

Subgroup #1 – Improving Quality
Draft Transcript
April 26, 2012

Roll Call

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Hi, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the Health IT Policy Committee, the Meaningful Use Workgroup Subgroup #1, Improve Quality. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself before speaking. I'll now go through a quick roll call and at the end ask any staff members to identify themselves.

MacKenzie Robertson – Office of the National Coordinator

David Bates?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety – Senior Vice President for Quality and Safety

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks David. Charlene Underwood?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Charlene. Marty Fattig? Michael Barr?

Michael Barr – American College of Physicians

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michael. Neil Calman? Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO – Internist, VP & CMIO

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. Eva Powell?

Alice Leiter – National Partnership for Women & Families

This is Alice Leiter, I'm sitting in for Eva today.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Alice. And is there any ONC staff on the line? Oh, David Lansky, sorry?

Michelle Nelson- Office of the National Coordinator

This is Michelle Nelson from ONC.

Jesse James – Office of the National Coordinator

And Jesse James from ONC.

MacKenzie Robertson – Office of the National Coordinator

Okay, David, I will turn it over to you.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Great, thank you. So, again we’re the Quality and Safety, Efficiency and Reducing Disparities Group and our focus is on getting ready for Stage 3. We’re planning to, in this work to apply the following principles; I’m just going through some stuff to frame things again for everyone. First of all to align things with emerging payment policies, to consider harmonized qualifications among CMS Programs, for example cross crediting between ACOs and Meaningful Use as a possibility, supporting population health data analyses, supporting innovative approaches to using HIT to improve health and healthcare, trying to develop flexible adaptive platforms, and then not to penalize success.

And we’re supposed to look for ways to focus on the following functions demonstrating real-time impact of information at the point of care, reinforcing and empowering patient partnerships, trying to utilize emerging sources of data including patient reported outcomes, covering a number of specific domains within clinical decision support and then using population health assessment analysis and surveillance to drive policymaking.

And our subcommittee, we will need to be done by roughly the June timeframe. The plan will be to iterate and then deliver our recommendations to the full committee in mid-to late summer. Paul, is that a reasonable quick overview?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes, I think we might be going more towards the end of the calendar year because we were intending to publish a request for comments around September.

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David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Okay.

Michelle Nelson – Office of the National Coordinator

I'm sorry, Paul, can you say that again? When did you say the request for comment would be?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

In around September. So, if we essentially went to the full committee in August, and I hope I’m reading from the latest calendar, full committee in August to get feedback from the full committee, then we prepare our RFC in September, get those results back in October, analyze and summarize those things and then input that back into the Meaningful Use Workgroup process to come up with our final for the Policy Committee by December.

Michelle Nelson – Office of the National Coordinator

Okay, that is what I had, it just sounded different. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay, sorry.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Okay and then let's see, so I have a number of notes from our March 8th call which I won't go through in detail, but on that call we talked about things from a relatively big picture perspective and asked questions like what should we include in particular in terms of disparities? Should there be a requirement to use data about race and gender? Lots and lots of specific points, which I think in the interest of time I will not go through now.

Let me just ask at the beginning, what do people think will be the most helpful way to go through this? Would you like to have more big picture discussion about what we want to do or would you like to go through the Stage 2 recommendations or what actually was included in the NPRM which we now have? How would you like to proceed?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And David, this is Paul again, do you mind if I eat all of my words because I had a sneaky suspicion we had updated this.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

May I go through that?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Absolutely, go ahead.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay and the main reason is because we had to make sure we could get the final rule from Stage 2 before we sort of finalized our Stage 3. So, let me start again. The small groups, as David reported, would be coming back to the Meaningful Use full Workgroup in the June/July timeframe. We would be presenting to the full community in August and then, because we're not expecting it until a little bit later, because it didn't come out until the end of...well actually not until March, early March, the final rule we're expecting a little bit later than we had originally anticipated, so we pushed everything back. So, that means reconciling our Stage 3 draft with the final rule, Stage 2 rules in the fall timeframe, September/October, then presenting our preliminary recommendations to the full committee in October or November, and getting information out to the Standards Committee, that's one of the things we're trying to link it more closely in December.

So, the RFC, trying to avoid the holiday period would not go out until January coming with comments due back in February. The summary of the comments coming back in March and then the Workgroups going back and reconciling the public comments and the HIT Standards Committee comments in April and coming back to the full community for feedback in May. And then, so finally getting the final approval in June which would make the transmittal letter in July. So, I apologize for mixing things up. So, we have a little bit more time, because we're trying to sync up with the final rule for Stage 2 and allow sufficient time for the RFC.

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

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Sorry about that.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

It’s confusing.

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

Yeah, we’ll have to...okay, that is helpful to know, it makes sense.

Michael Barr – American College of Physicians

David, this is Michael Barr, quick question for you or Paul?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Sure.

Michael Barr – American College of Physicians

At what point are we going to have a full set of data from what happened in Stage 1 to help guide us through what should be for Stage 3 in terms of quality measures and impacts, and changes or challenges? I know there has been some testimony already but are there going to be data we can review as part of this process?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

As, I understand it not until late June. Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, they are publishing things every month and there is actually now a webpage that has the most up-to-date stuff and I think, for example March is out. So, we have a really good idea of what is not being selected from the menu and most of the either ambiguous or hard things are not being selected. A lot of those things of course become core in the proposal for Stage 2. So, there is a fair amount known about the number of folks, you know, we’re up to like 4.5 billion dollars being distributed, a sizable proportion of practitioners are registered and even more on the hospital basis. So, there is a fair amount known. Does that help answer your question, Michael?

Michael Barr – American College of Physicians

Well, yeah, I understand that there is data out there, but as I recall from some of the testimony we heard just a few months ago, there were some issues with existing quality measures and it’s one thing to look at what people are doing but it’s another to find out why they aren’t being able to do other kinds of things or some of the measures or lessons in the field as it was and so you’re absolutely right, the data sets that we have are important, but obviously it has to be influenced by some experienced tales and stories and we got some of that from the testimony. Do, you expect to get any more during this process as we’re thinking about Stage 2, recognizing we’re not going to have anything from Stage 2 obviously when we start putting forth ideas for Stage 3.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. There are continuing reports we are going to be getting at the full Policy Committee from the field and particularly the RECs; you probably know there is some really active dialogue on quality measures because as you pointed out that was one of the number one challenges and obviously something that wants to change in Stage 2 and beyond. So the Quality Workgroup is working pretty intensively on that and as you know, CMS also wants to align it with its program. So, that is pretty active and the messages have been pretty well heard in terms of how challenging it was.

Michael Barr – American College of Physicians

Okay, that’s fair and I imagine we’ll be able to look at some of the comments submitted for Stage 2 with respect to quality to hear from folks, correct?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Correct.

Michael Barr – American College of Physicians

Okay.

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

So, Paul, this is Charlene, I was actually at the collaborative meeting today and listened to some of the presentation and was certainly very impressed with the alignment between CMS and ONC and the work they're doing to kind of align the programs, you know, we started there, I think that was one of the principles David gave us. I just wonder if it makes sense that some of that information, I think it was Suzanne from CMS shared, if we want to move to...and maybe you're more in touch with this, the more outcomes oriented approach in Stage 3, again they identified the domains and she identified where there are gaps in the domains, but, you know, particularly under pretty robust domains already under, you know, acute care, you know, the patient centered and patient safety ones where they're doing some work now, so I don't know if it makes sense to share that with the broader group in terms of that presentation or have her chat with us.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Are you talking about Kate?

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

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, let's see. Well we can certainly get NQF to share that or Kate directly; to share that with this group and you have a good idea to present. Now, you know that a lot of this is covered under the Quality Workgroup, right?

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

Yeah, and again it was unclear, you know, how it's aligned, but it was really exciting to hear it directly from CMS. And you know the map process and all that.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay, and my understanding was on the quality metrics that this is again through word-of-mouth through NQF is that we'll have a lot more definitive data about how people are doing with those in the sort of mid to late June timeframe. Does that make sense to you, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I'm not sure exactly what you're referring to and maybe I'm not remembering something, but?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Sure, sure, this is from some comments from an NQF Committee that I'm serving on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay, all right. So, let me just ask again, how would people like to proceed today? Would you like to, you know, start by marching through what we've asked for in Stages 1 and 2 or would you rather, you know, have some more general discussion as we did last time? I personally am ready to start going through the individual items, but I do want to do what the group would consider to be the most helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, that sounds fine to start making progress, right?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, okay. Okay, good. So, I'm going to work off the Excel spreadsheet that was sent out which summarizes where things were for Stage 1, Stage 2 and then the Stage 2 NPRM that was sent

out to the committee last week, which it will look pretty similar if you look for example at the document that we have had, which includes what was in the Stage 1 final rule and what was proposed by the Policy Committee in Stage 2. So, the first area on focused on quality safety and efficiency and reducing disparities, and Stage 1 said you had to implement one clinical decision rule. In Stage 2 the NPRM suggested focusing on high priority health conditions and then implementing five clinical decision support interventions related to five or more clinical quality measures at a relevant point.

And it also said that the EP-eligible hospital or CAH has enabled a functionality for drug/drug and drug allergy checks. So thoughts about where we might go for Stage 3 around that? I mean, I think that there are more quality measures that we could target a specific larger number of quality measures, for example. I think the focus on high-priority health conditions is a good one.

Michael Barr – American College of Physicians

David, it is Michael Barr, I'm at a bit of a disadvantage because I don't have the sheet in front of me since I'm driving, I apologize for that, but I agree with your, you know, vulnerable population. Is there anything you thought about going further into the health disparity issues and making those more of a focus for Stage 3? Is that something you're thinking about?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yes, and I think we'll get to that. I think that one should come...well actually I was thinking it was going to come up in a minute but now I'm trying to look and see where it does. But, I think we should definitely do that.

Michael Barr – American College of Physicians

I could see that being a major choice, if it's in a different section of the document I apologize, again, because I am not able to look at.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

No, its okay, actually as I scroll down, I can't find it.

Michelle Nelson – Office of the National Coordinator

David, this is Michelle, I think if you're looking at the document, there was a mention of health disparities within the demographic section because I believe what was being said for Stage 2 was that was really the only area that we were touching upon health disparities.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Okay, okay. So, you know, one thing that I think we should definitely do is for any of the quality measures, the clinicians should report basically the race and ethnicity as well so that you can do analyses around that. I think we talked about that at the last meeting, to say that you should be able to stratify by race and ethnicity. Do people feel comfortable with that?

Michael Barr – American College of Physicians

This is Michael...go ahead, I'm sorry.

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

Yeah, this is Charlene, the questions that we've started to hear on the measurement side are, you know, to what end are we doing this because there is a lot of burden on the part of changing the processes of the providers as he roll this out. So are there measures that correlate to this that we're capturing it for? I really think in Stage 3 we've got to look end-to-end as we make these recommendations. So, you know, evidence of use of making these investments.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Sure, so for example, for hypertension there are instances in which it's important to be able to stratify by race.

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

Yes.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

The same is true for at least some other chronic conditions. This is a question we could put to the quality.

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

Yes, I think so, you know, evidence of the value, because we're talking about that set of measures that matter.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

And I think that helps build the case, you know, if you will.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah. We do capture race and ethnicity and we're basically setting up things so that we can stratify all of our measures ourselves, you know, within the institution that way and it just...once you do that, you can look at disparities. If you don't do it, it's hard to. What do people think about the concept of going to some larger number of clinical quality measures again, this would have to be linked with a quality group and we would have to be going after measures that matter.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think one of the thoughts, as you know in part in Stage 2, part of the recommendations from the Policy Committee was that we'd have what we called a quality measure platform. I mean, the goal is to really have a flexible tool that instead of having all of these measures hardwired, that there be a tool that the healthcare organization could use to report on many measures and it wouldn't have to be hardwired. It's not clear, and maybe this is one of the things we reconcile once the final certification rule comes out, if we get that then more isn't much of a burden. Without that I guess what's been going on, and I understand this, the vendors have been...so let's say you have 100 measures or you have 200 measures where the vendors have to make all 200 reportable even though one organization might report on let's say, 12.

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

Yes, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And the way they're doing it now hardwired, that means they've got, you know, 200 and they make a mistake and have to release an update, that's sort of the bind we're in now. So, that's one of the

challenges with more measures even though the number of measures gives them perhaps more flexibility especially for specialists.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Right, so what’s the best way to try to get around that? I mean is there...can we say that they should be using say a table driven approach or some sort of approach that is not hardwired?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, that’s what we’re proposing right now. In fact there is a Workgroup with vendors to try to give us feedback as we, you know, make our final response to see how possible that is in 2014, you know, Stage 2 timeframe. I think a lot is being gated there, but I suppose...yeah, so a lot is riding on that capability.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Is this something we can ask for in Stage 3 even if it’s not in Stage 2? I mean, it seems to me like it should be.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, that’s a good point, that’s right, I sort of lost my bearings here in the sense of yes Stage 3 is 2016 at least and so that is a good 4 years from now and so hopefully we can assume that kind of flexibility is built in.

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

The comment...and I think this kind of...they comments coming out of the, this is Charlene, coming out of the collaborative meeting and requirements today, is again...there is an effort again whether we’re using QDM, but some mechanism to start to standardize the measures using common terminology and the vendors being able to uptake that and with that kind of scenario if the measures are derived from that what you’re talking about is more viable, Paul, in terms of having that platform and such that the data that are part of it are kind of already gathered in the workflow. Now, that is not going to be everything but as you start to get to more of them being instrumented in that way it gives you that pass to what you really want to accomplish.

But, right now we’re kind of in this world of, if there is a new measure that is added and a data element doesn’t exist, then we have to change our databases to add that data element and if we do not capture it, make sure that it’s captured in a way such that it feeds the measure correctly and at the appropriate time that it feeds the measure correctly, such that, you know, those workflows do get hardcoded. So, I mean, that’s the current state and we want to move to a more flexible state, but it’s going to be dependent on some steps taken to really start to look at that data and start to standardize it and I think that...I mean if we put that on the table, that’s possible in that 2016 timeframe I think because the vendors are going to have to do a lot of work to build some infrastructure to do that.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

I think that’s exactly right. Others?

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

And I think, you know, Paul, as we think 2014 we want to kind of be building in that direction, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Okay, okay, so I think we’ve talked about this first one. The next one is about the demographics, which was mentioned before, and there in Stage 1 we asked for recording of demographics for more than 50%

of all unique patients. And in Stage 2 we recommended going up to 80%. Now, the NPRM gets specific with respect to which demographics, which is good, because it includes preferred language, gender, race, ethnicity and date of birth, and uses 80% as the threshold.

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

And for ethnicity, and I don't know what feedback you're getting on this, it allows multiple fields now.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

So.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

And, I personally don't know if we need to change that in Stage 3, is there an additional ask that we should go after this particular area?

Michael Barr – American College of Physicians

David, this is Michael Barr, quick question for you in terms of the health disparities and I may be opening up a can of worms because I can imagine folks getting a little challenged in asking, but is socioeconomic status or financial status a marker that is a predictor of health disparities? I think it is, I'm unsure, so I'm asking you, and if so is that something that we ought to talk about?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, it certainly is. It correlates really closely with...I mean there is some correlation with race and ethnicity, and certainly with where someone lives. I don't know if we have a zip code someplace, but once you have zip codes that is actually pretty good at...

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

A surrogate?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, exactly.

Michael Barr – American College of Physicians

Okay, so it would obviate the need to ask about socioeconomic status if you know where they live and you have the demographics for that area.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

Michael Barr – American College of Physicians

Okay, good, because I think it would be a difficult question to ask folks to ask, even though it's an important element. So, if you feel we can get at it another way that's fine with me.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right, I don't know that we've asked for zip code any place and that would be a reasonable addition.

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

Well, we've got it in the patient, you know, all the financial systems capture it.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Exactly, so it's already there basically.

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

It's already there.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, maybe there's no need to add that.

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

Yeah.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Does anybody want to go after anything additional in Stage 3 for this particular one? I think Michael's question was a good one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

One of the thoughts that we had and I can tell you a little bit of the history, you know, we thought about going toward a highly granular codes that everyone was talking about, but I think in the process we found out that they certainly aren't standardized now, and I don't know whether there is an effort going on to standardize them in the near future.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, okay. Well, I think let's move on. I'm having some trouble with my spreadsheet which keeps sort of scooting past where I want to go next here.

Alice Leiter – National Partnership for Women & Families

This is Alice Leiter, I don't have the spreadsheet and it doesn't seem like Eva has it either.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, and I don't either.

Alice Leiter – National Partnership for Women & Families

Is there any way you could you circulate it amongst the group?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Sure.

Alice Leiter – National Partnership for Women & Families

Thank you, so much.

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

I could use it too, this is Charlene.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, in fact I was just sending an e-mail to MacKenzie and Michelle saying I...

MacKenzie Robertson – Office of the National Coordinator

I think we sent it out but we can't find it.

Michelle Nelson – Office of the National Coordinator

No it wasn't sent out; I think that Dr. Bates is just using what we used for the Meaningful Use Workgroup last week.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

I am.

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

Oh.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

But that would be helpful for everybody to have because many people weren't there. Do you have that handy, MacKenzie?

MacKenzie Robertson – Office of the National Coordinator

Sure, I'll pull that out of my e-mail and send it out to everyone.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, it's called MUWG Stage 2 HITPC Comments 19, April.

MacKenzie Robertson – Office of the National Coordinator

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I've got that one.

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

...

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay, because it is helpful to, you know, just to basically have it all in front of you here. Okay, so the next one is to generate and transmit...the next one is about prescription transmission. In Stage 1 we said 40%, and in Stage 2 it goes up to 65%, and you're asked to compare them to at least one drug formulary. And then there is a new objective that you're supposed to generate and transmit permissible discharge prescriptions electronically and the threshold was 10%. So, it seems to me like we could go up on the discharge transmission figure.

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

You know, David, I don't disagree, but I think it's really hard until we get some data on that, but I do support principally this end-to-end medication management process.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

And, I don't know if there is any other aspects of that. I know you've studied that, so it would make sense for us to think about in that process. This is Charlene.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Right. Yeah, so, thank you Charlene, I mean I have to say it’s been interesting reviewing my own Stage 1 data and I generate 100% of my prescriptions electronically, but I’m getting credit for much less than that because much of the time I end up printing them out and handing them to the patient because

that is what they want and at least the way that we’re scoring things locally, I don’t get any credit for that and I suspect that some patients are going to want to have their prescriptions in their hands, still. So, we need to be careful not to set the threshold too high.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Are you talking about ambulatory or hospital?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Well, I’m talking about ambulatory personally, but, you know, if we were to raise this I think we would do it for the hospital discharge orders.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right. So, we are commenting...the leading sentiment for ambulatory set at that 65 may actually be too high for reasons you’ve suggested?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Which is we don’t know whether it’s high for let’s say Surescripts in the rural areas and also people don’t always want it electronically.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Right. I mean, I think the right figure is probably in the 50 to 65% range. Paul, do you have a sense?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I’d probably agree and maybe 50 is still good enough because of the other factors like rural.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah. So, maybe we should suggest 50.

Michael Barr – American College of Physicians

This is Michael Barr, what you’re saying resonates well with what we hear from physicians that we talk to. Another issue is in the health system I’m familiar with, a community health center, that has pharmacies on site, they’re doing ePrescribing from electronic health records on site and the patient is beating the electronic prescription to the pharmacy and creating all sorts of issues because of the delay from the EHR to Surescripts back to the pharmacy, so their work around is to give them paper prescriptions so it’s multiple different factors lead to lower performance on these and so I agree with you lowering it to 50%. If they’re doing the 50% whenever they can they are probably going to do it, but the difference is those situations you’ll be covering.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And, also, you know, we’re going through this and saying what we do from Stage 2, we also want to reserve some discussion time for what different things, now that we, in theory, we’ve gotten stuff in the record, we’ve got stuff now hopefully in Stage 2 moving around more, what more can you do? And, also

something like this we might topped out at 50% not because people would stop doing it, but because there are all these other reasons.

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

Yeah.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Exactly. I think that’s right. And what do people think a reasonable threshold would be for sending discharge medication orders from hospitals?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, it’s hard to say that it’s a whole lot higher in terms of requirements just because a lot of people want all of your discharge instructions and your medications sort of on paper.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah. So, the current number is 10. Should we go a little higher than that? I mean, I would be inclined to even 30 or something like that. I think it will become the norm.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, yeah.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Does that sound like a reasonable...?

Michael Barr – American College of Physicians

This is Michael Barr; I really have no way of offering any insight to this so I’m going to be quiet on this particular one.

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

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You don’t by any chance have...well of course it’s a new functionality for hospitals.

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

Yeah and our experience with kind of the leaders in the field is pretty straightforward but the uptake of it is still, you know, limited because it’s just not a regular space.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Exactly, we’ve done a lot of it and the key issue here, you know, as I suspect every place else, is, you know, how ready are the pharmacies to accept these things and, you know, we went from a point at which most of the pharmacies just didn’t know what you were sending them when we sent these things out to...things kind of just flipped in our market, but I suspect that there are an awful lot of

markets that have not flipped at all.

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

So, I mean you can put a place holder and an increase and we’ll just have to watch how that goes.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

I support increasing it I just don't know to what.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right, that sounds good. Okay, so let's move to the next one which is to...let's see, I believe it's to maintain an active medication list. Have people gotten the spreadsheet in their e-mails?

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

Yes, we do now.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay.

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

Or, I have.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

The next one, I think, is maintaining an active medication list which, I guess this was consolidated with providing a summary of care. So, this one is off the table.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Now, are you reading row by row, because it's a different order, at least where I'm looking at it.

Michelle Nelson – Office of the National Coordinator

I think Dr. Bates, you skipped the problem list.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Did I skip the problem list? My spreadsheet is doing some really strange things.

Michelle Nelson – Office of the National Coordinator

It's because the rows are really wide.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay.

Michelle Nelson – Office of the National Coordinator

So, for the next meeting we'll consolidate this and make it a little bit easier to use for everybody.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And I can just update, at the least the recommendations that are currently on the table and seem widely supported is the response to the NPRM is to keep problems, medications and allergies still at a high level as an objective level rather than buried in the summary of care documents. And actually this is an important point. So, one of the reasons we want to keep it in front of people's face, because it's not in every practice that this is well-maintained let's say and can we move, and particularly in Stage 3 to functionality and policies and practices, such that physicians are assisted in maintaining up-to-date and complete problems, medication and medication allergies. So, you can imagine let's say the computer can

certainly probably figure out whether somebody is a diabetic with a fairly high predictive value, based on other ancillary information and that's one way you could almost propose for acceptance by the doctor let's say.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Right and I don't know if you've seen the trials that we just published on this?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

But, you know, we built a tool that does exactly what Paul says and we did it for 18 different diagnoses that all have important decision-support implications, diabetes being one of them, and it works great and people really like it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, that's something you self-developed and you can imagine how this would be helpful for others. Another great one would be renal insufficiency because that affects everything.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Exactly, right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Diagnosis to treatment and it's not necessarily...and then the decision-support triggers off of things well, it sometimes could trigger off the lab; it sometimes could trigger off the problem list.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, how should we put that in as what we would ask for?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, we have to find a way to signal for certification, so the Standards Committee and ultimately to the certification criteria, that EHR systems be capable of sort of computer assisted maintenance of problems, medications and medication allergies.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah. I think that's good, but that would be handling it through certification and not...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, another way we could do it, remember we talked about, so there is medication reconciliation where there could be problem reconciliation, right? Problem reconciliation and it could either be by humans like lets say a patient through the history taking process, or reconciliation from external sources like discharge from the hospital or a referral from specialists, whatever, or computer rules that look at your medications and your lab results let's say.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, our experience is that it's pretty important to have a human over read the...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yes.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

The recommendations.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah, so I mean, probably you think of it as a staging thing, so, yeah the computer says “hey it looks like this patient might have diabetes or the last creatinine was such and such, consider putting renal insufficiency on their problem list” and then there is an authentication, right?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, exactly.

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

So, Paul, this is Charlene; in Stage 2, whether it stays in there or not, from the certification process, we have to do that clinical reconciliation which is for problems, allergies, as well as for medications. So, the systems have to be doing that in Stage 2.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Based on what, though? Is it a check off thing or is it a...

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

Well, again, it’s being driven from the standards process but I don’t think it is that prescriptive, but typically, you know, here is the inbound transaction with the problem list, this is the current problem list that is up for the patient, you know, in terms of what’s in the other system and, you know, list to list, and then they choose which ones they’re going to populate it with, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right.

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

So, it’s still, in my view, and again we still have to develop some of this, it will require some oversight.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, that’s a document compare kind of approach, I think we’re also interested in the computer rules approach.

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

Yes. So, but anyway I just wanted to show that, you know, that capability in some form will be there with the certified software ready for Stage 3.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Okay.

Jesse James – Office of the National Coordinator

This is Jesse; to the extent that Meaningful Use is using features in EHR’s that previously weren’t available, the point about predictive selection of diagnoses is a feature that makes sense, it’s one that we’ve talked about before on the Meaningful Use team and the Quality Measures Workgroup, but I don’t think it has been discussed in detail in this setting, but it is a reasonable way to go a step further than we have in the past when it comes to adjudication of a problem list and there’s a good amount of evidence that shows often patients who have either hypertension, diabetes, chronic renal insufficiency, and maybe treated for that condition, do not have that condition in their problem list and that can be propagated over time when a clinician looks at the patient and knows the patient well but doesn’t add it.

Once you get to the point of CDS where you have computer-generated reminders that are based on diagnoses that tend to be inside of the problem list, it would help CDS if the system also thinks about what diagnoses might be there that hasn't been appreciated in the past.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, what Jesse says, this is Paul Tang, what Jesse says triggers a thought of one way to write an objective and you're asking about that, David, so one possibility is to pick on the high-priority conditions, let's say cardiovascular disease. We can even talk about hypertension because it is certainly under diagnosed and undertreated. So, if we had an objective of properly identifying, and my hesitation is I don't know quite how to measure this yet, but properly identifying all of your patients who have high blood pressure, have hypertension on the problem list and so that objective would require EHR functionality that one would help prompt things by looking at other parameters, but it is in this case blood pressure and reconciliation with external documents as a way of enhancing your score of having more complete records.

Now, I don't know how we're going to test it, but maybe we start and maybe Standards Committee does come up with a mechanism that says okay we're going to assume that people with repeated high blood pressure, we're just going to assume that, and let's see how many are in the problem list. Do you know what I'm saying? How did you measure it, David, in your recent study?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, so that is how we measured it. We looked at a variety of things. We looked at laboratory tests, we looked at drugs, we looked at vital signs, we looked at diagnoses.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, what did you use as the gold standard to say whether you improved?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

We actually, you know, we had a clinician over read and decide whether things were correct or not and, you know, it worked remarkably well. The positive predictive value of problems that were added was really high. We did have one interesting accident in that we started suggesting that patients had sickle cell disease when they in fact did not and we just had a glitch in our algorithm and we found that clinicians still added the problem even though...

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, the danger in suggestion.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Now, that you mention it...So, you can not only make the right thing that you need to do, you can make the wrong thing that you need to do.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Exactly, but I like Paul's idea, you know, especially for conditions like hypertension, diabetes, coronary disease, chronic renal insufficiency, those are all really easy to do this way in high stakes. And there is probably a couple I'm leaving out. There are some that are complicated, it turns out that asthma and COPD are kind of complicated because you can tell that the patient has asthma or COPD but usually you cannot tell which one it is without some clinical input.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

You know, the other thing this goes to, again prevalent things, is just control, anticoagulation control. So, we could pick let's say either the presence of having warfarin on their medication list and the...well if there is a complication obviously you have to say which range is appropriate for this patient, but clearly normal is not a range if they are on Coumadin or you could go the disease route like AFib, you know, so I mean we could pick on those kinds of things which could fall under both safety and medication management.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, I like that idea.

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

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, that might come under the medication...let's see, no, I mean that's a separate issue. It just might be a new objective that we weren't prepared for in Stage 1 and 2 that we could be going towards.

M

I think so.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

Yes, this is Charlene. And, Paul, I like the way that you're carving it out of David to be...I know we don't want to be too specific in conditions, but it's back to our high-priority conditions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Yeah.

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

And then if vendors want to do more, you can create a floor, they can do more.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, I hope they started doing more than hardwiring these things and, you know, it's a platform, it's a rule you're right, you decide what's high-priority in your patient population.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay. So, this has been really helpful. Okay, so we just talked about problems and medications.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

We didn't do medications yet, though right?

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

So, let's talk about medications.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, if we use the Coumadin example again, you could say let's go backwards, if they have and abnormal INR and it's being tested, my guess is they're probably on Coumadin and is it on the medication list?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah. So, that would be good.

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

So, on the medications, David this is probably some of your research too around, you know, the use of IVs, is there anything around that space that you wanted to consider? In terms of safety protocols?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Oh, good question. I mean, where we’re going is to take medication orders in the inpatient setting and transmit them directly to pumps, now there are only a few places in the country that have done that so far.

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

Okay.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

So, we’re probably not ready to require it. Other thoughts about that? I mean, we have done work on that, we’re actively, you know, doing work, we actually just had a death at our institution because we’re not able to do that.

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

Yeah and then the safety of administration too.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

I just wanted to...you know, if we’re going to look at that, it’s just, you know, it’s not one that...it’s certainly an area of risk, that’s all.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

It is. It is, but I am struggling a little bit with how to build an objective around that.

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

Well, maybe that’s one that we get some input on, right?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

That would be good.

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

In your survey, Paul?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

You know, is that even a viable candidate? Because we’re talking 2016.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

And, as a patient we maybe would want it, right?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

As a patient I definitely want it. Okay.

MacKenzie Robertson – Office of the National Coordinator

Can you describe what that proposal is? I think I missed it.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Sorry, so the proposal was to consider in 2016 the feasibility of transmitting orders in the inpatient setting directly to medication orders, directly to pumps in coded form where they could be validated by nurses. The other drug that’s important in the outpatient setting is steroids, but they’re so complicated that I think it’s better to leave them out. It turns out that if someone is on chronic steroids there are a number of things that you should do, but the issue is that people are always getting these short courses of steroids.

M

Right.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

The other set of drugs or some of the other immunosuppressants which are used chronically, but there is nothing that’s kind of important or as well worked out as Coumadin.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Oh, yeah, here’s another idea. So, we’re looking for up-to-date, accurate complete medications, probably one of the biggest problems we have is their short-term medications are still on the list and of course are still going to “interact” etcetera, so maybe detecting...I mean, I really wish the drug databases would have defaults like antibiotics should be time-limited, but until they do, maybe detecting the presence with a long duration from its start date, and sort of asking, is this patient still on this drug? Pick any short-term medication and try to have that be a prompt so that you can just say click “no, no” click so it gets taken off the medication list as a way of helping, you know, the efficiency and you could do it...let’s say you have four short-term drugs on the medication list and this reminder/alert pops up, the doctor asks the patient “are you still on this, this, this and this” you say no with one click you clean up that medication list.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

And we’ve struggled with this one. You know, the complicating issue really is that a lot of these drugs are used for short bursts with some of the herpes medications being an example.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right, yeah and still active.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

You don’t want to take it off the medication list. We have not had a way in our medication list to kind of stick those in a separate compartment which is the way it really should be from my perspective.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, couldn't you do it by drug class? So, let's say a macrolide, you know, you could see tetracycline going in for acne or something, but let's say a macrolide or quinolone are probably not going to be repeatable things unlike let's say antivirals.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, you can, we've worked on this one really, really hard and found it to be pretty complicated. I mean, Charlene do you know of people who have done it effectively?

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

No, but I would have to actually...again; I'd have to survey our customers and find out.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah.

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

So, I mean, I don't know if you want to make that a question in your survey?

Dixie Baker – Science Applications International Corporation – CTO, Health & Life Sciences

Yeah, so that would be another good question, you know, do people have a good approach for dealing with medications which are usually short-term? Because those really clutter the medication list.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, what we do is have a human pharmacist go through and literally set the default, so it's start plus 10 days let's say for antibiotics, you know, non viral antibiotics and just do that. So, at least it is less likely to inadvertently appear as a chronic medication.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, this is one where I would like to see someone who has really done it well and we've struggled on this one. We're very close to being at time. I'm wondering if we should stop here and then resume at this place the next time we get together.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Right and you have public comment.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

And have public comment.

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

Yeah.

David Bates – Brigham & Women's Hospital & Partners – Senior Vice President for Quality and Safety

Okay, so hearing no objections let's do that.

Public Comment

MacKenzie Robertson – Office of the National Coordinator

Okay, operator can you open the line for public comment, please?

Caitlin Collins – Altarum Institute

Yes. 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 do not have any comments at this time.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Okay, so thank you very much. Next time we will resume with allergies and then go on from there and if everyone could think between now and then of other things that they would like to see added that perhaps we have not done previously, we can consider some of those things. And also just requesting suggestions as Charlene has noted. So, I want to just thank everybody. We got a lot done and we will talk again soon.

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

David, this is Charlene.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yes?

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

Before you sign off?

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yes?

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

When you hosted the care coordination group, I don't know when our hearing was last year.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yes.

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

You did a great list of requirements. I don't know if you've got that in your file someplace.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

I do have it.

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

If you could send that to me we can use that as a tickler for the work we're doing, that would be great.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yes, I'd be delighted to, you might have asked me for that once already and I think it came in when I was on vacation or something.

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

That is fine, I get it.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Yeah, I will send you that.

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

All right, thank you very much.

David Bates – Brigham & Women’s Hospital & Partners – Senior Vice President for Quality and Safety

Sure, okay, thank you all.

M

Bye everybody.

MacKenzie Robertson – Office of the National Coordinator

Thanks, everybody.

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

Thank you.