't do numbers for Stage 3, they just did high, medium or low.

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

What does that mean?

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

They're leaving it up to CMS but will obviously be much higher than one.

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

So I –

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

High typically was 50% or more.

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

Well that's my concern, we've gone from virtually nothing to greater than 50% of our patients have electronic progress notes, that – I realize we're talking about certification criteria, John saw with a caveat my remarks appropriately. But that is a huge jump for the industry. I don't know what the penetration of progress notes, electronic progress notes today is, but I would suggest to you that it may be far lower than you think, or you may know.

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

Yeah, I mean, so the challenge is that all they've said is high –

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

– and so, right, we've experienced in the past that Meaningful Use has had 5% as low, 30% as medium and 50 or 60% as high.

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

Right, so that's –

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

So – sort of separate issue, it's more of a CMS issue, that going from zero to 60 –

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

– in one step is probably more than the industry can take right now.

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

Right, and that's – I was just asking if that's an appropriate comment back, recognizing it's not necessarily associated with standards or certification criteria, but I think it's something that we certainly have the knowledge to comment on.

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

Yup. Okay, well, we'll go with medium and high and there's just the clarifications, Michelle, on this one on searchability across multiple notes. And then just we do, for the record, just have a concern if you try to impose a 60% criteria, that would be quite difficult, not a certification issue.

Okay, hospital labs, eligible hospitals must provide structured electronic results using LOINC for ordering providers. And the standards maturity on this, 3 highs, 2 mediums, 2 lows. And development effort is 3 highs, 3 mediums, 1 low. So, on this one, I mean, again, Arien works in this realm quite a lot, I mean, I would think that although our ordering standards are still emerging that the laboratory results using LOINC are actually pretty robust and pretty widely adopted in our EHR communities.

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

Yeah, that would not be correct. I can do an assessment, if you wish, on the lab feeds that we currently have, but the last time I looked at this, almost all of the high volume lab at hospital-based community reference lab customers that we supported used proprietary terminology for their reporting.

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

So you're saying our problem's going to be when we – not from our internal labs that use LOINC, but from our reference labs that we're just porting over and reporting.

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

Yeah, so, the national labs, Quest and LabCorp –

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

Yes.

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

– are ready. The hospital lab that serves the community providers, the health system-based, hospital attached laboratory facility that serves community providers I think more investigation would be necessary to determine whether they're LOINC ready. The last time I looked, which was a couple of years ago, the prevalence was highly towards proprietary code sets.

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

So it's interesting. I mean, yeah, my experience in Massachusetts is that Quest and LabCorp are good and that our hospitals, purely because we have over the last multiple years done a variety of HIE activities, have fairly regularly implemented LOINC codes. But you're absolutely right, that may be an aberration.

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 let me take the action, so do a sampling across our current customer set, and determine current status and LOINC readiness.

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

And so, basically we're – I mean, I think probably the standards maturity on this one I would just postulate would be medium to high, depending on Arien's remarks on the – I guess, is there a difference, Arien, between the state of the standard and the state of hospital reference labs using that standard?

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

Yeah, so I rated this as high standards maturity, high development effort to do the conversion.

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

Because that's what I would say probably true is that the standard's okay, it's just that the development effort could be substantial.

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

And is your thought John or Arien, that we would receive these results into an EP or E – I think this is EP, or EH, excuse me, an EH and then we would have to add the LOINC codes? Because for example some of our academic hospitals use two dozen reference labs for very specific testing.

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

This is the other side of this. This is the other side of this, this is a community physician who orders from the –

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

Hospital –

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

– hospital-hosted reference lab...

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

Gotcha.

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

– and receives that result.

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

I see, this is not what we're receiving from the reference labs that take care of our internal patients.

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

Correct.

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

Okay.

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

So the only thing that Arien I might see is we have this very odd circumstance where a community doc orders a test from us and we send it out to a specialty lab.

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

Right.

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

And then receive it back from the specialty lab and then forward it on to the doc.

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

Correct.

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

Yeah, and we – and it doesn't have a LOINC code associated potentially.

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

Right. So that's why, and it's not a standards issue, it's just a development issue. So if we declare the standards high, development high, then I think we're probably in good shape.

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

Right.

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

Okay, next. Unique device identifier, so this is completely new, EPs and EHs should record the FDA UDI when patients have devices implanted for each newly implanted device. We have standards maturity 1 high and 5 lows. And development effort, 3 mediums and 4 lows. Now, so let me just comment on this, we know the FDA has worked long, hard and tirelessly and has developed a very good implementation guide for this that to my knowledge, is not deployed anywhere in production. So, it's good, it's excellent work, we want to see this used, it's very important. But I would say that the standards maturity, we see our vote here, is declaring it simply low because it's not deployed anywhere.

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

Well, I think the other thing is that we want to make note of again is, because – even though it's a menu item, how many people are going to try that comes in as a high threshold when they're barely getting started and they have to even qualify for menu status, it's at 50% or 60%.

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

Yeah.

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

So maybe 50% or 60 % of two wouldn't be too bad, I don't know, you know what I'm saying.

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

Right, and the development effort on this at the moment is a free text box where –

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

– somebody types in a number.

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

And has no checking to see if its valid or not.

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

Right, so, it would seem that this one is standards maturity low, but development effort to capture one new field, and I don't know, Michelle, has there been any notion of automated alerts and reminders, recall tracking or anything of that nature?

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

No.

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

So then it would probably be development effort low.

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

Yeah and hopefully, I don't know if the UDI has check – or other kinds of constraints to ensure validity, but I would assume it would be semi-structured in the terms of capture and validate.

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

Yeah. So, my question is, do you want to declare it low or medium, and maybe the answer is it's low if its text, its medium if there is some kind of validation, whatever that may mean. Check some analysis or going out and checking for validity in a data structure or something like that. So, if we declare it is standards maturity low and development effort low, but could be medium if there was significant validation required.

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

And I'd add that just capturing a text field to capture UDI has extraordinarily low utility –

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

Yup.

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

– because what you want to be able to do with the UDI is actually use it for something.

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

Right. And so, right, if this one were going to be more meaningful what you'd say is, and automate if a device is recalled, the alert somehow, of the provider or the patient that such a device had some issue. That would have utility, that's hard, but as you say, as stated, the development effort low to medium, but not a whole lot of utility for that low to medium investment.

Okay, Michelle, I think we're on next to view, download and transmit. So this one, EPs and EHs provide patients with the ability to view, download, transmit their health information within 24 hours, generated during the course of a visit and threshold for availability is high, use is low. Labs or other types of information not generated within the course of the visit are available to the patients within 4 business days. Well of course, the hospital or the EP may have absolutely no control over when that information arrives. And then, add family history to data available through VDT. So the votes on this one, standards maturity 4 low, 2 medium. And development effort 2 high, 1 medium, 4 low.

And so I guess this presupposes you have that Meaningful Use Stage 2 functionality already in place, and really all you're doing is changing the timeline and adding family history data. So in some ways it has possibly profound workflow and attestation implications, but from a certification standpoint, it's simply incorporating the family history into existent code.

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

Yeah, so I commented that if it's permissible to collect and represent family health history uncoded, then there's no standards issue. But that if there's – if we required coded and structured history, we've got low standards maturity.

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

Right, so that either SNOMED-CT or HL7 pedigree, they both exist it's just – I mean, they will be widely adopted, because they are certification criteria at Stage 2, but not yet. So I think we have on this one, standards maturity low and development effort boy, we're really split on this one. We've got lows, 4 lows and 2 highs.

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

And one medium. I'd split the difference on this one. My other comment is there's a significant operational issue, I'd love for Liz to comment on this. This – the bigger issue is how long does it take to get the transcription and to get all the information available such that it can be released to the patient?

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

Yeah, we – so, our data moves across for their viewing during the stay, so ours is real-time move.

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

Umm.

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

And I will tell you that today the requirement doesn't have, other than discharge summary, and we collect all that data down to the discharge date, but every data element mo – or data, yeah, data element moved real-time. So what we're doing with our patients is encouraging them to engage in their record during their stay. So that's how we manage this. Now one of the – and that's one of the discussions we've been having with CMS is the idea that somehow we can capture what they looked at when is – and the same thing you would find in an EPIC shop and John, I don't know how yours works. But we – all of our data is generated real-time, because that's the id – in our heads, the idea is, the patient can engage with their data not only post-stay, but during stay as well as future stays.

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

Right. Yeah, and so we make everything available in real-time except certain data elements like new cancer diagnoses and HIV status –

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

– which we delay. But –

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

Yeah, we have a 36-hour delay right now on lab and I know that's a really – we've had many discussions with the Medical Staff about the fact that if you look at the new CLIA rules, that the reference lab can give it to them immediately. And so, I think this is not a standards issue, but a change in the way we provide patients information. And like yourselves, John, we also have "sensitive data" that we may never display.

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

Right.

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

And then we have minors and psychiatric and I mean all those sort of quandaries that we have to deal with.

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

And so on this one then, do we declare the standards maturity on this one is low if you need structured family history and the development effort on this one is medium? And the workflow implications could be very significant, but that's not our issue.

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

Yeah, I think the only thing is that this – the way it reads here, and again I don't know whether this is a synopsis or where we'll end up but, it says if generated. And in the previous wording, I think it said if available. And the only reason I say that, John, is the very examples that we gave around data that we – is generated that we don't necessarily make available.

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

And I do think actually the operational implications are part of our mandate, in the sense the Implementation Workgroup's charter –

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

Yup.

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

– is exactly that.

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

Yup, yeah, and it certainly has to come from there but again, because I think the language has changed from “if available” to “if generated,” and I’m not trying to wordsmith it, I’m just trying to – Michelle, you may know whether that was an intentional change or whether that was – is just the generality that’s landed on this PowerPoint?

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

I honestly don’t remember if that was an intended change, so I’ll make sure that we clarify that with the workgroup.

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

Okay. Good.

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

So standards maturity on this one, as you’ve got Michelle, low if it’s structured family history and development effort medium.

Okay, patient-generated health data, so eligible professionals and eligible hospitals receive provider requested electronically submitted, patient-generated health information through either at the discretion of the provider structured or semi-structured questionnaires, such as screening questionnaires, medication adherence surveys, intake forms, risk assessment, functional status or secure messaging. And the standards maturity on this one is 2 mediums, 4 lows. And development effort is 3 highs, 2 mediums, 2 lows.

So I would suggest on this one the consensus is that if it’s receiving patient-generated data through either of two mechanisms, it seems as if we have low standards maturity and high development effort. It’s a noble and good thing that we all need for accountable care organizations, it’s just not widely done. So comments?

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

Agree.

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

Yup.

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

Yup. I agree, too.

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

Okay, well Michelle, that one wasn’t hard. So we –

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

And just the other thing is – just as a note for the Policy Committee, they need to be very clear, if “either” means “both” or if “either” means “or.”

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

Well –

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

It means “or.”

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

Right, but –

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

So is it –

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

But for cert that means “both.”

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

Yes. Is it permissible for the EHR – to support just one?

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

Right.

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

Or is it at the patient’s preference, in which case it’s both?

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

Yeah, and so every other Meaningful Use certification that has been enumerated this way means the developer has to develop both strategies, which are configurable by the provider and so, the level of development effort is going to be high. That’s my guess, but Michelle, if you – have you heard anything to the contrary?

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

No, you have it correct, John, that’s the intent.

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

Yeah, more work for vendors, they don’t have anything else to do –

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

It’s easy.

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

That’s right, Okay, next. So that was patient-generated health data. Secure messaging, no change in objective, patient’s use secure messaging to communicate with EPs on clinical matters. Certification criteria, capability to indicate whether the patient is expecting a response to a message they initiate and capability to track the response to a patient-generated message, no response, secure message reply, telephone reply, etcetera. Standards maturity we’ve got 1 high, 5 lows and development effort we’ve got 3 highs, 3 mediums and 1 low.

Now, we could, but it’s probably above our pay-grade, debate whether or not Meaningful Use needs to get as prescriptive as describing the way an email system needs to work. But, we have it laid out for us as two exceedingly specific and prescriptive functional criteria with, it appears, standards maturity being uniformly low and development effort a bit divided. So, any comments?

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

The only comment I would make John, and you're right, it's not – I'm not on the subject again about subject – about the standard or the maturity and so on. But as a physician, how do you respond to this? I know how the physicians that I talk with routinely will respond about being told that they – a patient can tell them they expect a response and that they have to document it. I don't think – I think that would be a fairly universal response. I mean, I already have docs worried about people sending stuff to them in the portal that's inappropriate to be sent that way and blah, blah, blah, blah, blah. I'm dealing with that, that's a growing change in the way medicine's practiced. But, how do you feel about it? I mean, how would you feel if you got a note from your patient, maybe not even your patient, expecting a response? And can we comment on that or do you want the Implementation Workgroup to do it?

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

Yeah, I mean that's probably an Implementation Workgroup item, but, we have been doing secure messaging since 1999 and in that implementation, early on, we ended up putting up dashboards and taking messages that were sent to the office and distributing them based on workflow to non-physician extenders –

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

– where there's the notion of an individual clicking on a message and saying, I take accountability for this message and therefore it disappears from the dashboard. So, it was a different workflow than they're articulating.

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

Ditto, exactly the same and I'd also note that – and so we do track response, including offline response, but I'd note that our response thresholds are physician and practice-determined, not patient-determined.

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

So maybe on this one, Michelle, we offer the following advice, standards maturity is low, development effort could be medium or high. The challenge here is that the industry already has implemented multiple workflow solutions to ensure that communications are closed loop, and it just seems to us to dictate that there must be one workflow is really inappropriate.

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

I mean, the objective is closed loop communications, but how you achieve that can take many forms.

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

Right. So we encourage the concept and discourage the specificity.

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

Exactly. I mean can you imagine Arien, RelayHealth has been doing this for almost 20 years and you'd have to rewrite all your applications because the way you chose to implement it differs from the way a regulation states it must be implemented?

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

It's slightly frustrating.

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

Yah. Okay, and chances are you've had the experience of hundreds of thousands of patients, if not millions, who have decided how the workflow actually is best done, as opposed to a suggestion of a small group, but anyway.

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

Correct.

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

Okay, so let's move on to slide 31, engaging patients and families in their care, visit summaries, care for EPs, provide office visit summaries to patients or patient authorized representatives with relevant, actionable information and instructions pertaining to the visit in the form media preferred by the patient. And certification criteria, EHRs allow provider organizations to configure the summary reports to provide relevant, actionable information related to a visit with standards maturity on this one being 1 high, 3 mediums, 2 lows and development effort 3 highs, 2 mediums, 2 lows.

So, my comment as a physician is, I have no idea what relevant, actionable information is.

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

Amen.

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

I mean, is relevant, actionable information, you need an appointment and here's a phone number? Maybe. Lose weight, stop smoking, exercise more? I don't know.

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

This is Michelle. So they grappled with this language a lot and they did receive comment from the RFC that it was unclear and they did try and update it. What they're trying to say is, from Stage 1 there were a lot of clinical summaries produced that were meaningless to the patient because of all of the information that was included. So they're intent was that the summary would be on – regarding that current visit and would be provided to the patient in a way that they would be able to easily understand it.

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

They're going to mandate usability in a Meaningful Use criterion?

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

Great. So, what I just don't under – I mean, believe me, I am as patient and family engagement positive as anyone, but I just don't kind of underst – to Arien's point, I don't know how one mandates that – who assesses relevance? Who mandates usability? And how can any regulation create measureable usability? I don't know. So I'm not even sure what standards we'd even be talking about. I mean, we could easily say the development effort is going to be high, because we're creating something that is of amorphous requirements.

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

But, I mean, I don't know, does anybody else on the call have any idea even what standards would be relevant? Expansion of Infobutton? I don't know.

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

Well John, if you put three of us in the room, we'd all have three different relevant opinions.

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

There we go.

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

Exactly. So I think this is again one that parts of it could be done fairly easily, like the instructions. I mean we do that, that's part of our current workflows. To me the maturity on that's much higher and the development would be lower. But when you get to these others, it's hard to – just because you can't interpret them.

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

Yeah. So, on this one then, maybe the answer here is, we believe the development effort is high, because we don't know how one can define usability or relevant and actionable with a standard. So, I mean the standard's maturity, we're not quite sure what we're standardizing here. I mean – unless, as you say, we highly constrain this to say, it's going to be educational materials and the nature of the Infobutton standard will have to be expanded somewhat or something of that nature.

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

Yeah, I'd also add that, I mean I understand the frustration of patients getting lots of data that may be historic or of limited value. But what is of value to a particular patient may not be – may include more information that was collected in the visit and it may not include information that was collected in the visit and ultimately a clinical judgment and a patient judgment. It's inherently hard to do this in a way that's generalizable and scalable.

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

And of course, maybe Michelle you could also tell us what the word form and media preferred by the patient means. I mean, does that in –

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

So that was because of the concern – so originally – the intent was that they heard that a lot of the patients were getting pages and pages of paper and then leaving it places that would make their information available to others. And so their concern was that it wasn't intended for them to have to necessarily print it out, but it could be given to them through a patient portal or something like that.

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

Because my preferred form would be a YouTube video of my follow up instructions, what do you think?

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

If the intent is – if the intent is to let the patient access this through VDT –

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

Right.

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

...then that's what it should be stated.

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

Yeah, and unfortunately because there are some pretty stringent requirements around that, they are going to get information, which they may or may not find helpful.

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

Correct.

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

So, do we have a consensus on this? We really need, I think, more clarification of the intent here and if it can be constrained to education materials or VDT or something of that, then we could say more about standards maturity. But at the moment, all we can say is, this appears to be high development effort and probably nearly impossible to certify.

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

Okay. And then 34, hey Michelle, is this our last slide?

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

I think so, you moved much faster through these than I expected.

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

Yeah, okay, 34, engaging patients and families in their care, continue educational material objective from Stage 2 for eligible professionals and hospitals. Additionally, eligible providers and hospitals will use the CEHRT capability – in fact, I should ask you Michelle, how do you pronounce CEHRT?

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

Cert?

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

Yeah, okay. Anyway, to provide patient specific educational materials in non-English speaking patients preferred language if material is publically available using preferred media, online, printout. Certification criteria, EHRs have the capability to provide patient specific education materials in at least one non-English language. Where our standards maturity on this, 1 high, 2 mediums, 2 lows and development effort is 2 highs, 3 mediums, 2 lows.

So the one thing I found very confusing about this is Beth Israel Deaconess has 37 different languages and so to say that we can use an EHR that supports one non-English language, it's a bit like saying we're going to record the universal device identifier in a free-text box. I mean, you could, but I'm not sure that's applicable for purpose or that useful. So I just will open it to others for comments on what the standard and the development effort to support the intent of this particular objective.

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

Well I'll speak to it. Like your situation, if you get into dialects and so on, it – for if we went across 77 hospitals, it would be hundreds of them. And I think material publically available is a very difficult thing to ascertain, I mean, I – we obviously have and will always provide translation services of all types, so that potentially, I guess is publically available. So are we signing up for hundreds of dialects? And the certification criteria itself doesn't help because all that obligates a vendor to do, and I am not objecting to this, is provide one non-English language. So how do we get all the other ones done? I'm sorry, but –

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

Yeah, I assumed in my comment, that providing Spanish translation for a subset of educational materials would qualify. So I was assuming use of existing patient education support and the ability to surface up a subset of that content in Spanish. Those capabilities are widely available –

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

Absolutely.

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

– and I noted that if you've got to do all of them, it's virtually impossible.

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

Right, better said, but the same problem. I mean I think John, what you're doing at Beth Israel sounds pretty remarkable to me. But I do think that again, that the certification criteria and then what the actual standards they require differ, so I didn't know how to rate it in terms of – obviously it could be huge developmentally, but why would they develop it if they only have to certify to one, and it will be Spanish.

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

That's right. If you only are required to meet the attestation requirement –

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

Right.

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

– relative to your certified EHR technology is low. If you're required to meet the letter that's – then clearly the EHR has to do a lot more work to support that attestation requirement.

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 the standard here presumably would be the primary language would be recorded and used in some context like Infobutton, to retrieve a piece of educational material in that language, I guess.

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

I guess.

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

And so – I mean, I have used Infobutton in only a limited set of applications and I don't recall, I don't know if either of you know if language is even a parameter in most of the Infobutton implementations.

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

I don't know, do you know Arien?

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

I do not know.

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

Yeah, so, I think maybe this one we could declare that if it is Infobutton and language, I mean that's probably medium standards maturity because I'm not sure if it's supported, but it probably isn't too challenging to extend Infobutton to include such a parameter, it's – I'll check into it. But on development effort on this one, again I think it's a little hard for us to say, because the nature of the certification criteria seems so divorced from operational reality. If it's – you have two pieces of instructional material, English and other –

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

Yeah, that's right.

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

That may be only medium, but if you had to support 100 different dialects and store and curate and ensure that the patient is getting in whatever means, whether that's online or print-out from various parts of the workflow. That could be a very significant development effort.

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

Agree.

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

So do we want to say, standards maturity medium, but development effort medium to high, depending on the number and nature of languages being supported and places in which those materials become available. So, any other comments on this one? Well Michelle, I think we have a couple of minutes to spare, we've gone through our first 12. Our next call will cover 13 through 19 and I think it was very important for this group to know that the Policy Committee did approve all the recommendations of the Meaningful Use Workgroup. And do you know Michelle, I thought that there was even further discussion that the Meaningful Use Workgroup should add back in a few things that they had actually taken out?

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

There was discussion, Christine Bechtel had asked the Committee to consider adding back in reminders. The Committee voted on it and decided not to add it back in. I will say that all of the items that were removed as part of the Meaningful Use Workgroup process are still going to be included in the Letter of Transmittal, but as the items that were removed, so they are there, but not in the final set of recommendations.

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

Very good. Well folks, thank you very much for your work today, before we open it up to public comment, any other thoughts on this first group?

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

Umm –

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

Except well organized, John. It's much better.

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

Yeah.

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

We made incredible progress in a short amount of time because of the organization.

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

Well that's Michelle. She gets a gold star.

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

Absolutely, amen. We also don't have any place here, and I would just recommend at the end we circle back and look at the cumulative impact both on, and Liz, I don't know what you think here from the Implementation Workgroup, but the cumulative impact both on the total amount of support that's required as well as the operational implications. One of the things that we heard on the Information – the HIT Policy Committee Information Exchange Workgroup meeting was that in many cases, for example transition of care, the – supporting the technology was 2 weeks of effort operationally and supporting the workflow was 6 months of effort.

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

Right.

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

So if there's a place for us to circle back and look at the total level of effort both from a technology support perspective and also from an operation support perspective.

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

So this is Michelle. There – so what the Meaningful Use Workgroup had done is they had a few different categories, one of them was provider effort, which I think would get to those workflows. So maybe we revisit that in – as well as the standards maturity and the development effort, and then provide a total effort to what you're saying, Arien.

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

Yeah.

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

That would be great.

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

Right, I mean I think this is a theme that we really do need to codify, and maybe Liz to the Implementation Workgroup issue, that as I've written about and said many times, that any one of these individual recommendations has societal merit and actually doesn't look too bad. But the combined weight of all of Meaningful Use 2 and 3, ICD-10, the HIPAA Omnibus Rule and ACA, basically makes it so that a provider cannot survive their day. So, how do we telegraph that?

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

Exactly.

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

At a time, by the way, when resources are being constrained, budgets reduced and we're attempting to do more with less. But anyway, we digress. So, I think we – Michelle, I certainly thank you for all your preparatory work and I believe we have made adjudications of scores on the first tranche successfully and look forward to our next call. And with that, shall we open it up 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?

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 are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comment at this time.

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

Okay. Well folks, thanks so much for all of your effort, I hope you guys have a great week. And Michelle, could you remind me, when is our next call?

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

Our next call is next Monday, I believe, the March 24 at 11 a.m. Eastern.

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

Very good. Okay folks, well I will chat with you next week.

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

Thank you.

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

Thank you.

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

Thanks, bye, bye.

Public Comment Received

1. Hi, David Tao here. I'd like to enter a comment to submit to the committee and for public record. I can't attend the entire call so I can't make the comment on the phone. On CDS, while the TF response is understandable, I think that there may be a misperception that the HIT PC recommended tracking "every" user response. I believe their intent was only for "active" alerts where the user is forced to respond in order to proceed. "Passive" alerts which might appear but not require a user action were not intended to be tracked. I don't know if that would change the assessment, but in case the "high" development was predicated on "every" user response, it might matter.