

**Meaningful Use Workgroup  
Subgroup #1: Improving Quality  
Draft Transcript  
March 8, 2012**

## **Presentation**

### **Operator**

All lines are bridged with the public.

### **M**

Josh, do you want to welcome people, or should I?

### **Michelle Nelson – Office of the National Coordinator**

This is Michelle. Maybe I'll just start us off. Good morning, everybody. This is the Health IT Policy Committee Meaningful Use Subgroup 1, Improving Quality. Just to take roll, do we have David Bates?

### **David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes.

### **Michelle Nelson – Office of the National Coordinator**

Charlene Underwood? Michael Barr? Neil Calman?

### **Neil Calman – Institute for Family Health – President & Cofounder**

Yes, I'm here, but only for the first 40 minutes.

### **Michelle Nelson – Office of the National Coordinator**

David Lansky?

### **David Lansky – Pacific Business Group on Health – President & CEO**

Yes, I'm here.

### **Michelle Nelson – Office of the National Coordinator**

Paul? Eva Powell?

### **Eva Powell – National Partnership for Women & Families – Director IT**

Here.

### **George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

And George Hripcsak. Paul and I are on all the calls, although Paul's the primary. He's not available for this call ... .

### **Marty Fattig – Nemaha County Hospital – CEO**

This is Marty. I'm on the call.

### **Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

And Charlene Underwood.

### **David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay, great. To just go through our charge again, we're supposed to be focusing on quality and safety in the Stage 3 part of things. We're supposed to apply the overall principles we set for Stage 3, which include aligning with emerging payment policies in the NQF, considering harmonized qualifications among the CMS programs, supporting population health analysis, supporting innovative approaches to

using HIT to improve health and healthcare, flexible adaptive platforms, and we want to try and not penalize success. Then as we go through our category we're supposed to look for ways to focus on several sets of functions, including real time impact of information at the point of care, like clinical performance dashboards or adverse event prevention. Secondly, on reinforcing and empowering patient partnerships, enabling access to information, contributing to the records, supporting caregivers, and working on measures that matter to patients, and then using emerging sources of data like patient reported outcomes covering a variety of CDS domains, including prevention, disease management, and safety, and then using population health assessment analysis and surveillance to drive policy making. So that's the broad summary. Let me stop there and just ask if that makes sense to people.

**M**  
Yes.

**M**  
Yes, it sure does.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. What I thought we might do is actually just to go through the existing measures for improving quality, safety, efficiency, and reducing disparities and then talk about where we want to go with those in Stage 3, and then also just think about are there things that we want to add for Stage 3 that are not in Stage 2. Josh, does that sound about right?

**Josh Seidman – Office of the National Coordinator**  
Sure.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

George, any other comments based on what the other workgroups are doing?

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Well, it's been hard to stay focused on Stage 3, so we have to avoid that temptation, although I guess the NPRM, to the extent that it changes what we thought with Stage 2, that has an effect on Stage 3, but, yes, I agree.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I have all these different summaries of the NPRM personally but it's a little challenging to figure out which one to look at. But hopefully we'll have a boiled down version of that reasonably soon that we can look at. The thing that I'm going to work off of is not from the NPRM, I'm just going to work off what our recommendations were, but if things came out differently I hope I'll remember, but if I don't anyone should feel free to note that. I'll be flipping back and forth between a couple of things. The first of these focuses on medications, and in Stage 2 what we said was more than 60% of unique patients seen during a reporting period with at least one medication, and their med list should have at least one med order entered using CPOE, do we think we would want to change that threshold in Stage 3? Is everybody there?

**W**  
Yes.

**M**  
David, was that the Stage 2 recommendation that you just read?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Well, I think so. Yes. So –

**M**  
From the NPRM?

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Again, I’m flipping back and forth here. Yes, so what I believe that Stage 2 says is that more than 60% of med, lab, and radiology orders created by the EP, or authorized providers of the eligible hospitals, or the CAHs inpatient or emergency department during the EHR reporting period are recorded using CPOE. So the threshold is 60% actually for med, lab, and radiology, for all three of those in Stage 2.

**Neil Calman – Institute for Family Health – President & Cofounder**

And so my clarification – this is Neil – is that 60% of each, or is that 60% of the three combined?

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

No, it’s 60% of each.

**Neil Calman – Institute for Family Health – President & Cofounder**

Okay, thank you.

**M**

Whoa, whoa, whoa.

**W**

That’s not how I read it.

**M**

No, no, it’s --

**M**

No, that’s not right.

**M**

Our suggestion was each, but the NPRM, I believe it’s combined.

**W**

Right.

**W**

It’s combined.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Okay, okay. I didn’t realize that that was the change.

**M**

But you actually could get there if you did 80% of two of them and none of the other, right, according to the NPRM?

**M**

That was our reading of it, Charlene, right?

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes.

**M**

Okay.

**M**

We can decide otherwise and make a suggestion in Stage 3. Separate from that we can make comments, not in this meeting on the NPRM itself, but –

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I think it’s probably fine, personally. It seems to me like we can raise the threshold a bit. For meds you’re not going to get to 100%, that’s clear. A lot of places that have been doing this for a while have gotten up to around 90%, 85% or 90%, and I personally think that we could go with either a 70% or 80% threshold if we wanted to.

**Eva Powell – National Partnership for Women & Families – Director IT**

This is Eva. I’m wondering, and maybe I’m not understanding what our task is here, but if I’m recalling correctly, we’re tasked with setting a visionary path for Stage 3, and I’m wondering if it might be a more productive approach to think about what’s missing from meaningful use thus far that we feel like we really need to have in order to achieve the goals that you read off to begin with, rather than talking about what we already have and whether or not to raise thresholds. Because I think part of what we learned in Stage 1 is that thresholds matter to a certain degree, but after a certain point they don’t really matter so much because once providers implement it, they implement it. And of course we don’t have the benefit of knowing anything about Stage 2 yet, to be able to use that for decision making about Stage 3, so it seems like to me that it might be a little bit more productive to really talk in a more visionary way about what are we lacking, because we’ve got a lot of good stuff in meaningful use but it seems to me like given what health IT is going to have to do according to the ACA we are still lacking an awful lot.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I was planning to do it in the reverse order, to go through the individual things so that everybody gets really familiar with them again, especially with what came out on the NPRM, and then ask at the end what things are we missing. But I’m open to doing it the other way around if you’d like.

**Eva Powell – National Partnership for Women & Families – Director IT**

Well, and that makes sense. Maybe we can just go through and, like you said, familiarize ourselves with at least what’s in the NPRM but not necessarily debate, because our task is not to come up with a response to Stage 2, correct?

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I think our task is to come up with Stage 3 recommendations, which is going to have to include alterations in Stage 2, and I think what we will come up with is actually probably going to be pretty close to Stage 2, but will include some additional things but not a vast amount. So we do have to decide about the threshold at some point.

**M**

So put forward a proposal. These things are all going to be flexible. David, what do you think?

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I’m fine with doing it either way. If everybody would rather just brainstorm about what additional things we should add, that would be okay too. What are other people sensing? David Lansky, which way would you rather go at it?

**David Lansky – Pacific Business Group on Health – President & CEO**

I think a lot of us are in other activities to go through the blow-by-blow in Stage 2 the next couple of weeks, so I think I’d do more of Eva’s suggestion and leap frog to the implications for 3.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Okay. Neil, are you all right with that?

**Neil Calman – Institute for Family Health – President & Cofounder**

Yes, I’m fine with it. I think that we should think out of the box here.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Okay, so let me just then, I’m going to spend three minutes just recapping what’s in Stage 2 just so that people get a sense of what’s in there in our area, and then we can blue sky. The first one is that med, lab, and radiology orders is the one that we just talked about more than 60% have to be recorded using CPOE. The second is that more than 65% of the permissible prescriptions be compared to at least one drug formulary and transmitted electronically. The third is that more than 80% of all unique patients who are admitted to the hospital should have demographics recorded in structured ways. The next one was that more than 80% of all unique patients have their blood pressure and height, length, and weight measured as structured data. The next one is that more than 80% of all unique patients have smoking status recorded. Then there’s one about five clinical decision support measures, which have to be related to five or more clinical quality measures. Then there’s one on implementing drug-drug and drug-allergy interaction checking for the whole period. Then there’s one that more than 55% of all clinical lab results, either in a positive or negative or numerical format, be incorporated in the certified technology as structured data. There’s one on generating at least one report listing patients. There’s one on more than 10% of all unique patients being sent a reminder for patient preference. And then the last one is that more than 10% of med orders created by authorized providers at the eligible hospital during the reported period be tracked using the electronic medication record. So those are the ones that are there. Now, what other things would people like to see added?

**Neil Calman – Institute for Family Health – President & Cofounder**

This is Neil. I think we haven’t dealt yet, on the CPOE issue, with the fact that we want the orders entered by the people who can act on the decision support. We’ve talked about that a number of times and I do just raise it as something for our consideration again, whether or not people are concerned about that folks have taken to using ... or having orders entered in by other folks other than those that can respond to the decision support. I’m not sure we want to deal with it, but it has been raised before.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Okay. That’s a fair point. And I’m hearing stories locally of a variety of types of data being entered by people who just don’t have the knowledge to deal with suggestions or to enter things in coded ways.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

David, one recommendation I heard was as we think of what we’re really trying to accomplish, which is to get to clinical decision support, perhaps spending more time building that out and getting rid of measuring CPOE and the feeder pieces of it might make sense. So that’s a big jump, but again what we’re really trying to accomplish could be part of the vision in terms of enabling that.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I didn’t follow that, Charlene.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

That would be saying, okay, if the real purpose of what we’re trying to do is to get the folks to use clinical decision support at the point of care, CPOE is just the means to do that and why not focus our measurement on clinical decision support. And then of course the byproduct of that is the use of CPOE and not measure that anymore, if you will. I don’t think we can go there in Stage 2, but Stage 3 we should really be thinking about having clinical decision support actually used.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Right. I think that’s an interesting idea and some of the stuff that we’ve done has suggested that people don’t necessarily, left to their own devices, include the clinical decision support that makes a difference, and that is a direction I think we’d like to go in. It gets a lot more prescriptive, so it’s a little challenging. Other thoughts about or reactions to that?

**David Lansky – Pacific Business Group on Health – President & CEO**

David, it's David Lansky. What I like about that direction is what Farzad also spoke to yesterday, is it takes the two paths, the measurement path and the clinical decision support path, and elevates them. Because ultimately that's what, at least not ultimately, but for the foreseeable future if we can create some framework that links adoption of CDS with adoption of the reporting of outcome measures then we're about as far as we're going to get in this stage of the overall work, and how do we do that and not get prescriptive. And part of it is maybe the ... issues that Paul's talked a lot about, and how do we make more plug and play capability in the platform by Stage 3, and then thinking in parallel about what is the library of decision support rules, or interventions I guess they're called now, and the library of corresponding outcome measures that could be implemented through EHR platforms and that would be fairly technology neutral and durable for the long haul, and then do that in a way which covers our five or six domains that we're trying to keep an eye on, care coordination, patient engagement, and so on. If in our group we can think about a way to build out that to test that ..., that would be a big win. And that's definitely what they're hinting at in Stage 2, but I don't know that we've thought through how to get there.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay, good suggestion. I think it would be possible, it would be a little tricky and it would be more prescriptive than we've been. It might require us picking some specific conditions and saying some things about them, for example. Eva, did you have other things that you –

**Eva Powell – National Partnership for Women & Families – Director IT**

And I'm just trying to think even further out of the box for what's not in there at all. To me things like telehealth and mobile health are things that we've not addressed at all, and yet have real significance, or could have real significance for all of the things in this area, quality, particularly quality, efficiency, and disparities. I don't know what that would look like in the context of any stage of meaningful use, but it would seem to me like somehow incentivizing the linkage between EHRs and some sort of telehealth that enables care in the least restrictive environment, so to speak, which is generally cheaper, which gets at the efficiency, and it's also where patients prefer to be, which gets at quality from the patient perspective, and it enables care where people may not have access to care, say, if they're in underserved populations and live 20 miles from the nearest care facility and don't have transportation, I think in the overall scheme of the national quality strategy and what we're all about, we really have to start heading in those more forward thinking directions for Stage 3. I think it's early yet to do that in Stage2, but definitely by Stage 3 we need to be sending, not just sending signals, but actually prodding people in that direction.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, so that's an interesting one. A complicated thing there is that the evidence has been somewhat contradictory in terms of how much difference it makes. There have been reports in which it made a huge difference, and then others which seemed to be pretty well done and which it didn't make a difference. But I'm confident that it will in certain circumstances and maybe we could require people to at least have tools that allow interoperability with telehealth applications, or mobile health applications.

**Eva Powell – National Partnership for Women & Families – Director IT**

Yes, and it may be something that we just deal with through standards, and the studies, because I'm not familiar with the literature, but the studies you're referring to in terms of the effectiveness, the effectiveness at what, what were they really looking at.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

There were two big studies of heart failure last year, which were very well done, which looked at the impact of telehealth on outcomes and costs in heart failure patients, and were both negative.

**Eva Powell – National Partnership for Women & Families – Director IT**

Yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

There's another study that came out from Geisinger today that shows that they got a 43% improvement in some outcome with telehealth in there.

**W**

Readmissions?

**M**

Yes, reduced readmissions.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Readmissions, yes, so it’s the sort of thing where we want to enable it but not be too prescriptive. I think we want to let the other incentives in the healthcare system help organizations do that, but if we want the systems to be able to handle –

**Eva Powell – National Partnership for Women & Families – Director IT**

Yes, exactly. I would totally agree with that, that this would need to be not prescriptive and fairly flexible. And I guess I come to that specific idea through the lens primarily of the disparities issue and using health IT to improve access, and by that I don’t mean anything about insurance coverage, but just physical access to the healthcare system, which is lacking in a lot of ways.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Sure, it has an especially big role in rural health.

**Eva Powell – National Partnership for Women & Families – Director IT**

Yes, yes. And I think, and Neil spoke to this before too, that so far in meaningful use we’ve got some things in there relative to disparities but it’s really not a lot, and I don’t know whether to talk about this for Stage 3, because frankly I think that we will be remiss if it’s not in Stage 2, but we’ve required, since the beginning, the collection of data to help us improve disparities, and yet even in Stage 2 there’s no requirement to actually do anything with that data. So in my view that is absolutely something that should happen in Stage 2, but in the event that it doesn’t, in my mind that’s another thing for Stage 3 that we really need to have in there.

**Neil Calman – Institute for Family Health – President & Cofounder**

Yes, I would agree. And I would jump in and say that we still haven’t done with some of the criticisms that were sent by members of the LGBTQ community to change the way we capture data. That aspect of demographic data I think we still have in the Stage 2 male and female, and there were a number of comments about that. I expected something to emerge, but nothing actually appeared in Stage 2, but it definitely should be dealt with in Stage 3.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Do you mean gender specifically or sexual preference?

**Neil Calman – Institute for Family Health – President & Cofounder**

I think both, was what was recommended. And clearly the way it’s currently laid out in the demographic field doesn’t respect the many ways that people self-identify. It’s interesting that that was dealt with substantially in the IOM report in relationship to race and ethnicity, but not at all in relationship to gender identification.

**Eva Powell – National Partnership for Women & Families – Director IT**

In the IOM? In the NPRM there is a question that asks for input on that topic, so I’m sure they’ll get a lot of feedback on that topic.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Okay. Marty, suggestions?

**Marty Fattig – Nemaha County Hospital – CEO**

The big thing that would really help us in rural communities is the development of standardization on interactivity so that HIE becomes a reality. The real benefit for rural hospitals in having an electronic

health record comes when we can share that data across multiple organizations, and that's the big thing I want to see in Stage 3 is that interconnectedness.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

David, this is George. As I sit here, as Marty just said, I'm thinking of the kinds of things we want to do in Stage 3 and I keep going over to something for patient engagement, something for care coordination, which are not the groups we're in, we're in group one, quality ..., but I think the people in this group have a lot of good ideas about what should go in those other things. So the thing I'd be cautious about is that when we have ideas, even if it's another group, those ideas get to those other groups, just in case, say, Marty's not on – Marty, are you on group three?

**Marty Fattig – Nemaha County Hospital – CEO**

No, I'm in group four.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

And I've got the care coordination one, so I think we –

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Okay, so that's good, Charlene, you're here.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

I'll listen. But that's a good catch and I'll make sure that I capture the notes.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

And in fact it may turn out that the innovation in Stage 3 is to do less in group one, consolidate further, and shift more towards these other things, because the outcomes are in the quality measures, that's one shift, and the emphasis is on patient engagement, care coordination, and public health perhaps, so it may be that we do less, not more, in category one, just as a question.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes, so to follow up, I was thinking about – this is Charlene – what David said, as we look at what's in Stage 2, I know we can't analyze that, but there's a lot of implications of that, you've got to choose one from each one and then choose a measurement, but maybe spending some time and going through those different categories, and again using that as a framework, it becomes more outcomes based, would help generate the thought process too. And I understand that we might have to be more prescriptive in one area or another, but we've been prescriptive before, so that's just another way to frame our approach to Stage 3, because it links the front end process to the back end process.

**Eva Powell – National Partnership for Women & Families – Director IT**

Right, yes, I agree with that totally, because the other thing that I think needs to go in category one for Stage 3 that I don't have specifics on yet are making sure that whatever we do in that category gives us the key functions and key data that we need for the quality measures of the future. And I think that links up to what Charlene was saying, in that if we focus on the domains of quality measurement that we're after, and obviously for the most part there are no measures there, or what measures there are, are few in number and some of questionable value, again, blue sky, what do we want to measure in those domains, and I think that we can be fairly realistic and on target about what the specific data elements might be. The difficulty I think comes in formulating the actual measure, but to me that's probably one of the highest value things we can do for the first category, and there will be elements, obviously, in the other categories as well. But I also agree with, I think David said that as we move forward that it will be harder and harder to delineate which category things go in, and particularly for the one that we're tasked with, that there will be less and less and more in the others.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I think that there's still some stuff for us here. One place that I would like to see Stage 3 go is where we talk about decision support and we just have now, say five rules, and I think we could ask for it for

specific domains including prevention in the outpatient setting and also for a couple of chronic diseases, specifically diabetes and coronary disease it works very well; some others there's less evidence that it works well.

**Eva Powell – National Partnership for Women & Families – Director IT**

Yes.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes, because there's not a whole lot in there yet for prevention either.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

No, exactly, and yet it works really, really well for prevention.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

That's where the evidence is the soundest.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes.

**Neil Calman – Institute for Family Health – President & Cofounder**

I think we're going to run into this specialty versus primary care stuff there, the preventive measures, the preventive decision support and things like that are going to be very different based on specialty. So I agree that it would be good to call out the various types of decision support and maybe suggest that we want to ... at least one in a variety of domains. But I think we're going to have to leave it fairly flexible so that they're relevant to the particular practices of the providers.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Or we could even just give specialists a free pass on the prevention part of things.

**Neil Calman – Institute for Family Health – President & Cofounder**

Well, there are a lot of specialists that are involved in prevention in their own areas, and the question would be to say, I think we can examine this to see whether or not there are exemptions for surgeons and other things like that, but I wouldn't want to just exempt all specialists because I think a lot of times people get their primary care from specialists and if we exempt them we're going to end up doing a disservice to folks.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, I think everyone should have a primary care provider myself.

**Neil Calman – Institute for Family Health – President & Cofounder**

Right. Well and with the extension of HIE in the future we ought to be able to fulfill the recommendations through information that comes from exchanges so that we're not plagued with telling people that they need to get their flu shot and having them say well, I got it somewhere else. We ought to be able to think about the way they got information and decision support, because we know that people go all over the place for care and right now we're creating more and more decision support, more and more of which are being answered by people saying they got it someplace else. And if we can think about ways to facilitate the satisfaction of those decision supports with information that comes from exchange, that could be an enormous benefit, and it would lessen the fatigue that people experience with all of the decision supports that they're getting now.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay, that makes sense.

**Neil Calman – Institute for Family Health – President & Cofounder**

That's a good interface between the HIE kind of world and what we're talking about.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Right, and that's also a good example to the degree that that enables the knowledge of a specialist to inform the practice of primary care, for prevention purposes, that care coordination.

**Neil Calman – Institute for Family Health – President & Cofounder**

The analysts for ... could potentially satisfy the decision support themselves through the portal, and I think that what we really want to do is create a much more flexible interaction between the decision support, so that they're not only satisfied by visits and by provider input, I think that's going to make them incredibly more useful.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. Just one thing I had a question about, and it's not clear to me how specific we were for the quality measures about how they'll actually be transmitted.

**M**

Do you mean transmitted to CMS, or to the ...?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Or some other central entity.

**M**

Or how they're made available to providers so that providers can actually easily access their quality measures so that they can do things in relationship to quality improvements.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Exactly.

**M**

That's the most important.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes. This is challenging, because who the holder of the data is does seem to vary a lot.

**M**

If it's not clear now, and maybe it's not, and specific, that the quality measures that we're calling out have to be accessible and available to providers through the electronic health sector we should clearly specify that, because that would just be absurd to collect all of this information and not have it be available to providers to act on.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I like that idea.

**Eva Powell – National Partnership for Women & Families – Director IT**

Yes, and if they're sending it to the HIEs to do reporting and that kind of stuff, that's harder to do.

**M**

Well, but it's got to come back ... .

**Eva Powell – National Partnership for Women & Families – Director IT**

I get it, so for Stage 3 it's a two way would have to be in place. I get it.

**M**

Yes.

**Neil Calman – Institute for Family Health – President & Cofounder**

Something else that came up, and I'm going to have to jump off in a couple of minutes, something else that came up yesterday which Paul ... to the safety column, was the issue of the safety involved with the actual IT systems and that in fact as we become more and more dependent upon these systems the major safety issue becomes what happens when they're down. And we really don't have any kind of requirement about downtime procedures or requirements about what kind of safeguards need to be put in place for the systems themselves. And actually I thought that was a great point that was brought up yesterday and we shouldn't lose it.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes, I'd agree.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I agree also.

**Neil Calman – Institute for Family Health – President & Cofounder**

I know, we're just completely devastated when our system's down. It's like people walk around like they're chickens with their heads cut off. We have downtime procedures and everything, but it so severely limits the quality of care, and the more dependent we become on these systems, the more it's going to affect our ability to practice without them. So I think that's a critical feature, and Paul wanted that put on the agenda for the safety area.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I think that's a good suggestion. I'm just still struggling a little bit with what we recommend.

**Neil Calman – Institute for Family Health – President & Cofounder**

I don't know if we need to – well, we could start with, one thing would be that there be some sort of a vulnerability analysis that's required to be done by providers and by systems. I think the major part of this is an educational effort, but that people would have to attest that they've done some sort of specific vulnerability analysis that could be developed that's very specific to the various types of providers. But I think that for us just the educational component of having hired somebody to come in and do that was enormous, because we didn't even understand what all the vulnerabilities were, that it's not just about the power going off.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes. Okay, that's helpful. George, do you have any other thoughts about this one?

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Yes, there are some unintended consequences. It feels like the privacy policies for data ..., it's that kind of style objective.

**Neil Calman – Institute for Family Health – President & Cofounder**

What do you mean by that?

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

It's kind of infrastructural, you have the policies and procedures, in other words, you have to check that your system conforms to all the security procedures. It's our security group that makes sure that we've done the right things to make sure our systems stay up 100% of the time. Our security audit is the one that makes sure we have 100% uptime. I don't know that Deven really wants it mixed in there, but the objective is similar, maybe it's a parallel objective.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

The other thing that came up a lot in our IOM committee is that when you look at safety issues that are created by the record, the key problem is that people will find problems but then they don't implement corrective actions. And it would be nice to say something about putting in place a plan that lets you track issues that you think might be related to safety and then deal with them in a systematic way or something like that. Again, it's a policies and procedures sort of thing.

**M**

Yes.

**M**

... .

**M**

Yes, I think it's a good idea to bring it in and then we have to avoid making it onerous, but just increasing awareness that they need to do this is important, at the very least.

**M**

Yes.

**M**

We're trying to get adoption ... so we're trying to do it in the right way.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Right, but we're also trying to –

**M**

No, we're trying to accomplish something here, which is improve quality. We're not going to improve quality if people keep making errors to the EHR.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Right.

**David Lansky – Pacific Business Group on Health – President & CEO**

I agree.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. Let's see, who's been quiet? Charlene, are there other ideas that you have?

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Well, are there any gaps in the end-to-end medication? We've worked through reconciliation on the front end, where now we're able to send the data out so that it's reconciled through the care coordination flow, we've got CPOE, we've got med administration, so is there anything else in that flow? I know there's other technology that's used in that flow, but is it anything relevant to an EHR that we want to put in?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

The other one that I think of is smart pumps, and eventually I think we'll want to be able to transmit orders to smart pumps. But I see that as being a little outside of where we want to go yet. That's the other one that I think of. What do other people think?

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Clearly we want to raise the bar at Stage 3, we want to change where we are in terms of safety in this space.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Right. I think a key thing there is what Marty suggested earlier, which is just to be able to, for medication administration, to make sure it's in coded form and then to be able to ship it around to various places. And that applies for other types of information too.

**Neil Calman – Institute for Family Health – President & Cofounder**

This is Neil. I'm going to jump off.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay, thank you.

**Neil Calman – Institute for Family Health – President & Cofounder**

Have a good day, everybody.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

I think then the only other one, I would rather use the measurement approach for this one, the clinical decision support measures. One of them that did not make the list again was clinical documentation, but you've got to document, for instance, that you're following – it generates that the patient's diabetic, and you do certain things and you document those things, and so we don't have documentation in Stage 2 again, so again as driven by what we need to do for clinical decision support to improve quality, it seems like at least we've got to touch on that.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

That's a good one. I think we should just say that the clinical documentation needs to be electronically available.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

We're doing some stuff now to see whether quality is associated with different approaches of doing it electronically, so using dictations and then just uploading it, versus doing it using templates, versus doing it electronically and not using templates. There aren't big differences. Actually the templates end up not looking so good.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes.

**M**

Which is not a huge surprise.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes.

**M**

Yes. Yes, I agree. And so when we go over the NPRM we'll have to address our response to not including documentation in Stage 2, but if we were including Stage 2 we'd be thinking of, well, what would we do extra in Stage 3?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

We can still add it in Stage 3, even if it doesn't make Stage 2, can't we?

**M**

Yes, I mean the argument is that it's already done in the NPRM.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

What do you mean, I thought it was left out of the NPRM?

**M**

Yes, because doctors have already completed it.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I don’t think –

**M**

Well, yes, well we did NPRM, but the rationale is it’s getting done and will get done and so we don’t need to ... objectives, that’s the rationale.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I got you.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Okay.

**M**

So what we’d have to do is come up with something that says if we don’t put it in as an objective, here’s what will go wrong.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

So I can just confess, like the issue that I think, David, you brought up in care coordination documentation, again, has been focused on billing, not necessarily care, and I think we want to change that paradigm a little bit in terms of you need it available but it also is relevant to care interventions you’re making too, right?

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Yes.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

So that was why I thought if we could have that focus on it we can change the paradigm a little. Maybe that’s happening.

**Marty Fattig – Nemaha County Hospital – CEO**

This is Marty. The other piece I see of this, one of the things that we need is physician documentation, we have pretty good documentation by other providers. But the thing we need to do is that our vendor, unless we specify that physician documentation is a necessary part of this our vendor’s going to go off and use those resources to focus on the other things that are specified as requirements.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes.

**M**

Yes.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

And physician documentation in hospitals is hard, so ... –

**Marty Fattig – Nemaha County Hospital – CEO**

Extremely hard, yes.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

This is George. I don’t know if this is Stage 3 or Stage 4, when we do our thing we always had the next column to push things –

**W**

We ...

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

... we need Stage 4. So if we're trying to create a learning healthcare system is there anything in this category that we need to do to accomplish that? Is there something about reusing the data, secondary use, sharing the data, analytic tools, I'm not sure what it is exactly, what is it that is needed? What are the components that are needed for learning health systems, where you're learning locally as well as nationally?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I guess I thought about just requiring that a lot of information be available in coded form. That obviously will enable that.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Again, we don't really want to be too prescriptive on what tools would be useful. I don't know what it is, but if we're going to do something with this category, that would be one direction. The other thing we're not doing that much of is how much efficiency.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

That's what I was thinking about too, actually.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Yes. But some of that efficiency could be in the quality measures, which would be efficiency measures, I guess, officially then. Or are there things we need to do in this category to promote efficiency? ... decision support, one of them being efficiency, that's for the NPRM response.

**David Lansky – Pacific Business Group on Health – President & CEO**

I think it goes back to the CDS, but the issue of appropriateness as part of the efficiency bucket, there may be some way to call it out in the CDS strategy. But what I was getting at, to David's point, about capturing the right data, when we start getting into some of these appropriateness studies we often don't have the indications we would like to have that map easily to ... professional societies appropriate use guidelines, and maybe it's worth a little bit of analysis or talking to some of those societies about the appropriate use criteria work they're doing, what the indications are that they're beginning to look for and whether we're properly capturing those indications in the chart.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I think that's a good point. Some of the exciting stuff that we're thinking about doing now basically involves having a specialist see a patient and before they actually see the patient all the stuff that their society is going to require is sucked in and that lets them generate a patient specific consent, which basically includes all the patient specific risks for a procedure, which makes it much more patient-centric and gives them a more realistic sense of what to expect. It also just makes it easier for the provider to get stuff to the specialty society, and it appears that a lot of the patients who probably should not have surgery are ones who are too high a risk and they might take a look at this patient specific data and decide maybe I shouldn't have this procedure after all. So I like David's suggestion. I guess what would be involved is maybe just doing a little more homework with a couple of those groups. Is that what you were thinking, David?

**David Lansky – Pacific Business Group on Health – President & CEO**

That's what I'm thinking, at least exploratory. I know ONC staff spends a lot of time hearing from them, maybe they have a better handle on it and we could shortcut that a little bit.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, and anybody from ONC want to comment?

**Josh Seidman – Office of the National Coordinator**

I'm sorry, what was the question?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

We're asking, one thing that's been suggested is making sure that the data that we're collecting can be mapped to appropriate use criteria, many of which have been developed by specialty societies. Is there more homework for us to do around that? I know you guys interact with them a lot, do you have a sense of how well the recommendations so far line up with their needs?

**Josh Seidman – Office of the National Coordinator**

Well, we certainly have been trying to think about how to address their needs. I think to the extent that there are additional things that you all can recommend to us, I think that would be helpful.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay, so maybe a little more homework with a couple of those would be useful. At our own place we already collect pretty much everything that, for example, the two biggest ones need and we map it in sufficiently coded ways. But I suspect that's not the case for most institutions.

**W**

Right.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

And that they would have a sense of what some of the big gaps are. The other place on efficiency is I think it will be valuable to have information available to the ... in the record about, at least relatively speaking, how much things cost. We have something in there about the formulary, but I think that's really the only thing that we say about that that I can think of. Is there anything else that's in there?

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes, the formulary is just for eligibility typically, not for that whole thing in terms of when you're putting the most cost effective, being part of that drug on the top of the list, so you're driven to make the right choices, that type of thing.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Right.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

And I don't know if there's a criteria we can put in there, make it easy to do the right thing is kind of what you're talking about.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Right.

**David Lansky – Pacific Business Group on Health – President & CEO**

David, is there anything going on in interfacing between the clinical EHR and any of the cost tables that the provider systems are maintaining that would lend thinking of it as an interface question as much as a specific CDS question?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Sure. There's cutting edge stuff going around that. A lot of the research that we're doing now relates to stuff like that, but I don't think that there's very much like that that's commercially available at this point. But for medications, anyway, it is possible to at least give providers a sense of what the relative expense of a variety of medication choices is going to be. There's pretty good evidence that that makes a difference, so that's something we can call for.

**Marty Fattig – Nemaha County Hospital – CEO**

Just as an example, this is Marty, back in my laboratory days I was able to, through an LIS, every time I reported out a sensitivity report out to cost of all those drugs that were appropriate to be used for that ..., so I think this can happen and it's of great value.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes. Let's see, I think we're not supposed to use the words "cost effectiveness."

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Was that an ... alert?

**M**

Yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, but I can't remember what the –

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

What we're supposed to say now.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes.

**Marty Fattig – Nemaha County Hospital – CEO**

I've never been very politically correct, I guess.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

But I think the point is a good one. If you look at where we're strong and not so strong, this is one place where we're not so strong. And we're not so strong in disparities either, as has been pointed out. We talked about that a little before, but are there other things that we can do that would help on the disparities front? I'm not coming up with anything.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

The things I'm coming up with fit better in other categories.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes.

**Eva Powell – National Partnership for Women & Families – Director IT**

Yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Eva, I like your suggestion from before of at least requiring providers to do something with these. We might, for example, so if we require that the quality data be available to providers we could require that they be available to providers in ways that let them stratify by race and ethnicity, or the like.

**Eva Powell – National Partnership for Women & Families – Director IT**

Right. That's the place where I see it being entirely reasonable to want that for Stage 2 is that we've got the collection of the data and then we've got the report by condition, and while there are a number of uses for that report by condition, the methodological one in my mind is to look at disparities of care and how can we address, from a population health level, the condition and the disparity. So in my mind linking the collection of ... data with that report makes total sense and brings value from both of those criteria that otherwise won't be there. But for Stage 3, I don't know what the next step would be, other than moving into the other areas of data collection such as disability status and cycle orientation gender identity kind of stuff.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

The other area, and again we were talking about this on the population health one, when we were looking at secondary data use was, for instance, and again this could affect our domain if, for instance, identification appears to be eligible for trials and helping to manage them, there's a lot of functionality required to do that. So I don't know if that's anything that we want to – there's clinical decision support there too, so I don't know if that's relevant. That's just another one, as we're thinking out of the box a little.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, I think it's good to make a note of that. As I go back to the safety things, something that did not make it in is having the providers take some sort of test to see if their record actually does include some key decision support. Again, they did this study in the inpatient study and hospitals did really terribly on that. That would be a substantially different approach than has been taken so far, in which you just tick a few boxes and self-attest. But I think that adding a test to see, for example, if you have the most important drug allergies in place, drug-drug interactions in place, would raise the bar, at least on the drug side of things. What do people think about that? Okay.

**M**

... .

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Are we running out of steam here?

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

I think just as a strategy perspective, I think David said that earlier, it's like as we start to look at if we can focus on some of the clinical decision support and some of the domains that we need to get more prescriptive in those domains moving forward, especially if aligned with measurement. Because it seems like you can do clinical decision support in a lot of different places within a system more than CPOE –

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Sure.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

So it would seem like we want to build out on that. You can do it during the assessment process. You can do it in the reminder process. There are a lot of places. So it would seem like we want to continue to leverage that.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, I agree. And if we did do something looking at during CPOE, you could give people credit for doing it in a variety of ways. That would be the intent. Okay, if we're running out of steam I could just recap here.

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Okay.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Do you want to do that?

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

So lots of good points were brought up. One was the notion of considering spending time focused on decision support and potentially even getting rid of the CPOE threshold. David brought up the point of ... issues, what do we do to get to more plug and play, and I feel like we have some more work to do there, and also the notion of taking a set of decision support and linking it to a library of corresponding outcome measures. Eva brought up the notion of telehealth and mobile health and we want to do something that enables that clearly. Around disparities, we talked about broadening things to have it include a requirement to use data about race and gender and also sexual preference. We talked about development of standards on interactivity to make interoperability a reality. That will be handled by another group, but that's an important notion. We talked about the possibility of making clinical decision support more specific, including prevention and some specific chronic diseases. We talked about electronic transmission of quality data. We made a point about possibly making quality measures in Stage 3 a two way sort of thing so that they come back to the practice, which I think is exciting and a good notion. The suggestion about downtime, the suggestion about tracking unintended consequences and showing that you have an approach for dealing with them, and on the clinical documentation, including something about that, that it goes beyond whatever is in Stage 2, I'm concerned about leaving that out because, as was said, I think the vendors will leave it out if we –

**Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs**

Right, we've got a lot to do. We've got to build all this interoperability.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

There's George's notion about making sure that we are able to reuse the data and use it for secondary use and share it, the notion about mapping to appropriate use by specialty societies, the idea about relative cost effectiveness of drug providers ... status, doing something around trial eligibility, and then considering requiring providers to take a test periodically. So those were some of the ideas that came up today, anyway. I think this has been a really good discussion. Obviously everybody's going to be going over Stage 2 quite a bit in the near term, because we have to come to some consensus about that. Other things before we open it up to the public? Okay, hearing none, can I –

**Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor**

This is Mary Jo. I am back on the line. Thank you very much. So we'll ask the operator to open it for public comment.

**Operator**

(Instructions given.) We have a comment from Carol Bickford.

**Carol Bickford – ANA – Senior Policy Fellow**

This is Carol Bickford from the American Nurses Association. As you proceeded with your conversation you spoke about the specialist activities and what's in Meaningful Use Stage 3 for those folks. I would like you to broaden your thinking in light of the fact that this is a tipping point sort of action and many other clinicians would be benefiting from the thrust of the electronic health record distribution and the technologies. So please don't think just physicians. Thank you.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Thank you.

**Operator**

We have no more comments.

**Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor**

Thank you.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay, so thank you all and we will be in touch.

**W**

Thanks.

**M**

Very good. Thanks so much. See you all next week.