

**HIT Standards Committee
Clinical Quality Workgroup
Transcript
December 19, 2013**

Presentation

Operator

All lines are bridged with the public.

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

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 Clinical Quality Workgroup. This is a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. Also, if you are not the person speaking if you could please mute your line it would be appreciated. I'll now take roll. Marjorie Rallins?

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

Present.

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

Danny Rosenthal?

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Present.

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

David Baker? Keith Boone?

Keith Boone – System Architect – GE Healthcare

Present.

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

Anne Castro? Chris Chute? Jason Colquitt? John Derr? Bob Dolin? Floyd Eisenberg?

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Present.

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

Rosemary Kennedy? David Lansky? Brian Levy? Rob McClure? I know –

Robert McClure, MD – Owner/President – MD Partners, Inc.

Present.

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

Hi Rob. Galen Murdock?

Galen Murdock – Veracity Solutions

Present.

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

Gene Nelson? Philip Renner? Eric Rose?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Here.

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

Joachim Roski? Randy Woodward? Kate Goodrich? Kim Schwartz? And are there any ONC staff members on the line?

Julie Crouse, PMP – IT Specialist and Project Manager – Centers for Medicare & Medicaid Services

Yes, hi, this is Julie Crouse with ONC.

Alicia Morton, DNP, RN-BC – Deputy Director, Office of the Chief Medical Officer – Office of the National Coordinator

Hi, Alicia Morton.

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

Hi Julie and Alicia, and with that, I'll turn it back to you, Danny and Marjorie.

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

Okay, so good afternoon everyone. Today we're going to continue, this is Marjorie Rallins, and today we're going to continue our discussion of items that we've received from the Meaningful Use Workgroup and specifically we've been asked to comment on standards readiness as it relates to medication adherence for certification and the certification as it relates to drug monitoring.

And if everyone has the presentation, is the presentation up? Yes, okay. So, can we move onto the next slide whoever is driving? Yes. Next slide. Okay. So, we're going to talk about those two items first. We've been specifically asked to look at the ability of the data feeds for PBMs as well as the data feeds for PDMPs and some other issues and the ability to actually look at or analyze, excuse me, that data through important signals that come from those feeds.

So, we thought we would actually have an open discussion, a little bit of a free form discussion, on the medication adherence issue what your thoughts are and then we'll go from there. And then after we talk about the medication adherence and the drug monitoring, the PDMP issue we'll also talk or ONC staff will bring us up to speed on what's happening with the 2014 work plan and then we'll have public comment.

So, with that I'd like to open the floor for the medication adherence discussion and ask you if you have any thoughts.

Keith Boone – System Architect – GE Healthcare

So, this is Keith, I would sort of – I am struggling a little bit with the information request in trying to understand what is the goal of the medication adherence component that we're being asked to evaluate standards for? What are we trying to accomplish?

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

So, as I'm reading that, and maybe this doesn't come through as a goal Keith, and then Danny you might want to jump in and others as well, but as I'm reading this the goal is to identify the standards that are currently in place that will –

Keith Boone – System Architect – GE Healthcare

I'm sorry, you misunderstood my question.

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

Okay.

Keith Boone – System Architect – GE Healthcare

I can identify standards no problem I understand that. What is the – when we talk about medication adherence what is the goal in Meaningful Use Stage 3 trying to accomplish in terms of medication adherence? Are we trying to determine if patients are adhering to medications? What's the imperative that is driving the need for standards? That's what I'm looking for.

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

So, I think this – and then ONC staff you might want to jump in, but this is my opinion, I think one of the things that some of us have discussed in the past is that this goes a little bit beyond just, you know, the first criteria from Meaningful Use Stage 1. So, it's not just exchanging drug information, right, or medication reconciliation it goes beyond that.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Marjorie, this is Danny, you know, on the slide on the screen the functional requirement looks like our number one identify data that patient is not taking a drug or a patient is taking two kinds of the same drug including in there the detection of abuse and then lastly multiple drugs that overlap. So, Keith, does that answer your question about what the goal of the objective is?

Keith Boone – System Architect – GE Healthcare

No.

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

No?

Keith Boone – System Architect – GE Healthcare

It talks about three different things that could be done but it doesn't really –

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

So, it's –

Keith Boone – System Architect – GE Healthcare

But what's the challenge they're really focused on? Because these are three different kinds of problems that medication adherence could help resolve and I'm trying to understand what problems they're really focused on –

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

Okay, so –

Keith Boone – System Architect – GE Healthcare

How can we solve everything?

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

Yeah, so let me – so I'm not sure completely what the goals are and there might be others. I'm going to kind of articulate how I understand it. I do think this goes beyond ePrescribing and I do think that we're looking for, again, you know, the readiness of standards themselves and I think that the readiness of the standards themselves to –

Keith Boone – System Architect – GE Healthcare

Standards are the solution what's the problem?

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

So, this is Michelle from ONC, so I work with the Meaningful Use Workgroup and so I think the policy problem that they're trying to solve is understanding why patients may or may not be taking their medications. So, these are, as Danny identified, those three bullets identify the problem that they're trying to solve.

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

This is –

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

Now they've –

Keith Boone – System Architect – GE Healthcare

Yeah, but –

Floyd Eisenberg, MD, MPH, FACP – Independent Consultant

Yeah, this is Floyd; I might be able to add something from discussions I've heard I think the issue is EHRs generally don't have all of the compliance information. For instance, you've ordered a drug and you don't know if it's been filled and you don't know if – so you can't necessarily decrement I've ordered 90 days worth and it's now 100 days and it hasn't been refilled I have to notify the patient.

So, I think the use case they're trying to fix is can we get information back to the EHR so we could expect the EHR to be able to manage compliance and adherence to medication and there is missing information and they would like to know are there standards to provide it? Does that help?

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

Well, so Floyd, that helps me, but I think what we're looking at is also somewhat of a staged approach because, you know, you've got to be able to accept that data first and to exchange it and then you've got to be able to do something with that data once you have it and it seems to me that there are two pieces of – you know, that that's two different issues and, you know, the first bullet captured that and maybe that's something we should discuss to make sure we get to the right point.

But, I would also ask Keith does that help you understanding that clarification of the goals then help you with these two bullet points?

Keith Boone – System Architect – GE Healthcare

So, what I'm hearing from the statements seems to help prioritize – I'm still a little bit confused about overlapping drugs and drug abuse. To me if you're going to be looking at standards to resolve a particular problem it strikes me that there ought to be a fairly clear problem statement and then the impact of what the particular problem is.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

So, Keith, I'm sorry I didn't mean to interrupt you but I had a thought about what just articulated. I was just – this is Eric Rose, I think that – in my mind at least the problems that they're describing are clear, it maybe because I sort of deal with them frequently in clinical practice, it might be perhaps a little bit confusingly worded, but I think that there are really three problems there, one is when the patient isn't following through with a prescribed, some aspect of their prescribed medication regimen.

The second is when there is unintended, what's the word, redundancy in the medications that the patient is taking either they're taking two forms of the same drug with the level of drug ingredient and that gets a little – I mean or they're taking two drugs in the same class or what have you, redundancy is the umbrella or super fluidity is the umbrella that would cover all of that.

And the third is inappropriate abusive use of medications by the patient or other signs that might fall under a diversion like it might not be the patient who is taking them but they're doing something regarding medications particularly controlled medications that they shouldn't be doing.

Those to me seem like three very clearly recognizable problems, they're problems at the level of the, you know, they're healthcare problems that clinicians face every day and I think the question is, you know, to what degree are there standards that can support data flow that will help – that will enable workflows that will help address these problems and I think that's an answerable question by our group.

Keith Boone – System Architect – GE Healthcare

Oh, so –

Robert McClure, MD – Owner/President – MD Partners, Inc.

And this is Rob, let me jump in here for a second Keith because I want to add to that what Eric just said and again, you know, as a clinician, and I was a little confused by this at first too because I missed kind of the assumed base which was that we were talking about providing a standard so that an EHR could do this or provide this information presumably to a clinician although we could also imagine, you know, kind of quality managers or clinical managers or something like that looking at this.

So, the idea that – you know, because for right now if we're talking about, you know, in a US funded, US government funded entity like Medicare, Medicaid or something like that PBMs, from what I understand, do send their data there and someone can look at this but they're doing it from a quality and retrospective analysis perspective not that these issues that are noted here couldn't fall into that.

But what's I think being proposed is the question of should we – well, are there standards that would support the idea of bringing this to the – directly to the clinical team so that they can assess and I think, again I would agree with Eric, those are three different, although somewhat – the last two are somewhat overlapping, you know, clinical scenarios that are important and would directly impact patient care.

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

So, this is –

Robert McClure, MD – Owner/President – MD Partners, Inc.

So, but not available right now there is no way that an active clinician can get that information and so the question is should we have standards that allow that.

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

Right, so this is Marjorie and that kind of gets to the – I think gets to the question Rob and thank you and everyone who has commented so far, so right now I think the Meaningful Use Workgroup has tried to simplify, although it might not be clear, that, you know, you're going to need one data feeds right?

And right now we're hearing that the data feeds are primarily administrative in nature and don't necessarily get to the – you know, the clinical side, correct?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Actually, I'm not sure that's quite correct, there is an NCPDP standard for transmitting fill attempts which are a little bit different from dispensing of medication, there is a subtle difference that's important to understand, but it's not just – it's contingent on data going through a PBM, it's contingent on an administrative transaction occurring.

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

Okay.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

But it actually records the action of a pharmacist filling a prescription.

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

Right, so a pharmacist filling the prescription but then isn't it important that the data go back the other way? Is that what I'm hearing?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

The other way?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, I mean, I think that's exactly the question the thing that's, you know, NCPDP apparently does have some standards that support this, but that we haven't had a requirement for EHRs to understand those standards.

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

Right, so if the pharmacy fills it does the EHR know that the pharmacy has filled it?

Keith Boone – System Architect – GE Healthcare

Okay, so –

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Yeah, well the data has been following from Surescripts to EHRs for years with this transaction. I mean, I designed an EHR module to ingest that data in 2009 I think. So, I mean, it's in common usage and it's been, I mean, I think there's proof that it works out there. All it does is display the data in a, you know, more or less – not necessarily structured way, but at least a provider can browse the list of fill events.

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

So, if we look at –

Robert McClure, MD – Owner/President – MD Partners, Inc.

I think you're pointing out the point that, you know, for example it's not surprising that of the EHR vendors Surescripts might lead the way in this particular area. Again, my understanding is the question is, should we make it a Meaningful Use criteria so that other EHR vendors are required to do it?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Well, to clarify this is not an EHR vendor.

Keith Boone – System Architect – GE Healthcare

– are already using NCPD?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Well, it provides – it does now make available an EHR that's my point.

Keith Boone – System Architect – GE Healthcare

Well, as an EHR vendor, this is Keith, okay, I don't want to jump back into the conversation, I still don't understand what the priorities are, let's just move beyond that. I understand what the problems are. So, there are NCPDP transactions I'm quite aware of them that are used on the ePrescribing side and also to understand what fills have occurred and those transactions are intended to be used between providers, between payers and between intermediaries in that particular space.

The challenge with those transactions in the past has been that the vocabulary for specifying the medications has been very loose and I believe that's being tightened down at least for the ePrescribing components for Meaningful Use it's certainly being tightened down for the prescribing side and presumably could also be tightened for the fill side.

And you're missing the structured SIG or have been missing the structured SIG on the NCPDP side. So, you can start to get some of that data. I think the challenge for EHRs is that they've not been getting high quality data that is going to allow it to be used in an automated way such as part of CPOE or automated medication reconciliation in a way that has the same kind of fidelity that is specified elsewhere in Meaningful Use Stage 2.

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

Okay, so that's helpful, so I want to make sure that we synthesize things back to the Meaningful Use Workgroup in a way that they are expecting us to respond. So, if we look at the first bullet again that says the ability to accept the data feed from a PBM, right, so you just simply need to do that. What I'm hearing is the NCPDP standards do that, correct?

Keith Boone – System Architect – GE Healthcare

Yes.

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

We already have that.

Keith Boone – System Architect – GE Healthcare

Yeah.

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

So, that answers that.

Keith Boone – System Architect – GE Healthcare

And we never need to use anything else.

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

Excuse me?

Keith Boone – System Architect – GE Healthcare

And there's no reason to even look at anything else.

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

Well there are existing standards, this one is in place and there is no need to do that, right? And that's also a standard that's identified in ePrescribing.

Keith Boone – System Architect – GE Healthcare

That's in the HIPAA transaction rules, in Medicare Part D prescribing.

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

Double rules.

Keith Boone – System Architect – GE Healthcare

In Meaningful Use Stage 2.

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

Yes.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah and I'll second that.

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

Right and so then –

Robert McClure, MD – Owner/President – MD Partners, Inc.

I mean, so in other words what you're hearing is that we have the standard and the question is should it be applied here.

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

Should it be applied and so to me that's real simple from what I'm hearing the answer is it can. But then –

Robert McClure, MD – Owner/President – MD Partners, Inc.

But, you know, I think that Keith pointed out and I was going to ask Keith this question, I mean Keith you were pointing out that the fidelity and the data in those transactions has – I'm going to put words in your mouth, but it's, you know, typical of administrative data and –

Keith Boone – System Architect – GE Healthcare

Okay, I'll say, yes, it does indeed suck.

Robert McClure, MD – Owner/President – MD Partners, Inc.

But, so in making a recommendation that this kind of, I'll put words in my mouth, clean it's act up, we would say that one way that happens is say we're going to start focusing on using this as clinical patient care data so let's set up the ability to do so and then everybody's got to sign into that expectation start, you know, focusing on data that meets that level of quality.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

This is Eric, I don't disagree with that but we should be careful not to create a misunderstanding that somehow, you know, changing the way that data is formatted would solve all the issues of noise and absent data and, you know, the fact is that many prescription transactions occur without a PBM being involved and, you know, as long as all parties understand and accept that, you know, this data is never going to be perfect, you know, as long as it's contingent on a PBM transaction having occurred, you know, versus somebody paying out of pocket for instance or those rare folks that have a health plan that doesn't use a PBM then, you know, then, you know, cool it's certainly better than nothing and it's just there.

There shouldn't be an assumption that there could ever really be complete data until we have some, you know, something that, you know, some network that connects pharmacies and providers without a PBM being an intermediary.

Robert McClure, MD – Owner/President – MD Partners, Inc.

And I agree that's a good point to make.

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

Right, so –

Robert McClure, MD – Owner/President – MD Partners, Inc.

So it can keep us from moving forward, but –

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

Right, so that brings me to the – us to the next bullet and it sounds like we're getting into, you know, the ability to identify the important signals and can you – do you need the, you know, elaborate network in order to do the cool data analysis that's identified here. So, you know, that the patient is not taking a drug, if the patient is taking two kinds of drugs or multiple drugs that overlap with one another.

Keith Boone – System Architect – GE Healthcare

–

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Well the signals will be unreliable, but they'll be sufficient to at least generate the question from, you know, one human being to another.

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

So, you're saying the signals are there but you can't do anything with them.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

No, no I'm not saying that I'm saying that there has to be a human intermediary so that the workflow that can currently be enabled is the provider or someone in the provider's organization, you know, identifies an apparent issue and has a conversation with the patient and says, you know, it looks like you filled a redundant medication are you really taking both of these "oh, no I threw that other one out when I realized it was redundant" or what have you, you know.

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

Right, so the signals are there but they're not necessarily computable is that what I'm hearing?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Yeah.

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

Okay. And is that something that we need to flush through even further or should a computable signal be part of the EHR certification criteria?

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Hey –

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

I would not make it part of certification criteria – no I think that the purpose here is just to alert providers to the fact that there may be an issue.

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

Okay.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Hey, it's Jon White, just a quick question. Was there any desire on the part of the Meaningful Use Workgroup to have an indication that something had been done about it, i.e., are you taking these, you know, redundant medications, oh, no I threw one out, and then somebody has to record that okay issue resolved or just that par one is all they're really looking for?

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

Sorry, Jon, I missed the last thing you said, but, so just to give a little bit of history for the Meaningful Use Workgroup, this was identified as certification criteria because they didn't believe that EHR – that standards were readily available, that there was the ability for vendors to be able to easily do this for them to require a functional objective for providers.

So, their first step was to be able to make sure that the functionality was available to do these things so that once its available providers can act upon it accordingly but there is no requirement.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Okay, perfect, so they're just looking for step one not for step two?

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

Yes.

P. Jonathan White, MD – Agency for Healthcare Research & Quality (AHRQ)

Okay.

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

Okay, so that's the – any other comments on, I'm being sensitive to the time, on the medication adherence? Have we flushed through that to your satisfaction?

Keith Boone – System Architect – GE Healthcare

Well, so one small observation after going through and saying there is no reason not to use any other standard and as I think about the medication section of the Consolidated CDA document which has the ability to capture information about medications that have been dispensed to, you know, to the patient which have been ordered for the patient and which the patient is actually taking and thinking about the – there are a variety of different approaches for trying to get at – and that’s really what we’re trying to do, trying to get at what’s the patient’s medication list, what are they taking?

And so I think that some consideration needs to be given to there are different sources of information you could have PBMs who would be already required to use the NCPDP standard for other activities but then you have providers which are already required to use C-CDA for their activities and there may need to be some need to support both because you may also have ACOs who are getting the information from Medicare and potentially PBMs on their patients and then would have potentially the ability to create a C-CDA with the medication list that contained information that was based on a lot of that.

So, I think there’s some thought that needs to occur around how that part works and how that gets reconciled. Reconciliation is already in Stage 2.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

This is Eric, I agree with that, was that Keith that was speaking?

Keith Boone – System Architect – GE Healthcare

Yes.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

I think the opinion that the NCPDP SCRIPT standard is the only one to consider really applies just to the question about accepting data feeds regarding fill events and I think that it might be worth reminding – I’m sure that the Meaningful Use Workgroup realizes, but it might be worth reminding them, that there is a whole chain of events that occurs up to the time a medication enters the patient’s body and that for each event there are possible data sources and potential standards to use.

And so from prescribing to filling, to, you know, to administration of the medication and probably others in between, so, I mean, and there are plenty of other standards and possible ways to approach some of those other points in the chain of events like, you know, smart pill bottles and so on and so forth.

So, it might be worth reminding them of that, but I think if they’re interested in just fill, you know, the fill event then, yeah it makes sense to use SCRIPT. And other – the only other thing that I would –

Robert McClure, MD – Owner/President – MD Partners, Inc.

I’ll just – I want to just – also just highlight that short comment that that’s a good point and I think that if the question being asked is, one is it important to get information about patients actually taking medications and what medication they’re actually taking, you know, I for one would say, unequivocally “yes” that’s valuable for all kinds of reasons not just actually the direct patient care but public health and things like that.

And then that means the ones that are traditionally, and I say that in the context of the past decade maybe, that would be pharmacy information that we really need, i.e., fill information now granted that’s not perfect but nothing that we have is perfect, but the fact is in the past five years we’ve started to hear about the sort of technology that was just mentioned and we should definitely have the committee think about the fact that, you know, if you want to think a little bit farther out in the future, because I haven’t seen any pill bottles in our house that have ways of monitoring them, but that’s another source of that kind of information and it’s a very important source. So, I agree.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

There is only one other thing that I might suggest mentioning in our feedback to the Workgroup which is that various states have started to accumulate data on prescribing of controlled substances and make those available or excuse me filling and dispensing by pharmacies with controlled substances and making those available to providers usually through secure websites that are completely – have no actual data integration with any other system.

So, we have something like that in Washington State and I'm not sure how the data gets from the pharmacies to the State Department of Health, but there may be some connections to explore there, you know, to making that stuff flow easier.

Keith Boone – System Architect – GE Healthcare

And that's where the question of competing priorities – that's why I went up against the question of competing priorities in my head because there may be different standards for different systems and there's one system here that's designed to address drugs of abuse or potential misuse and for all of the kinds of problems that are being discussed yes it's conceivable, it's possible to use standards to support what's being requested.

But if we go back to looking at the principles trying to figure out what's appropriate and relevant in terms of the context it would be helpful if these problems were prioritized instead of saying, deal with all these – deal with these three different problems, because if one problem is a lot larger than the other in terms of its value to the country it would be useful for us to know in our deliberation in order to be able to provide and appropriate recommendation.

If you come to the auto shop with a flat tire, a bent frame and a leaky oil pan do you want to put all of that money into the tire and the oil pan only to find out that the car is still un-drivable, no, so you want to focus on the thing that's most important first.

Robert McClure, MD – Owner/President – MD Partners, Inc.

This is Rob, I mean, I certainly agree with what Keith has said, but honestly, and I get this is really where this committee is being asked to provide some input. I would have assumed that we could cite – I would actually now say the two things that were just mentioned, so primarily NCPDP fill standard, you know, we should note that there are other standards now that potentially could be added that gives, you know, that could provide access to pill bottle, you know, data directly and stuff like that.

But that our existing world primary it's this NCPDP list, the standard, that that actually would be a one-size fits all thing that in fact it isn't even though there are three different questions or even more questions that are being asked, if you got, understanding the limitations of the data both in terms of quality and also the fact that there are ways around it, you could ask all three of those questions. So, I mean, that's my take on it, so that's what I would say we should say.

You know, I think that in fact it's not asking a frame versus a fender, versus an oil pan question, it's a I can fix all of those with one bullet.

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

Okay. So –

Robert McClure, MD – Owner/President – MD Partners, Inc.

I mean – and I'm not trying to make that sound like I'm giving a definitive answer, but, you know, am I wrong? Maybe not.

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

So, I guess my question is –

Keith Boone – System Architect – GE Healthcare

I'm talking.

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

Go ahead, go ahead Rob.

Keith Boone – System Architect – GE Healthcare

Sorry, this is Keith, so in responding to you Rob, I would be careful how I invested my money in trying to address those problems because they strike me as needing different kinds of attention.

Robert McClure, MD – Owner/President – MD Partners, Inc.

No, I get you Keith, I absolutely get you and believe me it's important to acknowledge what you're pointing out which is if I give you this bullet, you know, make sure you aim it in the right direction essentially is what you're saying and I absolutely hear you.

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

Okay, so again, this is Marjorie, so it looks like we've got some, you know, clarity around the first bullet about accepting the data feeds and using NCPDP and –

Keith Boone – System Architect – GE Healthcare

Well, let's go a little bit further than just saying NCPDP.

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

Well, that's where I'm going.

Keith Boone – System Architect – GE Healthcare

So, NCPDP structured SIG and RxNorm.

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

Well, that's where I was going Keith, structured SIG and RxNorm where the –

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Well, actually it's – the standard is NCPDP SCRIPT and it's SCRIPT in all Caps and I'm not sure structured SIG applies in the Rx fill transactions, the more technically savvy folks on the call may know, but I thought that structured SIG applies in the actual prescribing transactions rather than fill transactions.

Keith Boone – System Architect – GE Healthcare

Well –

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, I haven't been on the recent things, but I think you're right unless structured fill has been updated because, sorry, I said the wrong phrase, unless the fill SCRIPT standard – because I think structured SIG is still kind of a part of SCRIPT but it may not be, it really is a distinct standard and so by adding, you know, by Keith saying, look we also need structured SIG that complicates our response a little bit because now we really do need someone who is up on these NCPDP standards.

Keith Boone – System Architect – GE Healthcare

You want to undo duplications and overlaps to the level of trying to figure out is the patient taking too much of a particular medication, you need structured SIG.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, you need, I agree, you know, I think stating that adding the standard for structured SIG provides information that we really need, it gets back to this issue about how useful is the simplest data in answering some of these questions and I think it's certainly a shotgun if not a plunder bust.

Keith Boone – System Architect – GE Healthcare

Yes.

Robert McClure, MD – Owner/President – MD Partners, Inc.

So, adding the capability that you could get from a structured SIG really enhances that but I think it's a legitimate question as to where NCPDP is in terms of adoption, aligning those standards and stuff like that.

So, I think, to the extent we can punt, given that it's today and I didn't see the request actually until recently to see if we could bring somebody else on that knows NCPDP it would be nice to have somebody like George Robertson or even Lynne Gilbertson would have been fantastic.

Keith Boone – System Architect – GE Healthcare

Or Scott Robertson.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, well, so to get a sense of how these things are integrated. But, I think what we should say is SCRIPT standards for sure, you know, structured SIG you know is a very important addition to that pending the alignment with SCRIPT standards which we're not aware of yet.

Keith Boone – System Architect – GE Healthcare

And –

Robert McClure, MD – Owner/President – MD Partners, Inc.

And then the use of, you know, the thing about –

Keith Boone – System Architect – GE Healthcare

–

Robert McClure, MD – Owner/President – MD Partners, Inc.

The thing about SCRIPT standards is it does reference RxNorm, so, I mean we can say that, but in fact by following SCRIPT you're going to be following standardized representation of medication lists.

Keith Boone – System Architect – GE Healthcare

That would be a recent change if it says RxNorm.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Well, it doesn't – I don't know that it restricts to only RxNorm but it's always been in the SCRIPT standard it just – I think it's broader than just RxNorm.

Keith Boone – System Architect – GE Healthcare

Right.

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

Can I just ask a question, where does NDF-RT fit into this –

Robert McClure, MD – Owner/President – MD Partners, Inc.

That also was in the SCRIPT standard.

Keith Boone – System Architect – GE Healthcare

– drug classifications.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, so NCPDP –

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

So, there are multiple people talking at once, so Rob finish and then I think it was you, Eric, who made a comment?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, so here, so I'll finish, so NDF-RT is the cited standard, you know, by a number of organizations including actually, previously, I mean, I haven't seen the latest, but it could still be there, it may have been removed from SCRIPT standard, as a way of representing – the intent is the use of NDF-RT to represent drug classes. NDF-RT has a lot of other stuff but the expectation in terms of its citing and regulation, and standards is to use NDF-RT concepts to represent drug classes.

The kind of meeting the goal of that expectation – well, we have not met the goal of that expectation yet. I think there's good evidence to say that that will be accomplished and if not – well, we're so close to the end of this year, it was supposed to be done by the end of this year so I'm going to say maybe not, but Q1 of 2014.

And then it would be slightly incorrect to just, you know, simply say, okay NDF-RT is fixed. In fact what we will likely do is point to a subset of NDF-RT and that subset will meet the goals as needed. So, it will be a value set. It will say, this value set represents drug classes for use in classifying drugs primarily around the use of those drug classes to identify drug-drug interactions and adverse events and then we're good.

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

Okay and then Eric you might – I think you had a comment?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

No, no I – the only thing I might have to add is that any – and again I think the Meaningful Use Workgroup knows this, we don't have any CMS/ONC has no control over what the PBM sends. So, they could chose to include or not include codes from various coding systems, but I do think it's reasonable to say that the EHR ought to be able to ingest and deal with an RxNorm code as a drug identifier in a fill transaction if it's present.

Keith Boone – System Architect – GE Healthcare

So, ONC does not, your colleagues over at CMS certainly do.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Or at least not within the context of, you know, Meaningful Use and EHR certification Regs.

Keith Boone – System Architect – GE Healthcare

Right, but in terms of aligning with ePrescribing regulations CMS has some levers.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

So, it might be worth mentioning that and saying, you know, that coordinating with other, you know, regulatory activity might be, you know, helpful to create a good outcome as far as availability of the standard.

Keith Boone – System Architect – GE Healthcare

– how about crucial, because otherwise we run into the challenge we have with labs everybody can accept structured lab results and we still can't get the right stuff out of labs because the labs have no incentive to do so.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, so this is Rob, let me kind of add to that. This actually is important there's a lot of – I was going to use the word competing and maybe that's being a little bit too proscriptive in the – what's the right word – anyway, you know, there are a lot of agencies that have a finger in this pie, FDA also being a member of that play and the – so many things, probably the majority of content that's coming out of PBMs and the SCRIPT standard are not including things like RxNorm, they include NDC codes and so some of the hard details that I don't think we need to necessarily get down into this mud, but I think it is important to encourage the transmission of something like RxNorm perhaps in addition to other ways of representing drugs that are deemed valuable.

And the reason for that is that we, you know, while many people think of NDC codes, probably nobody on this call, but, as a really kind of solid standard it's not. To the extent that RxNorm can be a solid standard it has a better shot and therefore what we would like to see more of and there are changes that are occurring elsewhere that would make this more likely that those who are filling prescriptions would include both an NCD code and an RxNorm code.

In other words, say we really want the RxNorm code because that's a definitive standard, we expect you or your supplier to give you a clear indication that that particular NCD code aligns with this particular RxNorm code as opposed to the only other solution we have is NCD codes through the hard work of the NLM and RxNorm they go and try and do that work but it's based on everybody kind of providing the information that if the suppliers did it right off the top it would be "perfect." So, that's a big thing that if we can kind of tie into this somehow it would be great.

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

So, this is Marjorie and that's exactly where I'm going again is sort of tying things back to the original ask and if we're still on medication adherence and if we get to – if we go down to – it looks like we talked about the data feeds but we're really more into interpreting what's in the signals and I want to make sure that I'm clear that structured SIG for example and RxNorm, and possibly NDF-RT address those sub-bullets under identifying the important signals, is that correct?

Keith Boone – System Architect – GE Healthcare

Oh, NDF-RT from a standards perspective is useful to identify drug classes and it's really the only thing that's readily available.

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

–

Keith Boone – System Architect – GE Healthcare

However, adoption in the EHR space is very, very limited and unless you're dealing with a large IDN that has the resources to actually make critical use of NDF-RT it's not something that you're going to find readily implemented or readily understood and there have been a lot of challenges with the various content of NDF-RT which contribute to the fact that people are concerned about using it and so –

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yes, let me tag onto what Keith is saying, so the short answer is Keith's right, we're a regulatory cycle away from being able to put a lot of emphasis on NDF-RT even though it's already there, because of some may say nuanced issues around it and so I think that we would say that we want the ability to associate class, drug class-based information in the same way you're doing specific drug information is always going to be a target for our standards.

And that the expectation, full expectation is NDF-RT will provide that, but we are, you know, six months away from being able to definitively point to the place and the way that that should happen and so we, you know, so saying "yes" we want people to adhere to the use of NDF-RT is reasonable but we have to acknowledge that NDF-RT doesn't fully provide the information yet, it should.

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

Well –

Keith Boone – System Architect – GE Healthcare

The other side of that, Keith again, the other side of that issue is that on the fill side you don't fill a beta-blocker.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Right.

Keith Boone – System Architect – GE Healthcare

You fill a specific drug and the knowledge that that specific drug is a beta-blocker is clinical knowledge that doesn't need to be transmitted so long as you transmit either the RxNorm code for the medication ingredient or the NCD code which leads to the RxNorm code for that package and the linkage from NDC to RxNorm to NDF-RT is knowledge that really ought to be rather than everybody trying to attempt to communicate those three things every time we talk about a medication –

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah.

Keith Boone – System Architect – GE Healthcare

Let that now be provided by an authoritative source rather than transmitting it every time.

Robert McClure, MD – Owner/President – MD Partners, Inc.

That's exactly right and –

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

Okay, so that –

Robert McClure, MD – Owner/President – MD Partners, Inc.

That terminologic knowledge is what I'm talking about being definitively provided as of the middle of next year.

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

Okay so then that speaks to the readiness of the standard then, right?

Robert McClure, MD – Owner/President – MD Partners, Inc.

It does in the sense of –

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

Not quite ready yet.

Robert McClure, MD – Owner/President – MD Partners, Inc.

It does only in the sense of drug class-based information based on NDF-RT and it's one that should be, you know, made whole very quickly.

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

Right.

Robert McClure, MD – Owner/President – MD Partners, Inc.

As opposed to a lot of standards where I can't say that, this one I'm pretty confident of.

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

So, I guess my question is should we list that here in our recommendations or we just –

Robert McClure, MD – Owner/President – MD Partners, Inc.

I would.

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

Okay.

Robert McClure, MD – Owner/President – MD Partners, Inc.

You know with the caveats that we've just discussed.

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

Okay. Okay. All right, it's almost the top of the hour I know some of you have to leave, I think Eric you were one, you had to leave very shortly?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

–

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

Do you have any other comments before you have to drop off?

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Well, thank you for asking, no I think I've abused the privilege enough, but we still have 8 minutes left.

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

Okay, great, all right. Should we move onto – Michelle you mentioned in our chair call that the Meaningful Use Workgroup is not as focused on the PDMP standards. Should we move onto –

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

It's –

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

What's your recommendation?

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

Well, maybe I can just give a little bit of background.

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

Sure.

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

So, both of these two items were designated as a future stage originally. Medication adherence is something that's really important to the Meaningful Use Workgroup so they were hoping to find a way to incorporate it into Stage 3 which is why they're coming back and asking for the readiness of standards and making sure that it won't be too difficult to include in Stage 3 if they decide to do that.

For the PDMP certification criteria they worked with MITRE who was the contract through the S&I Initiative to come up with the certification criteria that are listed here, so it's based upon their pilot work and their feedback that they came up with this certification criteria. Julie can probably speak to it a little bit more than me, but there is future work happening on the S&I side but we are not necessarily sure if this is something that can be included in Stage 3.

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

Okay. Julie, did you want to comment on the PDMP?

Julie Crouse, PMP – IT Specialist and Project Manager – Centers for Medicare & Medicaid Services

Yeah, I mean – yeah, hi, this is Julie Crouse, I think Michelle pretty much covered it but for those of you that don't know there was an S&I Initiative that happened last year and MITRE helped support that work and we worked very closely with different stakeholders in the industry and there was a recommendation's paper that came out of that, however, it didn't seem that all stakeholders were comfortable with the final recommendations including – you know, so obviously it didn't make it in time for Meaningful Use Stage 2.

Right now I think we are unsure whether or not we will have harmonized agreed upon standards in time for MU3, however, for those of you that are interested in more actively participating there is an initiative if you go to the S&I website it's literally just right on the left side you can click PDMP we encourage your organizations to participate in helping refine and harmonize the final standards for PDMP that can be used as I think a few folks pointed out earlier in the call, you know, the standards that should be used really depends on the stakeholders and the organizations that are participating in the exchanges.

So, here we've got the EHRs, the state PDMPs and then also state to state exchanges as well. So, there is sort of different standards they're looking at depending on who the two entities are that are exchanging standards and, you know, hopefully the work can be done in time but we're not sure that it can be.

Keith Boone – System Architect – GE Healthcare

So, this is Keith, the PDMP and Health IT Initiative launch took place via webinar November 15, 2013, I read from the S&I Framework website, and that was the launch of the PDMP work they're just now doing consensus on the project charter for that.

Julie Crouse, PMP – IT Specialist and Project Manager – Centers for Medicare & Medicaid Services

Yes and so that was most –

Keith Boone – System Architect – GE Healthcare

So, let me finish please, so from a readiness piece, you know, this was launched shortly before Thanksgiving and quite honestly because of end of year activities I've not taken a look at anything that's gone on here but I can tell you if that was the launch date and because of where I'm involved in other standards activities I can tell you none of this is taken place in like HL7 or IHE, or ISO. So, this work I would say is way preliminary for us to be considering. I will go look and find out more, but I'm very dubious – that standard.

Julie Crouse, PMP – IT Specialist and Project Manager – Centers for Medicare & Medicaid Services

Yes, you're completely right, I don't think the Policy Committee or anyone else will be surprised if this group basically restates what you've said in paper and says, you know, basically at this point in the game we cannot make recommendations for standards because they're still be flushed out.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

This is Eric Rose, can I make a quick comment before I drop off?

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

Sure.

Eric Rose, MD, FAAFP – Director of Clinical Terminology – Intelligent Medical Objects

Actually, two quick comments, one for those who aren't familiar with the phrase prescription drug monitoring program it's not particularly obvious but it's a euphemism, it's those are the – and I didn't even connect it when I made my comment earlier about how we have the program in Washington State to see what controlled substances someone has had prescribed by other doctors and it's intended to address the legal issue or the criminal issue of diversion of controlled substances.

So, that's what these are, it's usually under the auspices of law enforcement agencies that are trying to identify people who are diverting controlled substances and this really reminds me of the situation we had a few years back where it was really hard to integrate EHRs with state immunization registries because some state immunization registries were using a more or less standard approach, but many of them were just kind of building their own thing and so you might have to, you know, build 20 different versions of integration technology.

So, I think that the policy goal here, which is to make it easy for clinicians to access, appropriately access PDMP information when they're in the course of patient care is a fantastic goal and really should be supported and I think that the approach really needs to be first getting the states to standardize the PDMP, the technical architecture for their PDMPs so that there can be one solution not 50 and that maybe something that, you know, CMS and ONC can exert.

But I think the weighted deal with this is not trying to standardize just what we have a lever on which is the EHRs, because, you know, we'll have a situation where we can't connect, we'll have wonderfully, you know, functional standardized technology that can't connect to the other to where the data it.

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

Okay.

Julie Crouse, PMP – IT Specialist and Project Manager – Centers for Medicare & Medicaid Services

Yeah, so this is Julie Crouse, I think that makes a lot of sense. I will say that there are some standards that have been used by the PDMPs as a proprietary standards, so I think that they – I don't want to, you know, be crazy and say that, you know, this group may be ahead of where the immunization state registries were, but I have a feeling that they are and really the missing connection now is that data is in a silo right now and, you know, the current work flow for allowing providers to access that data is pretty awful. So it's really now trying to link up the EHRs with the data.

Keith Boone – System Architect – GE Healthcare

This gets back to, Keith again, my prioritization question because when I look at this from the perspective of a healthcare provider and the services that they are trying to perform for their patients this strikes me as being something that's very low on their list of priorities in comparison to being able to determine what medication the patients are on when they show up in the emergency room for example and that's why I keep asking some of those questions.

Another point that I would like to make, we have been struggling with a number of these questions coming from the Meaningful Use Workgroup in terms of trying to interpret and understand them, I'm appreciative of ONC folks who are available to help with the interpretation.

I think that in the future should we have a set of questions like this that it would be very helpful to have a joint meeting and discussion to help us get some clarification in and around those questions rather than playing a game of telephone tag in trying to understand what they are.

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

Yeah, Keith, this is Marjorie, I think that's a good idea and I think that's a great segue into our next discussion. Were there any other comments on the PDMP issue?

So Michelle, are you ready to move forward on the 2014 work plan? I want to do that and then we can recap our – some of the points that we discussed previously.

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

Sure, thanks Marjorie. So, I think Floyd was on the Standards Committee yesterday I think he might have been the only one, so during yesterday's Standards Committee meeting we discussed the 2014 work plan and as part of that discussion we talked about restructuring the Workgroups into six different or new Workgroups not necessarily new but kind of reorganizing the set up.

And so some of them will stay similar and some of them will change quite a bit and so based upon that restructuring we will be doing some re-alignment of the membership of each of the groups and making sure that we have the appropriate expertise on each group to be able to speak to the topics that they're discussing.

Just very quickly the six Workgroups that they identified were Quality and Safety, Health Information Exchange, Consumer, ACOs and Population Health and Care Management, Privacy and Security, and a sixth one that they discussed was Research Strategy and Innovation.

We've still yet to identify the specific charges for each of those groups who will lead them, what the – you know, what they will be. Our assumption is that some form of this group will evolve into one of those six groups but we just want to set up expectations that you will see a change and the final changes will be discussed, we're hoping to be able to do that by the February Standards Committee meeting.

In alignment with that we're also supposed to receive all of the policy recommendations from the Policy Committee related to Stage 3 in February so their meeting is February 4th and the Standards Committee meeting I believe is the 18th. So, it will be a quick turnaround but we're hoping to take their transmittal letters and all their recommendations and align those with initiatives that are happening within those workgroups and be able to provide specific charges for each of the Workgroups.

And in addition to that ONC has announced that there will be a 2015 certification rule and there will be work to be done by each of the Workgroups to respond to that NPRM, the exact timing will be discussed later, but – and the exact assignments obviously will be discussed later, but just so the expectations that will be part of the work for 2014. So, more to come, but just want to set expectations that there will be changes.

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

Okay.

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

Sorry, Marjorie –

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

No that's okay.

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

And just in addition in January this Workgroup actually has three meetings on the calendar, we discussed earlier during our chairs call that we most likely will cancel the January 6th meeting because it is so close to the holidays, but we will then, I forget the date off the top of my head and I will look for that, at the second meeting scheduled in January we will follow-up the principals that we started to discuss with Keith, I think three meetings back at this point, just finalizing those recommendations and putting a close to those things and if there is any open discussion items.

So there was also the open discussion item from the last meeting regarding NCPDP and there was also a discussion about that today, so we may want to have a representative from NCPDP just to kind of close the loop on those things as well.

So, we can decide if we need one meeting in January or two and then hopefully by the February Standards Committee meeting we'll have the restructuring done and the new charges complete.

Keith Boone – System Architect – GE Healthcare

So, just commenting on the January meetings, the last two weeks of January are some fairly significant Health IT activities, HL7 has its, one of its working group meetings in the third week of January and then in the fourth week of January is IHE Connect-A-Thon. I think the later impacts people less than probably the HL7 meeting, I know there are several people on this call who will be attending the HL7 meeting including Rob, Floyd and myself.

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

And that was Keith?

Keith Boone – System Architect – GE Healthcare

That was Keith, yes.

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

So, we'll keep that in mind as we try and figure out the January meetings.

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

Yes, I think that would be very important since most of this group will probably be at HL7. So, maybe we have a meeting there if we could I don't know, probably not.

Okay, so I guess what I'd like to do is recap what I heard as it relates to the medication adherence recommendations that we'd like to provide.

Where we are so far and Keith I think we all heard you, we need some clarification on what the goals are for Meaningful Use in order to really cogently ask this question I think and then perhaps prioritize the problems that we're trying to solve. Does that sound correct? Okay.

Keith Boone – System Architect – GE Healthcare

Yes.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Yes.

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

Okay and then with respect to the standards NCPDP SCRIPT, SCRIPT in all Caps, structured SIG and RxNorm are standards that we feel are ready to recommend as it relates to medication adherence. And, we've considered NDF-RT however it's limited at this point and needs some further – it's not ready for this particular regulation, correct? Yes?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, the expectation is that it would be ready in 2014, which obviously begs the whole question that we've mentioned before which is when you have something new and it hasn't been adopted.

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

Right and then some other things for consideration are that –

Galen Murdock – Veracity Solutions

Actually, if I may, this is Galen, Keith your discussion about C-CDA as a potential way to communicate a list of medications, realizing that the source may be from other than PBM does that need to be part of our feedback as well I would ask to the group?

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

That's on the list that I have Galen I just hadn't gotten that far yet.

Galen Murdock – Veracity Solutions

My mistake, thank you.

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

Yeah, so I won't cover that bullet point. And then other points of consideration is I heard that the EHR should be able to accept a RxNorm code. As it relates to the specific question on identifying important signals the signals are there but they're not necessarily computable and we also heard that actions on the signals are out of scope for this particular question. Are those two items correct?

Robert McClure, MD – Owner/President – MD Partners, Inc.

I'm not sure if that was the characterization of some of the things that Keith and I said.

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

Okay.

Robert McClure, MD – Owner/President – MD Partners, Inc.

What I had said was that traditionally –

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

Is this Rob talking? Is that you Rob?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, it's Rob, sorry. What I'd said was that, you know, the use of the SCRIPT standard targeting what appears to be the goals which is direct, you know, impact on clinical care as well as, you know, public health and administrative review, may require, you know, I don't know how you want to phrase it but basically, you know, an increased, I'm blanking on what I want to say, but not just what you would get with the normal administrative data.

And so I think we just, you know, the point that I was making is that I think we would suggest that these standards are in fact ready for our being implemented and are ready for use but that in doing that we would be taking standards that in some cases had been focused on administrative, you know, kind of data analysis and exchange to clinical use and when you do that you need to understand that that means that the data may indeed need to be cleaned up and evaluated with an understanding that it's transitioning from administrative use to clinical use.

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

Okay, that helps, good clarification. And then we also heard that coordinating with other regulatory activities is actually crucial for advancement so looking at some of the things that CMS is doing. Did I hear that correctly as well?

Kevin Brady – Group Leader, ITL Interoperability Group – National Institute of Standards and Technology

That's correct.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, this is Rob again and yes that absolutely is true, I mean, that's true of anything we do where we have to make sure that CMS has got aligned goals across all of its different programs. I know that they see that as an important thing anyway, but the one thing that I had mentioned also is that when we're talking about drugs you've got to include FDA.

So, FDA has expectations with regards to for example the information that suppliers provide, i.e., you know, they do expect that medications get NDCs and one of the things that we'd like to see is in addition to that that suppliers also identify RxNorm codes associated with their supplies, you know, where appropriate. And just in general that the Workgroup needs to consider agencies that have a direct impact on standards and in this case we're talking about drugs so it's the FDA.

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

So, and I also heard that we may want to have another call and invite some experts to talk with us or do we still feel that we need that?

Robert McClure, MD – Owner/President – MD Partners, Inc.

Again, this is Rob, what I would suggest is that when we communicate this, because I don't know that we have to have a lot more discussion over it, but in communicating this to the Workgroup that we would suggest that for their full understanding of our suggestions and perhaps additional clarifications they should ask for an NCPDP expert to discuss it with them.

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

And then –

Keith Boone – System Architect – GE Healthcare

That's probably a more effective thing for them to do is actually have direct communication and I think names that were mentioned Lynne Gilbertson.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yeah, Lynne Gilbertson is the person at NCPDP who is responsible for all these standards.

Keith Boone – System Architect – GE Healthcare

Yes.

Robert McClure, MD – Owner/President – MD Partners, Inc.

And so she would be really the primary point-of-contact at NCPDP and we mentioned George Robertson because George is someone we know who is an active participant in many of these things, but to be honest I think the request should go to Lynne.

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

Okay, so noted. All right is there anything else that we need to discuss before we go to public comment? Danny did you have any comments? I haven't heard much from you.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

No thanks Marjorie I have just been listening to the excellent dialogue.

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

Good, great, Julie and Michelle and Alicia I think we're ready for public comment.

Public Comment

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

Sorry, operator can you please open the lines?

Ashley Griffin – Management Assistant – Altarum Institute

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

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

Well, thank you everyone and –

Keith Boone – System Architect – GE Healthcare

Thank you, Happy Holidays all.

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

Thank you Happy Holidays to everyone as well.

Robert McClure, MD – Owner/President – MD Partners, Inc.

Yes, yes thanks a lot.

Danny Rosenthal, MD, MSc, MPH – Director of Healthcare Intelligence – INOVA Health System

Thank you.

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

Thank you, Happy Holidays.

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

Bye-bye.