

**Meaningful Use Workgroup
Subgroup #1 – Improve Quality
Draft Transcript
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Presentation

Operator

Ms. Robertson, all lines are bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This a meeting of the HIT Policy Committee's Meaningful Use Workgroup Subgroup #1, Improved Quality, Safety, Efficiency, and Reduce Health Disparities. This is a public call and there will be time for public comment at the end. And the call is also being transcribed, so please make sure you identify yourself before speaking.

I'll now take roll. David Bates?

David Bates – Brigham and Women's Hospital

Here.

MacKenzie Robertson – Office of the National Coordinator

Thank, David. Charlene Underwood? I know Charlene is on. Marty Fattig?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Yep, here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Marty, Michael Barr? Neil Calman? David Lansky? Paul Tang? Eva Powell?

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Eva. Are there any other workgroup members on the line? And is there any staff on the line?

Michelle Nelson – Office of the National Coordinator

Michelle Nelson, ONC.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Michelle. Okay, David, I'll turn it back over to you.

David Bates – Brigham and Women's Hospital

Okay, well, thanks so much, uh, everyone. Um, the, the plan for today is to, ah, go through, go through the referrals from other groups and we're, ah, going to try and spend a little bit of time trying to identify what's missing. Michelle has highlighted a number of things, which were actually included, ah, all the ones that were on my personal list of what's missing. It's always hard to figure out what exactly what's missing when we're looking at something as big as this. We are we'll plan also to reword some of the items, so that they read as objectives and measures, and then eventually we'll, we'll prioritize and consolidate that we may or may not get to today, but we'll, we'll see what we can do.

Um, how, how does that sound, sound as a plan to everyone?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Sounds good.

David Bates – Brigham and Women’s Hospital

Great. Okay, and any questions or thoughts at this point?

So, so first of all, let’s look at, at the three referrals. This is, these are 125, 126 and 127 on the spreadsheet. Um, the first one is on medication reconciliation. This is a referral from Subgroup #2 to, to us. And here, here the issue is the ability to accept a data feed from a pharmacy benefit manager and it really goes beyond that because you not only want to be able to, ah, accept the feed, but then to identify important issues. Ah, and examples of that would be, um, data suggesting that the patient is, is not taking the drug, ah, dating, data suggesting that a patient is taking two kinds of the, of the same drug or that they’re taking, um, multiple drugs that, that, ah, overlap in some way. Um, those are as I think about are the, are the, the main categories that, that, ah, people have looked at.

Um, so let me just stop there and, and, and see what the thoughts and reactions are.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Um, David, this is Charlene. One of the things, and again, we have in our functions under care coordination, we’re trying build a pretty—identify the need for a pretty robust, if you will, reconciliation import functionality as data comes in and then ultimately the ability to be able to track that that data comes in, so I don’t know if this is, because Larry Wolf had identified, gaining, gathering some data, if you will, from, um, some of the prescription space, too. So I don’t know if this is one that might make more sense to, again, if you could identify, um, you know, the importance from a policy perspective of putting this in there, it might fit better, better for you to report to us and we’ll add it to that list of potential data that’s still in. Does that make sense to you?

David Bates – Brigham and Women’s Hospital

So that, that’s, that’s a possibility, I guess, um, I mean I think it’s important that it be dealt with by some subgroup, and, ah, and I don’t feel strongly that it, that it be us. I do feel strongly that, that, um, we not just ask for the, the information to come in, but that we ask the, that the, ah, vendors be able to have, have an approach for identifying important signals, which are the, the ones that I mentioned that is not taking the drug, taking two of the same, the, the same drug or, or taking drugs that overlap in important ways.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, so those are left, yes because what we were kind of working toward is as that data comes in and get reconciled, then we could wrap some clinical decision support around it, so maybe that’s the—

David Bates – Brigham and Women’s Hospital

Well, I think it’s the time to ask for it.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes.

David Bates – Brigham and Women’s Hospital

I mean this is the 2015 criteria.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, so—

David Bates – Brigham and Women’s Hospital

And I don’t know if we can get kind of too prescriptive just because it hasn’t been done a whole lot, but, but those are the broad categories.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, so I’m definitely okay for like if we just identify those needs, I’m definitely okay in terms of, um, whether we put it in my section or your section identifying those, because I think that’s in the policy, policy perspective of what we want to capture. Any assistance today once you standardize this, you should be able to do that type of thing. It’s a challenge in getting the data in in a standard way.

David Bates – Brigham and Women’s Hospital

Exactly, so, um, someone from ONC, you know Michelle or MacKenzie or who-, whoever, ah, what about referring this to the care coordination group?

Michelle Nelson – Office of the National Coordinator

I think that makes sense because they do have the ... um, objectives already. Um, just one other note I would add, I was actually in a meeting on Friday with, um, NORC, who did a study for ONC and that they’re working on, um, putting together a summary of what they found, but, um, they did a lot of work related to med reconciliation and, um, patients verifying the information, so there may be a piece that we want to incorporate as well. So I’m not sure which group that would fall into, but, ah, just something, ah, to keep in mind, so Charlene, should I bring that up with your group when we get to—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, and if you could list specifically the points that David made in terms of what we need to be monitoring for, that will be I think, and you know, the requests coming from this group is that we don’t wait to detect those things till Stage 4, right?

Michelle Nelson – Office of the National Coordinator

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

We can import it, but we can also detect those cases. Now whether we can do it or not I think will still be in question, but I think we should always put it there.

David Bates – Brigham and Women’s Hospital

Yes, exactly. That, um, having patients verify things, ah, you know, this is, is kind of another level.

Michelle Nelson – Office of the National Coordinator

Yes, maybe that will be the Stage 4 item, but once we have that information, I’ll share that as well, because it’s all related.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, and, and Larry has brought this one up, so I’ll reconcile it with what, you know, Larry Wolf had brought up, too, so, but we actually had put that detect-, or that identification, the alerting later, but we’ll add that back here.

David Bates – Brigham and Women’s Hospital

Marty, were you, were you going to make a comment?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

No, I think it's a great idea, but is there any way to, um, some way monitor abuse in this in this same way?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Online, yes.

David Bates – Brigham and Women's Hospital

Yes, you can actually do a very good job getting at abuse and when you, when I was reflecting about taking multiple, ah, drugs, that are related, that's, that's one of the things that you know that just can jump off, ah, off the computer screen.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

That's really good. That'd be, that'd be very helpful, especially for the ER docs and whatnot.

David Bates – Brigham and Women's Hospital

Yes, yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So Michelle, in terms of the duplicate drugs, if you just put abuse in parentheses, we'll just, it'll help remind us.

David Bates – Brigham and Women's Hospital

Right, including detection of abuse or something like that, yes, exactly.

Okay, are we ready to move to the next one? Okay, so, ah, the next says the, I assume this is for patients, right? This just says the ability to compare self with other patients see risk status and understand what evidence-base care for the patient's condition is. Now are, are we talking about the, the patient's ability to do that in, in through, say a PHR?

Michelle Nelson – Office of the National Coordinator

Um, so I would, from what I remember, I would say yes, especially coming from subgroup #2.

David Bates – Brigham and Women's Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

But, yes.

David Bates – Brigham and Women's Hospital

Okay. So this is an interesting one. Um, it's, you know, it's different than most of the other ones that we have. Um, it seems to me like all those things or you know would, would be valuable. Um, and instead of for the patient's condition, I might reword it as for, for their own condition, because it, so the ability for the patient to compare themselves with other patients. See risk status and understand what evidenced-based care of their condition is, and that makes a lot of sense, ah, to me. So if somebody is a diabetic, they could see that their hemoglobin A1C is, you know, nine and that's higher than a lot of other people's that makes their risk relatively high, and, um, and there should be some links to evidence-based, um, therapy.

Does that make sense?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So, um, oh, I'm on, this is Charlene. So does that, are we doing it sufficiently? Isn't it a challenge to know what the evidence are? Are we even doing it for the providers by Stage 3?

David Bates – Brigham and Women’s Hospital

Well I think, I think, ah—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

It’s in clinical decision support, right?

David Bates – Brigham and Women’s Hospital

Ah, yeah, I can’t remember—

Michelle Nelson – Office of the National Coordinator

It’s, it’s not quite called out anywhere yet.

David Bates – Brigham and Women’s Hospital

Yes, so it’s, it’s a fairly basic thing. I mean, it’s the sort of thing for providers that they should be doing even in Stage 1.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Right.

David Bates – Brigham and Women’s Hospital

For, you know, for patients we’re not going to prescribe I don’t think which specific source of evidence-based care, but I think it’s a good thing to ask for it just because, um, this is a way of directing patients to material on the Web, which we think is, is good material as opposed to just what you find, um, poking around, on, on your own. And I think that most PHRs already, already do this, ours, our certainly does.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Because it’s a PHR, how do we, um, I don’t know PHR to some extent acts like the boundary of the EHR. How do we write that?

David Bates – Brigham and Women’s Hospital

Well, perhaps something like, ah, as a clause to begin this within the PHR, comma, the ability to compare themselves with other patients, etc. Would that, would that make sense?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Ah, just say that again.

David Bates – Brigham and Women’s Hospital

So, just thinking of rewording within the PHR, the ability, ah, to compare themselves with other patients, see their risk status, understand what evidence-based care for their condition is.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So in Stage 2, we got the capability for, whether it’s, um, we got the capability through secure emailing back to their professional to be able to access, um, all their information, so then Stage 3, and what’s—because we’re holding the provider accountable for that, right, if we can actually be registered and their preferences hopefully are identified. And for stage—how are we going to measure that from a provider perspective that, um, that’s where we always get stuck on these when it comes to the PHR.

David Bates – Brigham and Women’s Hospital

Yes, well, I, I was thinking this, this is, this is a kind of a function of the PHR, so that the provider would, would attest that their, the PHR that they’re using, ah, has, has these functionalities. Um—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay.

David Bates – Brigham and Women’s Hospital

Ours has lots of links to, to information. It doesn’t, it doesn’t let, it doesn’t let people compare themselves with others, but I, or see their risk status, but I think it certainly should, and, and, you know, this, this would send a, a good signal.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, and so, and so Stage 3 would say at least access and then the comparability might come later then and attesting.

David Bates – Brigham and Women’s Hospital

I mean, I was, I was, I was thinking we could ask for this in Stage 3, but I’m, but um, I’m interested in, in other’s comments.

M

There’s no, there’s no

David Bates – Brigham and Women’s Hospital

Could you, I’m sorry, you’re just a little quiet. Could you say that again?

So, um, but other, other comments? Michael, do you have thoughts about this? Michael may have dropped off for a little bit.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, I’m back on, on mute, this is Charlene back off and on. Um, where the challenge I think in Stage 3 is, and we’ve talked about this. We referred one to the population health registry, so that—and if you think about our patient list and how we’re trying to evolve that into a registry function, the ability to be able to look at population of patients and track them and do comparison. We kind of have talked about needing that capability in Stage 3, which you would need that same kind of capability to do this, right?

David Bates – Brigham and Women’s Hospital

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So I’m not, I think we should just leave that. I think you should leave that piece a question, right, at this point in time, because I’m not quite sure where, you know, um, where we’re going to end up resolving that even with the requests that we made ... to care coordination, we wanted to be able to identify patients at risk, so we could track them, right? We just didn’t where we were going to find that cohort of patients, whether it’s in, you know, the build-out of the patient list functions, and more like a registry, right, if that’s what we’re doing, or if it’s under the population health function, so that’s kind of why I’m hesitating a little bit.

David Bates – Brigham and Women’s Hospital

I mean I, I would have thought it would be under the population health, ah, thing, and the, the very first thing that anybody who’s going to set up an ACO is going to do is to, is to establish a risk status, ah, for, for everyone. And the question is just, you know, will people be transparent about it. Um, Eva, you’ve been quiet. Thoughts about this, about—

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, sorry, I was ... Um, which, which ... are we on?

David Bates – Brigham and Women's Hospital

So we're talking about the ability for patients to compare themselves with other patients, risk status and understand what evidence-based care for their condition is.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Um, hmm, so the idea is to get, um, the information to the portal somehow.

David Bates – Brigham and Women's Hospital

Correct, the idea is that they'd be doing this through the portal.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Let's see. Which, um, sorry I'm looking for it on the—

David Bates – Brigham and Women's Hospital

Yes, we're on 126.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

126, okay got it. Hmm, well, I mean I agree that it's important. I haven't really thought through how that might, um, come into play. To me there's a, the, there's a huge link here with decision CDS, so I'm wondering if there's a way to tie it to the CDS requirement, um.

David Bates – Brigham and Women's Hospital

I think that would be, ah, hard just because you, in part because you're doing it in a totally different place. You're—

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, well, that's true, yes.

David Bates – Brigham and Women's Hospital

And there should be ah, a CDS to patients, ah, requirement.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, yes, that's what I'm thinking, but you're right. I didn't think about the fact that the, um, process wise they occur at different times.

David Bates – Brigham and Women's Hospital

Right. Michelle, do, do you know if there's a CDS for patients, ah, requirement?

Michelle Nelson – Office of the National Coordinator

Not yet.

David Bates – Brigham and Women's Hospital

Okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So, oh, just a moment. Am I on, sorry. I am on. This is Charlene. What we had asked, and I'm not sure, you know how you lose things through these processes, because there's so many conversations?

David Bates – Brigham and Women's Hospital

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

We had felt that at a minimum we would ask, add the capability to CDS, you know, kind of in the criteria that, um, patient preference could be one of those criteria. I think when we were working with Christine, so we were adding some more criteria to clinical decision support, so that it would consider patient preferences, but it doesn't quite go—I think this requirement extends beyond that, so. But I think there's six criteria or something, one, which is evidence to be able to demonstrate the evidence, so that's in clinical decision support and then we were going to add in, you know, the ability to consider patient preferences as a ... to clinical decision support. So that was kind of where, um, you know, I, I had seen it factored in. Does that make sense? And I'm not sure this one factors there, but at least that was the only element that I saw being brought to the table.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, I mean to me to be able to do this meaningfully, um, I agree with Charlene, it is, there's definitely a tie with patient preference, um, and clinical decision support, clinical decision support for patients, but to be really meaningful, we're going to have to have information in a database somewhere, whether that's native to the EHR, or the other thing that's made me think about, um, is the requirement in Stage 2, for registries, um, to some. We're basically going to need to link decision support aimed toward the patient to a database of information that matters to them, which I'm not sure is being collected now, such as, um, ah, and, and it does kind of fall into patient preference bucket, but it's basically, ah, ah, um, the, like if you've got some sort of standardized quantified risk status, um, if you've got information about, um, experience of care, if you've got information about, um, functional status change, that kind of thing. Um, because I, I guess in thinking as a patient, I wouldn't want to know information that is currently reflected in most of the quality measures we have. I would want to know, you know, if I'm a white female, um, you know, age 40 with a, um, you know, ah, pneumonia that manifested itself and just, you know, I mean, there would be some specific criteria, um, that would probably evolve over time, but I'm just not sure we're collecting the kind of information that would make this a useful thing.

David Bates – Brigham and Women's Hospital

And the kinds of things that we could do easily would be, for example, for somebody who is diabetic to, to show, you know, how, how well controlled they are with respect to, to say A1C and blood pressure and cholesterol compared to some other, some group of, of diabetics like the ones in the, in the clinic, um.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Like they still want factors, like age, it is the basic demographic information or—

David Bates – Brigham and Women's Hospital

I mea-, usually those things aren't, aren't, aren't really adjusted.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes.

David Bates – Brigham and Women’s Hospital

The, the other sort of thing that, that one can do pretty readily is, ah, is, um, um, ask, ask a few questions and then, and then get, and give back, ah, to a patient some information about what the risk is for developing, ah, colon cancer, or breast cancer, or that kind of thing. Um, there are tools like this tool, ah, your health snapshot, which make it pretty easy to, to do that.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, I mean I, I think, um, in, in my mind this is, this is most helpful when making decisions before, like a big, um, a decision about a major care, um, option, so, um, so, um, so maybe not so much chronic conditions, other than, you know, a newly diagnosed person, who, who does, you know for whom there are different options, um, that are significantly different. I, I guess what I’m trying to say is your second example to me seemed like, um, ah, a more meaningful use case.

David Bates – Brigham and Women’s Hospital

Okay, and it could be either one. I mean, it could be that you’re thinking about hip surgery or a bypass or something and you want to, your risk of an adverse outcome is 28%. You can see how that compares to people at large—

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, do you, I mean do we have information? Like, like, that’s a great example, I think, for, say, a hip, hip replacement. I would want to know information about functional status, range of motion, um, time to, um, like recovery time, infection rate. Is that, I mean, I think it’s ... survey-able perhaps.

David Bates – Brigham and Women’s Hospital

Right. Of those, of those things, we could give you infection rates.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, see, and, and I think that’s what I’m saying is, is what I worry about is, is that the kind of information we have that we could work into a, a criterion isn’t terribly useful to patients, although infection rates definitely would be, and so maybe that’s a good place to, to start. I don’t know.

David Bates – Brigham and Women’s Hospital

Yes, you have to, you have to start someplace and you know and I think that the, you know, this is a situation which is perfect to be immediately good, but I also agree that it’s enough of a reach and that we’re far enough away from what we’d like to be able to do. Maybe we’ll end up prioritizing this relatively well.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes. Um, yes, I’ll continue to think on this, because it is definitely of high value to patients if we could get the information. I guess, well, I guess this leads me back to the notion of the, um, the registry. I mean do, are there any registries that collect this kind of information? That might be another starting place.

David Bates – Brigham and Women’s Hospital

Well, there, there are lots of registries, but the ability to, so, you know, to get data back from the national registries is, you know, is, is a challenge. I, I think it would make it easier for people to, to, understand this if we supply a couple of use cases just very briefly.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, yes, and it may be that, um, you know, that, that if this a far reach for a number of reasons, one is the kind of information that we're, we're aiming to collect, or that would be useful that we're not collecting. Two would be that the infrastructure or the, the two-way pipeline back from a national registry, so it may be that those are places where we can take some initial steps here, um, and, and provide, like you said, the use cases and then more clearly define a specific step three to the, that would be an option for meeting this criterion.

David Bates – Brigham and Women's Hospital

Sure.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

But you know I'm not familiar enough with how registries work or, you know, I think many of them are, are, um, proprietary, so I don't know if meaningful use is enough of a lever to, to, um, to advance those, the flow of information in the opposite direction, so—

David Bates – Brigham and Women's Hospital

Well, there, there a couple of kinds of registries. There are the registries that you use yourself, that you use to do care improvements and those, that, those data are accessible. And there are the, the national registries, which tend to be sort of more like black holes—

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Right.

David Bates – Brigham and Women's Hospital

You know, you send the information out and you don't, you know you get a report every, every three months or year.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, yes.

David Bates – Brigham and Women's Hospital

Um, okay, well, maybe we should move on from this one. This is a good discussion. Um, and the next one is, is also a challenging one. Um, sub, subgroup three was kind enough to hand this over to us here. Um, but, um, the things in this were, um, there's a lot of different things in this. One is the ability to maintain an up-to-date med list inclusive of patient generated data. The second is to maintain an up-to-date interdisciplinary problem list inclusive of versioning in supporting collaborative care. The third was order referrals and transitions of care. Um, another is immediate capture of concise narrative in support of care transitions indicating course of care and changes in treatment plan. Another is identifying care team members. Another is identifying patient goals, contraindications and care preferences, including advanced directory directives. Another is the ability to create and update an evidence-based longitudinal care plan. Another is incorporating standardized functional assessment scales and another is the ability to capture patient reported data.

Now this seems to me like, ah, like several different ones, and I, I actually thought some of it was going to stay within care coordination, but, Char-, Charlene, do you want to comment?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, so, um, we've been working through, let me kind of tell you how we framed, um, the care coordination process into like three major types of functionality. One is communication, so communication about, you know, the current state of the problem's care, so it was, um, for the kinds of things that again the up-to-date medication list, um, the ability to be able to, um, this time, um share the problem with and, um, the ability to understand what's active and, you know, what's not active that was kind of the requirement, um, so there's a set of those kind of functionalities, which we need today in terms of, um, a little bit at the high level with, um, the care record of summary, um.

Then there's a set of functionality around tracking care, so again, knowing that we have received for instance, and this relates to the referral. The feedback that we got in the testimony is we should be treating, um, referrals and frankly, um, transitions kind of as orders, so if the order is generated and sent out, then we would track, um, in the EHR the ability that it would be noted and sent out and be waiting, if you will, for that to be closed, either that they've received, um, a care record of summary, and/or we got a consult report back, so again, just trying to close that loop, that's kind of where that was coming from. So what we didn't do was kind of do the sending end of that.

Um, the next one we actually have in ours, the capture the concise narrative, um, in support of care transition, um, because that seems to be a, a big one that they want, but it would require that, for instance, when you're discharging a patient, that short test that a doc kind of sums up that care with is captured somehow. Um, clearly when you're communicating, we have in our, um, also the capability to understand who the care team members are. And again, this is on transition. We don't have to know during the whole course, but know who those care team members are, so that when you transition a patient, you can call them, right? So that could probably come out and be included in ours.

Um, again, when you're transitioning a patient knowing, um, some key elements of the care plan and we're actually identifying them now, um, so it includes things like patient goals is in there. We've got, um, well, you know, so we touch on all these patient goals, contraindications. Um, and then, um, we've got in there, um, disability to create this evidence-based longitudinal care plan, so again, we touch on that, so we've got that in ours. So it's kind of at the, you know, it's one of those requirements that would be driven from the back end of the process. We also include in ours, the functional assessment scales. Um, and then we don't touch on as much this ability, we talk about this a lot, but that ability to capture the patient reported data, but how we put that in there with the—as a list of data that, you know, that data could eventually, um, be captured as one of the data types, that, you know, we're reporting in terms of the receiving of information. So we would know, um, we'd have the ability to capture some of that information.

The third, the fourth, the third major area that we have is reconciliation, so again there's today reconciliation of medication, reconciliation in the future state of allergies and contraindications and problems. That's what's proposed, so we have those categories.

So I would think, David, some of these could probably come out if they're being driven from our end. And the one that I know is really important is that order referrals and potentially the orders for transitions of care and I don't know what your thoughts around that are.

David Bates – Brigham and Women's Hospital

Say that last bit again.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Um, the one that's important I know that we're really depending on that spending piece, being if order referrals and the transitions of care.

David Bates – Brigham and Women's Hospital

Okay, okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So I don't know if you want to treat those as orders, but that was certainly the testimony, um, that we heard. I think we've captured at the back end pretty much the rest of these requirements.

David Bates – Brigham and Women's Hospital

Okay. Did, did, go ahead.

Michelle Nelson – Office of the National Coordinator

Sorry, David, on the update, um, medication list, I think a lot of that is covered by subgroup two. That's actually a little bit further down. I just wanted to signal to subgroup one that they were going to be covering that, but we just want to make sure that it is covered somewhere.

David Bates – Brigham and Women's Hospital

Okay, yes, so, I, I agree, so it looks like three through, though, um, the end is, will be covered by sub, subgroup three.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I'd say four, four, I think four. The one we don't cover is—

David Bates – Brigham and Women's Hospital

Sorry, four through the end, yes, that's what I meant.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

And Eva, you'd agree with that, right, I mean we pretty much covered those. Eva, she'll come back on.

David Bates – Brigham and Women's Hospital

Yes, so and did you, Charlene, did you do the, the someplace we have to have the ability to capture patient reported data. Is that, do you have one on that?

Michelle Nelson – Office of the National Coordinator

Subgroup two does.

David Bates – Brigham and Women's Hospital

Subgroup two does, okay, okay. So let's, let's go back to one, one to three. Now one I think is being handled elsewhere, which really leaves us with two and three. Um, on, on two, there's a problem list item someplace, right?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, so we have in ours, but as a rec-, as a reconciliation, it's got to show up on our care record summary, um, coded in SNOMED and then it has to, we have the capability proposed in Stage 3 that it can be imported and reconciled in Stage 3. The issue that we face in care coordination is because again, a problem can be active and, you know, they can be chronic and acute and that kind of thing if they're, um, and the problems really have to be managed. Um, we didn't get into, um, that conversation at all. That was kind of what the reference was is, um, and does it include, you know, um, the care team's problem, you know, um, you know, broader problem list than those based in SNOMED, although SNOMED is clearly outstanding, you know, the breadth that it covers.

David Bates – Brigham and Women's Hospital

Okay, well, I, I think this should be folded into, to, to, um, ah, a problem list one, ah.

Michelle Nelson – Office of the National Coordinator

So the problem list one got consolidated into the, um, summary of care.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, so we lost it, okay, so what we did in Stage 2 is we lost it, right, it went away.

Michelle Nelson – Office of the National Coordinator

Yes, and we'll see, but probably.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, so that means I get it back. If that's the case, then I get it back if it gets consolidated into the summary of care.

Michelle Nelson – Office of the National Coordinator

Okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Whatever the final Stage 2 comes out, David, then I'll have to deal with it over there.

David Bates – Brigham and Women's Hospital

Yes, okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

All right.

David Bates – Brigham and Women's Hospital

And then, and then in terms of referrals and transitions, ah, I like the idea of treating those the way you suggested.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, I do, too, because systems can do that.

David Bates – Brigham and Women's Hospital

Yes, and, and this is a soft spot of systems, too.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

It is.

David Bates – Brigham and Women's Hospital

So, so they won't do as well as they, um, might otherwise, you know, if we don't call it out.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, and the testimony we got, again this was, um, by one of the Deacon partners if we ever get that presentation was, you know, kind of as that next step, which would really build a nice infrastructure for care coordination is the treat these as an order, because ultimately we can get smarter in terms of knowing what specific data to send with an order. We're not assuming that, but it's just to build out that infrastructure for sending the order out and tracking that it actually gets sent and it's received and the whole tracking mechanisms get created, so it's just made a lot of sense.

David Bates – Brigham and Women’s Hospital

Okay, okay.

Michelle Nelson – Office of the National Coordinator

So, David, just on that note, um, 130 was a, a placeholder for test tracking and follow-up. Would it make sense to make it orders, an order tracking, and include referrals there, or should I just wait till we get there?

David Bates – Brigham and Women’s Hospital

Well, we definitely need test tracking and follow-up and, and in tests are, ah, so this would be tracking and, I mean it’s, it’s a little bit different, but—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Actually, we’ve got a tracking piece and actually Larry Wolf had just said that he wants to track some, you know, this was, they were really worried that for instance, um, when a, and this is on the transition when you got a new result in and we had already sent out the summary of care record, and there was a resolve that that any updates also get followed through, so our tracking piece is probably going to expand to that. So that was the kind of tracking we, we’re doing that transition stuff tracking under care coordination, um, so I don’t know how that’s relates to 130. But what we really needed to do was the order would be sent out, you know, so we had something to track.

David Bates – Brigham and Women’s Hospital

Right, okay, so, okay. And Michelle, do, do you feel like you have a good sense of how we want to handle those?

Michelle Nelson – Office of the National Coordinator

Um, I think so.

David Bates – Brigham and Women’s Hospital

Yes, okay, okay, in that case, let’s, let’s, ah, move on, and, ah, and talk about what’s missing. So, um, so test tracking is, is, is down here, and, and that I think is, is really important, um, so, so this would be tracking of all tests that have been done, ah, with the ability to, to flag, um, abnormalities and ensure that they receive appropriate follow-up, and let’s call it important abnormal test, test results. I mean there’s a lot of work that’s been done on this, I, I chaired a task force in Massachusetts that went through and, and made recommendations about this and there are recommendations about, you know, what’s, what’s, um, you know, ah, really importantly abnormal enough that you need to follow up and, ah, um, and then records include a variety of different tools for, for making sure that tests do get followed up. I’m talking about things like, like, abnormal pap smears and abnormal mammograms and, and, uh, IPSAs, so does, does that make sense to people?

Michelle Nelson – Office of the National Coordinator

Um, so David, can you just clarify for me, are you talking, first talking that so the order was placed and that the patient went and got the order, so then you have a result? Are you doing that piece first and then once you get the result, you’re tracking whether there was an abnormal, or are you just doing the abnormal piece? Are you following me?

David Bates – Brigham and Women’s Hospital

Yes, it’d be very nice to be able to do both.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women’s Hospital

Ah, um, you know, the, the hard thing is to know that the order was made and then it was, whether it was fulfilled, and that’s, that’s, ah, you know, moderately tricky. The, the most important piece from the clinical perspective is, is actually to ensure that the important abnormalities get followed up. And given that we’re trying to have as few objectives as possible, it seems reasonable to combine those two to me.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women’s Hospital

Other thoughts or comments?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Does this go under clinical decision support at all as combining as a type of tracking, or is kind of clinical decision support? That’s kind of where we do or not, like in our systems, where you’re monitoring—

David Bates – Brigham and Women’s Hospital

So you mean like in 128 for appropriateness of lab and radiology orders? Is that what you’re thinking? I mean, Charlene, is that what you were thinking?

MacKenzie Robertson – Office of the National Coordinator

Charlene, are you on mute?

Michelle Nelson – Office of the National Coordinator

Maybe she unmuted and hung up on mistake.

David Bates – Brigham and Women’s Hospital

That likely could be.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Sorry, this is Eva. I had to take another call. Were you calling on me?

Michelle Nelson – Office of the National Coordinator

No, Charlene.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Okay, sorry, sorry. We’re all doing multiple things for multiple workgroups at the same time I think.

David Bates – Brigham and Women’s Hospital

Yes, um, well, yes, um, I mean the two functions are, are a little bit different, so there’s decisions of what you do on the front end and then there’s decision support that you do at the back end, but, um, if we really want to have as, as few, ah, recommendations as possible, I think we can put them together.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, and this is Charlene, my phone—I just failed So what is the clinical 128, right?

David Bates – Brigham and Women’s Hospital

So what we’re talking about doing is putting 128 and 130 together.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, I agree.

David Bates – Brigham and Women’s Hospital

I mean it is true that you could easily do one without having the other in place, but, but, ah, I suppose that’s okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes.

David Bates – Brigham and Women’s Hospital

Okay, should, should we talk next about, um, medication dosing? Ah, so here, ah, the, the, the most important thing, ah, or is suggested, ah, a dose that is appropriate for the patient’s, ah, kidney function and age. Um, do, do we have that someplace else? I don’t know that we do. I’m just trying to flip through and find it someplace else.

Michelle Nelson – Office of the National Coordinator

It talks about, um, there’s something else related to medications. Oh, it was for short-term medications, no, there was nothing related I don’t think.

David Bates – Brigham and Women’s Hospital

Okay, so, so, ah, here I guess I think the things that we should call out are the, the patient’s, ah, kidney function, age, and, and, ah, and weight. Um—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So, David, in Stage 2, the discussions going on, because we were talking about this reconciliation, it’s medication allergies, we’re looking to, you know, capturing medication allergies, but the discussion is expanding to really just contraindications, you know, and then—

David Bates – Brigham and Women’s Hospital

Well, contraindications, go ahead.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, and, and then what procedures, yes, this is a different type of clinical decision, but we hadn’t got there yet. It more on the allergy checking and even we had expanded even the checking to, you know, other types of, um, allergy checking. It was just medication, so, um, that, this would be different.

David Bates – Brigham and Women’s Hospital

Yes, I, I think it’s, I think it’s pretty different and it’s, it’s actually the, um, the, the class that delivers, the, the most benefit of all, of all the various subtypes. But Michelle, did that make sense?

Michelle Nelson – Office of the National Coordinator

Sorry I was muted, yes, that makes sense.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Yes, this is Marty, ah, it might make sense to add in here, ah, reflexing for, for test required, required testing, depending on, ah, you know, ah, levels of drug in the system or, ah, or how long a person has been on the drug or whatever.

David Bates – Brigham and Women’s Hospital

I think so, too, so what sort of clinical example are you thinking of?

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Well, I was thinking, you know, I mean INR is a perfect one of course, but, but certain antibiotics that you need to check, ah, levels on, any drugs that you need to check peak and trough measures on, those types of things.

David Bates – Brigham and Women’s Hospital

Yes, right, so, and, the, the term I think of for that is, is that it’s corollary orders or, ah, um, but I don’t know if that’s a ... if everybody knows that term, but it’s basically when you do one thing and it implies you should do something else.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Exactly.

Michelle Nelson – Office of the National Coordinator

So David, in 106 I think we talked about that, so I’m not sure maybe we do combine these things together, I’m not sure.

David Bates – Brigham and Women’s Hospital

Let me go back to 106.

Michelle Nelson – Office of the National Coordinator

But that one, the ability to detect the long duration of a typical short-term medication, separate drugs by drug class, um, there’s even the INR example.

David Bates – Brigham and Women’s Hospital

Yes, um.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

The drug thing is more than you stated there, but it probably could be put together.

David Bates – Brigham and Women’s Hospital

Yes, well this is, um, God—

Michelle Nelson – Office of the National Coordinator

This is related to an objective that might get lost anyway, so it might just be a new one altogether.

David Bates – Brigham and Women’s Hospital

Yes, I think I’d rather have it be a new one. It’s a pretty important one.

Michelle Nelson – Office of the National Coordinator

Okay, so move, kind of move these thoughts to the dosing one, or—

David Bates – Brigham and Women’s Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women’s Hospital

What, you mean the thoughts in 108?

Michelle Nelson – Office of the National Coordinator

One zero six.

David Bates – Brigham and Women’s Hospital

One zero six, well, I think what Marty has suggested is actually more important than any of the thoughts in, in 106.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women’s Hospital

And now I can’t see 106 for some reason, here we go. Um, I mean those things are, are all useful things, but, but they just don’t come up as often as, ah, the things, the things we were just, ah, discussing; and they’re not specifically related to dosing. Okay, um—

Michelle Nelson – Office of the National Coordinator

Sorry, David, I’m not sure if I followed, so were you keeping these two separate objectives?

David Bates – Brigham and Women’s Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women’s Hospital

Okay, um, now another one is, is the CDS trigger monitoring and that’s, that’s a very important one. Somehow I hadn’t realized this, but that got lost, ah, I guess in, in Stage 1, but there should be a requirement to, to track, ah, every, ah, CDS trigger that, that goes off and, and how the provider responded to it.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

You’re right; we lost it in Stage 1.

David Bates – Brigham and Women’s Hospital

Yes, and, and that’s just important from the, from the infrastructural perspective.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So would go under the criteria for clinical decision support as one of the capabilities?

David Bates – Brigham and Women’s Hospital

Um, that would be a reasonable place to put it.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, so I think you put that back in there.

David Bates – Brigham and Women’s Hospital

Where’s, where’s now, let’s see where—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I’m not sure where it is anymore, but, um, you never—

Michelle Nelson – Office of the National Coordinator

It’s 113—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

One thirteen.

Michelle Nelson – Office of the National Coordinator

And, I did put a question in there about trigger monitoring.

David Bates – Brigham and Women's Hospital

Okay, so, so instead of trigger monitoring question, should we do something like what I just said?

Michelle Nelson – Office of the National Coordinator

Yes, so we did ... triggers and how the provider responded to them?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes.

David Bates – Brigham and Women's Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women's Hospital

Yes, um, now, who, who's going to handle clinical decision support for, for patients. I mean, is group two working on that do you think, or?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So under, um, 113, I think was the reference. It was referred from subgroup two.

David Bates – Brigham and Women's Hospital

Yes, here it is, let's see.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes.

David Bates – Brigham and Women's Hospital

Um, so there's, so there's stuff about preference sensitive care, which is, which is, ah, important, but, but there's, there's a lot more decision support that's important than that, so for example, just, ah, telling patients now of their health maintenance items, what they're overdue for is, is very powerful, and you know not that hard, so, so that should be included, ah, that should be included someplace. I'm, I'm reluctant to, to lump too much stuff in, in one recommendation especially when part of it it's in the EHR and part of it's in the PHR.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So David, our customers like, you know, in terms of like they implemented that clinical decision support rule related to high priority hospital conditions.

David Bates – Brigham and Women's Hospital

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

You know, it would remind, you know, it can remind us if you have a need for flu shots and all those types of things to, you know, you know, or, you know, addressing pneumonia or whatever, so that it strikes me that some of that maintenance, that health care maintenance requirement would get generated, you know, would be handled by those kind of capabilities, because you're really ... hospital or high priority clinical condition. If you're trying to manage a diabetic, you're going to do a lot of preventive maintenance on them and so I'm not sure that the current definition excludes on health maintenance kinds of reminder. In fact I would think that it would encourage them, given, you know, where we're going.

David Bates – Brigham and Women's Hospital

Okay. And, and, is, where is that? Is, is it under subgroup two or subgroup—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

It's under what, it's, it's currently MP—well, Stage 1 and Stage 2 for the clinical decision support, so we've got to do five clinical decision support interventions related to actually the quality measures is what it says to date, but again, I would expect that the preventative types of reminders would be included in that.

David Bates – Brigham and Women's Hospital

Okay. But there's nothing so far that I can remember about actually showing those to the patients, as well as to the providers.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

You're right, you're right. That's the gap.

David Bates – Brigham and Women's Hospital

Um, and, and there's some other types of decision support that I don't think we necessarily do want to show to the patients. Um, so, ah, ah, I mean, for me the easiest way conceptually to handle this would be to make it a separate, a separate, ah, item, even though I know we're trying to avoid separate items.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

This is Marty. I think it's wise to keep it as a separate item right now. I'm sure it will get rolled up as we move forward, but, but as a placeholder, I think it needs to be a separate item.

David Bates – Brigham and Women's Hospital

Okay, so let's, let's do that. Okay, um, okay, and I think we covered all the, all the addit-, all these other things that Michelle, ah, ah, identified. Ah, other things, ah, Marty or Charlene or Eva that, that you can think of that, that are things that we have left out?

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

I think we go it.

David Bates – Brigham and Women's Hospital

Okay.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

I can't think of anything right now.

David Bates – Brigham and Women's Hospital

Okay, I can't think of anything more. Charlene, anything else?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

No, I can, I agree with Marty, um, as I'm sure we'll figure out ways to roll these together within in a cross-group as we, um, you know, work through these, so.

David Bates – Brigham and Women's Hospital

Okay, um, all right, so, so next what I think we'll do is, is, ah, you know, basically go up to the top, and then, and then—

Michelle Nelson – Office of the National Coordinator

David, before we do that, I'm sorry—

David Bates – Brigham and Women's Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

Can we just answer, um, subgroup two's questions, and I think we kind of already did, I just want to make sure I got it right.

David Bates – Brigham and Women's Hospital

Sure.

Michelle Nelson – Office of the National Coordinator

So for 208, we had asked them to, um, identify patient preference for communication and part of the PHR conversation that we had, um, Eva identified some things, standardize risk, standardized risk status and information about expansive care, information about functional status change, because subgroup two was just asking for a little bit more information of what we were looking for. I just want to make sure that we give them back what we really want.

David Bates – Brigham and Women's Hospital

Okay. So I'm just looking at this here, so, so the, the question was about, ah, preferences for, for communication and I think what, and then, so they wanted to know what, what we wanted, so in terms of preferences of communication, I was really thinking about that mode of communication. In other words, do they want to be notified, ah, through their, their PHR, ah, about things? Do they want, do they want a phone call? Do they want, um, you know, something mailed to them, that, you know, that, that sort of range of things, at least that's what I, I was thinking.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women's Hospital

Does that resonate for others?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, and then it could include, yes, I think mode is one and then, uh, you know, um, it's when, you know, or how, when and how, do they want an alert or, you know, so there's probably different aspects relative to communication. Um, and it will be based, and it's kind of like if you think about, when you, you know, sign up to get, you know, a credit card and you list, okay, I want alerts here, there, and I don't want, I want alerts for this, but I don't want an alert for that. But it's that kind of, um, is not only the kind of the mode, but, you know, in what condition for what conditions do we want communication. So as you start to think about even though we're not covering it, is it's just an appointment referral, or is it availability of a lab result or is it, um, you know, or a health care reminder alert and those kind of things, so those two aspects.

David Bates – Brigham and Women’s Hospital

Okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So mode and then what do they want to be communicated to, you know, for what purpose.

Michelle Nelson – Office of the National Coordinator

Okay. Can I ask one more question?

David Bates – Brigham and Women’s Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

That I think kind of came up, um, I’m not sure if anybody is doing anything related to the patient’s experience of care and I’m not sure which group that falls into.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, quality, send it over to quality.

Michelle Nelson – Office of the National Coordinator

But then that’s this group.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Oh, wait. No, no, no; I meant the quality measured group.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

I think that’s a quality measurement.

Michelle Nelson – Office of the National Coordinator

Okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, we’re sending it to quality measure.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

..., not that we’re deferring things, but.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women’s Hospital

But that’s a controversial one we’re still figuring out how to measure it.

Michelle Nelson – Office of the National Coordinator

Yes.

David Bates – Brigham and Women’s Hospital

Okay, um, and Michelle, an-, anything else that you wanted along those lines?

Michelle Nelson – Office of the National Coordinator

No, I think that's it for now anyway.

David Bates – Brigham and Women's Hospital

Okay, okay. So, um, shall we, shall we go back up to the top and just work our way down gradually? Um, I think 101 is worded reasonably well unless anybody differs, and 102 got consolidated, so we don't have to worry about that.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, so the only one on 101 were you going to add in like we put referrals there, you want to add in transitions there, that's a jump, but, you know. Should we put it out there? I mean when you do a transition to a nursing home, you write an order, right, so, or is that considered a referral?

David Bates – Brigham and Women's Hospital

I'm just thinking about it and, and trying to—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I'm really not sure because, you know, I get a little confused.

David Bates – Brigham and Women's Hospital

Yes, I think I would handle this, ah, you know kind of, as a, as a separate one, even if we roll it up later as Marty was suggesting earlier.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay.

David Bates – Brigham and Women's Hospital

Um, you know, it's not traditionally high on the list for, for orders, but would be a good place to put it.

Michelle Nelson – Office of the National Coordinator

I think we talked about this during one of the workgroup meetings and this is where they wanted to put it.

David Bates – Brigham and Women's Hospital

Okay, in, in this one, or, or like next to this one?

Michelle Nelson – Office of the National Coordinator

In this one, at least that was my understanding.

David Bates – Brigham and Women's Hospital

Okay.

Michelle Nelson – Office of the National Coordinator

Because there's the note in there of transitions of care order added to CPOE when send the transition something is ordered—

David Bates – Brigham and Women's Hospital

Okay, okay, go ahead.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

What I didn't know David, so when you like transition to a nursing home or home care, is that a transition order or is that called a referral? Do we have it covered under referral?

David Bates – Brigham and Women’s Hospital

It's not a, it's not a transition order.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes.

David Bates – Brigham and Women’s Hospital

Um.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

It's a discharge order, or—

David Bates – Brigham and Women’s Hospital

Yeah, yeah, exactly.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So I don't know how to depict that, that's all.

David Bates – Brigham and Women’s Hospital

Right.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

And then, and then you actually just have a lot of discharge, you know, you have a list of orders that ... with it, right?

David Bates – Brigham and Women’s Hospital

Right, I mean, there are a whole lot more, ah, ah, these other types of orders than there are transition orders, so, you know, the, the, the effect of sticking it into this pot would be that these things would just get totally lost in the ocean of med and lab and orders—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Oh, you're right. Yeah, you're right.

David Bates – Brigham and Women’s Hospital

So, so that's, that's a problem.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Sure, yes, and my denominator would, my, the lab orders would consume my denominator I think.

David Bates – Brigham and Women’s Hospital

Yes, so you could get a good score and never send a single order for a transition.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

All right, so maybe we want to because, ah, we want to raise the boat in Stage 3 that really starts with this making this change, um, maybe we need to carve it out separately.

David Bates – Brigham and Women’s Hospital

I mean, that’s, that’s what I think. Um, let’s at least for now do it, do it that way. Um, how, now on the next one, on the, on the drug/drug, how are we going to get the, the DDIs in? Will that be done through some sort of—certification is separate?

Michelle Nelson – Office of the National Coordinator

So we did put a list together of things to send over to the Standards, um, that was included in the list.

David Bates – Brigham and Women’s Hospital

Okay, good, just so long as it gets in there someplace. Okay, the next one is—

Michelle Nelson – Office of the National Coordinator

I’m sorry, David, can we just go back, so you’re going to separate out referrals and transitions of care from med, lab and radiology.

David Bates – Brigham and Women’s Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

Okay, just making sure, thank you.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

And what percentage does want, 10%. We kept it pretty low for this.

David Bates – Brigham and Women’s Hospital

Yes, 10% or 20%, you know some—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, so we’ll just keep it—I think ours is like, they received a closure of it for like 10% or something.

David Bates – Brigham and Women’s Hospital

Right, so, so that would be good.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So this whole concept is e-referrals and starting to get that infrastructure in place.

David Bates – Brigham and Women’s Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

Charlene, you said 20%.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I forget that we put, but it was in the range of 10% or 20%, pretty low.

David Bates – Brigham and Women’s Hospital

Okay. Um, so let’s, let’s go to 103, um, so this is an interesting one, um, let’s, um, um, this is, this is actually, so this, I think that the way that this worded is reasonable. Um, ah, it’s asking for 65 to be transmitted, ah, electronically. Um, we’re actually having trouble getting up to that sort of level, um, in part, ah, just, ah in part because they’re narcotics. There are a lot of things, there are a lot of things where the patient just wants take up their paper prescription, um. I think it’s at 40% now and that’s manageable, but there are a lot of people who even though we generate all our prescriptions electronically where that is sending them, sending them electronically, that’s about where people are. Um, so I wouldn’t want go up any further here. And I think, I think the way that this is worded is, is okay. Other, other thoughts?

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

This is Charlene. I’d agree. I think there’s, you know, it’s just getting this infrastructure in place.

David Bates – Brigham and Women’s Hospital

Yes, and it’s having the pharmacies, you know, get used, getting used to accepting the hand-offs, because, you know, it only takes a couple times when the patient shows up at the pharmacy and nothing, and the pharmacy says they can’t find it for the patients not, not to want to do that way. Okay?

Um, so next one is 104 and, um, okay, do we know anything else about gender identity issues? We may not.

Michelle Nelson – Office of the National Coordinator

We sent that question to the standards group as well.

David Bates – Brigham and Women’s Hospital

So we’re waiting to hear back.

Michelle Nelson – Office of the National Coordinator

Yes.

David Bates – Brigham and Women’s Hospital

Okay. Um, should we, ah, let’s see. Should we amend the, this to say demographic, demographics and other, ah, and I’d like to get these other categories. What is this? I’m trying to really figure what the, the, um, what does SOGI, S-O-G-I stand for? Sexual orientation, gender identity?

Michelle Nelson – Office of the National Coordinator

Yes.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, yes, that’s it. This is Eva.

David Bates – Brigham and Women’s Hospital

Okay, but is there, is there a name for, for the broader group of things like this disability, SOGI?

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Um, I think, well, the only one really know of is demographics, but that’s, I don’t know. I think it’s good to specify, because ultimately you’re going to have to get down to the nitty gritty. But are you, of the standards and, and I think that each of those various things are in different places with regard to readiness. Um, so are you trying to think about just a, a better way to save them as a whole?

David Bates – Brigham and Women’s Hospital

We’re just thinking about whether, what we should add to the objective, um, and we could add disability status and then, and then sexual, sexual orientation and gender identity status.

Michelle Nelson – Office of the National Coordinator

Um, but just to note from subgroup two, their concern is that that should be in a clinical field because demographic information often shows up at the top.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yeah.

David Bates – Brigham and Women’s Hospital

Okay, so, should we, could we say like demographics and then clinical data, or something, and, and then have the, the next couple be as, as, as clinical fields? I’m just trying to think of how do we handle this and end up with as few, a few, ah, objectives as possible.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yeah, so we’ve got disability status so the—

David Bates – Brigham and Women’s Hospital

Because the others are really just do gender and, and language better.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yeah. I guess what is rolling through my brain, but I’m not sure this is right is, is the primary purpose, I think, of collecting this information is for purposes of stratification for, ah, disparities reduction, although that’s part of the, part of the reason for keeping the, um, disability status as a clinical field is that that also has implications for the individual’s care, so unless that’s the best way to describe it or not.

David Bates – Brigham and Women’s Hospital

I think it really is both. You want, you want, you want to be able to do both.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes.

David Bates – Brigham and Women’s Hospital

So how about handling it as, as saying the end clinical data within a couple of bullets, on, on disability status and SOGI status?

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Yes, yes, that covers it and people will know what we’re talking about I think.

David Bates – Brigham and Women’s Hospital

Yes, okay. Are we ready to move on? So 105 ended up getting consolidated, um, so did 106 and 107.

Michelle Nelson – Office of the National Coordinator

But we had a lot of stuff in 105.

David Bates – Brigham and Women’s Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

I'm not sure where that goes. It becomes a new objective.

David Bates – Brigham and Women's Hospital

Let's, let's see. Um, um, somebody, somebody is typing. They want me to, ah, mute.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Sorry.

David Bates – Brigham and Women's Hospital

Um, so, you know problem reconciliation we gave to Charlene.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, reconciliation from discharge.

David Bates – Brigham and Women's Hospital

That's yours, too.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I got that.

David Bates – Brigham and Women's Hospital

Okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

And we're building this reconciliation capability. We'll just have to make sure that we assume it's going to be readable, but we'll try not to lose that. HTML.

David Bates – Brigham and Women's Hospital

So, um, so, ah, here the issue is defining high priority conditions and, and, ah, um, I mean the referral here is the study that we did, which is we're now actually using routinely, which is something called Maple, which is a tool that goes through and looks through your data and then, ah, asks the doctor to, ah, add things, ah, to the problem list if, if they're, if they're present. Um, I mean I think we could, ah, ah, I don't know that we need a specific requirement for this.

Michelle Nelson – Office of the National Coordinator

Way down at the bottom it said a new objective maybe for appropriate medical for diseases.

David Bates – Brigham and Women's Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

Do we want to put that in somewhere else or part of the conversation that we had earlier?

David Bates – Brigham and Women's Hospital

I think I would probably handle it through decision support.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

Right.

David Bates – Brigham and Women’s Hospital

Um, so I think, you know, I’d deal with it that way. And, ah, um, I’m not sure what the aim was around the patient information reconciliation.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So in the patient generated work group, there was just a lot of discussion and, again, this is kind of around, um, if they saw something on their problem list that wasn’t accurate, then to say, then, but we kind of talked through could you use secure messaging in and communicate it and then it’s up to the provider to make sure that problem list is amended and that kind of stuff. So I’m not sure exactly what their final conclusions were, but it was a recognition clearly they can’t update the problem with, but they could send in a comment relative to what’s on the problem list and that’s kind of where we were going and we use the secure messaging to do that. Um, so again, um, I think that’s, I don’t know if you remember Michelle if subgroup two still has that capability in it.

Michelle Nelson – Office of the National Coordinator

They do.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, so we got it there.

Michelle Nelson – Office of the National Coordinator

It’s, it’s kind of lumped into something else than just a phrase that it kind of got lost a little bit, but.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes.

David Bates – Brigham and Women’s Hospital

Well, it’s, it’s an important capability. You need to be able to annotate and then request a change and probably both are important. I mean, there may be situations where, you know, the patient disagrees and they should just be able to annotate, but then—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So, David, you know, maybe what we do, I’ve got problem reconciliation under the reconciliation under, um, care coordination, maybe we build that out with the, how we, and describe that in terms of just that capability to be able to annotate based on corrections, you know, and document that or something, you know, or I build that out under the reconciliation function. Does that make sense? So we get that?

David Bates – Brigham and Women’s Hospital

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

And then if it comes in through secure messaging, we capture it. Well, the whole discussion was we don’t want people to update the problem list that the provision during that process should be able to annotate it with, um, patient information or, you know, patient generated data should be possible, right?

David Bates – Brigham and Women’s Hospital

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, so why don't, why don't you refer that one back to us and we'll put that, so we don't lose it. We're trying to work through that problem reconciliation function, but we could certainly put that there.

David Bates – Brigham and Women's Hospital

Okay. Um, the next one we talked about already. Ah, this, these could go in a sort of a general medication safety CDS one, too. Um, it seems like we, we have, ah.

Michelle Nelson – Office of the National Coordinator

Do you want to break out what's currently there for CDS or just add it?

David Bates – Brigham and Women's Hospital

Just add it.

Michelle Nelson – Office of the National Coordinator

Okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I agree.

David Bates – Brigham and Women's Hospital

Okay.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So do you have the DDIs under CD-, so there's a set of stuff around improved management and medication, that will all go under clinical decision support? Do the DDIs go to clinical decision support?

Michelle Nelson – Office of the National Coordinator

No.

David Bates – Brigham and Women's Hospital

The DDIs I think went to the Standards Committee, right?

Michelle Nelson – Office of the National Coordinator

Right.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, all right.

Eva Powell – National Partnership for Women & Families – Direct Chief Technology Officer, Health Information Technology

As we get there, then we can look at them as a whole ... that's the one I'm struggling with, you know, a lot of things that we forward there.

David Bates – Brigham and Women's Hospital

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

And I think, um, ... sending that capability for Stage 3 will make a lot of sense holistically.

David Bates – Brigham and Women’s Hospital

Right, but let’s see, what, what number were we just on?

Michelle Nelson – Office of the National Coordinator

One zero six.

David Bates – Brigham and Women’s Hospital

One zero six, okay, ... too many times I lost my place here.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I was on 107, so I’m really in trouble.

David Bates – Brigham and Women’s Hospital

Okay. Now we’re on, now we’re on 107, okay, so this was also consolidated and here we have allergies and kind of cleaning up the allergies, and I’m a little nervous that that will get lost someplace, but there, I don’t think that there are mature standards for this. Um, do we, do we have something going to the Standards Committee about this?

Michelle Nelson – Office of the National Coordinator

Yes.

David Bates – Brigham and Women’s Hospital

Okay, so I think we live with that. Okay, the next one is, um, recording and charting changes in vital signs and, and collections, collecting data in structured terms around that. And I, I think this is worded pretty well. Um, I, I mean I, I know that there’s some stuff in the summary of care, but I don’t know that there’s a request to actually, uh, code it off in structured ways explicitly.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So the types of things that we had under care coordination, which we got now are, you know, functional status, um, activities dai-, you know, some activities of daily living, those kinds of things, um, they’re standards now for ... of status. There’s some things were coming in there, but I, I guess since we’ve got them under, um, the transitions of care and the direction is they’re consolidating them. I guess we’ve got them captured there, so I would think we should be okay, right?

David Bates – Brigham and Women’s Hospital

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Okay, so do we, um, remove this one?

David Bates – Brigham and Women’s Hospital

Well, Michelle, what, what do you think?

Michelle Nelson – Office of the National Coordinator

I don’t know.

David Bates – Brigham and Women’s Hospital

Yes, I’d rather leave it, you know, um, a lot of times it’s not, it’s not there. And I’m, I’m just afraid that if we don’t call it out specifically, there’ll be blank stuff in the summary of care record, or, or uncoded data.

Michelle Nelson – Office of the National Coordinator

Well, let’s keep it in and the Meaningful Use Workgroup maybe consolidate it, but—

David Bates – Brigham and Women’s Hospital

Yes, that sounds good.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

All right.

David Bates – Brigham and Women’s Hospital

The next one is smoking status, and, ah, and this, this looks reasonable to me. One could argue that, that, ah, you know, that it might already be done, but, but, ah, um, this is the other, actually of the in Stage 1 of the smoking-related thing is, is one of the more challenging ones. It’s been really good to go through and, and buff up the data.

Michelle Nelson – Office of the National Coordinator

So for, for Stage 1, the smoking status right now only has a to be a structured field and you could identify the appropriate CPT code that it goes with, but then that means that you’re automatically billing for something, so it’s a little bit tricky.

David Bates – Brigham and Women’s Hospital

Right, right, so I think I would leave this in. Um, okay, ah, the next one was drug formulary checks and that was consolidated, which I think is, is okay. Um—

Michelle Nelson – Office of the National Coordinator

But we have a note about, um, generic substitution should be required.

David Bates – Brigham and Women’s Hospital

Yes, and I agree with that. Can we, can we, can we incorporate that within the ERX core objective?

Michelle Nelson – Office of the National Coordinator

Um, probably, that was 103, so I’ll add that up there.

David Bates – Brigham and Women’s Hospital

Yes.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women’s Hospital

Okay, and then, let’s see.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Otherwise, Michelle, do you know if that’s a certification requirement today? I mean, most, in most of the, um, drug data bank’s capabilities is the provisioning to—

David Bates – Brigham and Women’s Hospital

I’m pretty sure it is.

Michelle Nelson – Office of the National Coordinator

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Yes, it’s all kind of there and it’s just now whether people use it and/or, um, and again, that stuff changes pretty quickly. You got to get updated, but, um, it’s all pretty standardized in those databases today.

David Bates – Brigham and Women’s Hospital

Yes, okay. So, 1-, 111 is, is done. Um, it’s been incorporated, ah, elsewhere. Um, and I’m, I’m just wondering how we’re doing time-wise. Are we at the, we’re five minutes to ending. Are we at the point where we should open up the phones, or?

MacKenzie Robertson – Office of the National Coordinator

This is MacKenzie. You’re okay to keep talking for a little bit longer. If we run five minutes over, that’s fine.

David Bates – Brigham and Women’s Hospital

Okay, okay, so let’s keep going. Um, next one is, ah, is advanced directives.

Michelle Nelson – Office of the National Coordinator

So this one is the one we’re hoping to have a hearing around, so we maybe we can skip this one until we, we’re trying to plan that hearing call, so—

David Bates – Brigham and Women’s Hospital

Good. Okay, so this is an important one, um, great, but there are a lot of tricky things about it, okay. The next one is the decision support rule and we have these Stage 2 and then in Stage 3 we recommended going up to 15. Um, so the, so the objective would be, ah, use of clinical decision support to, for performance on 15, high priority conditions. Um, now there’s the issue about chronic conditions, which don’t apply to some specialties, which is true.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Actually, um, it wasn’t, what was in Stage 2 was five clinical decision support interventions related to five or more clinical—

David Bates – Brigham and Women’s Hospital

You’re right, you’re right, you’re right. So—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So you wanted to do 15 clinical decision support extensions related to—

David Bates – Brigham and Women’s Hospital

I think still to maybe five or more—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I think that’s fine, yes, I think that would be great, actually, because otherwise it’s really—

David Bates – Brigham and Women’s Hospital

Yes, so that doesn’t ... end too much. Um—

Michelle Nelson – Office of the National Coordinator

I’m sorry; say that again, you decided to change it to five or more.

David Bates – Brigham and Women’s Hospital

No change the, the first five to 15.

Michelle Nelson – Office of the National Coordinator

Okay.

David Bates – Brigham and Women’s Hospital

And then, and then, ah, add as a number three, the, the request to do the, to be able to, to, ah, do the monitoring, and, ah, now we could include as a fourth, um, something about, about patients, you know, both the ability to capture preferences, um, and, and also to deliver, ah, recommendations to patients.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So what we did in Stage 2 is we made here’s the criteria, do we add in at a minimum, the ability to use patient preferences for clinical decision support. That’s going to be even a, we’ve got to capture them first right?

David Bates – Brigham and Women’s Hospital

Right.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

So, um.

David Bates – Brigham and Women’s Hospital

Yes, I’m, I’m reluctant to stick this in here, because if—

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

I am, too. You don’t want to de-, you don’t want to decrease the value of the overall objective.

David Bates – Brigham and Women’s Hospital

Yes.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Right?

David Bates – Brigham and Women’s Hospital

Yes, you know, or make it you know include something that makes it so difficult that nobody is going to get there and, ah, so I mean it seems to me like the patient specific part of things should be really a sep-, separate objective. Would, did we decide that before? I think we might have.

Michelle Nelson – Office of the National Coordinator

Yes, I kept it, well—

David Bates – Brigham and Women’s Hospital

Kept it as separate.

Michelle Nelson – Office of the National Coordinator

Yes, I’m not sure where that falls now maybe in 126 or maybe not.

David Bates – Brigham and Women’s Hospital

Yes, okay. Um, well, it is now 2:29. I think, I think we should stop at this point, um, just to respect people’s time and go to the public comment period.

MacKenzie Robertson – Office of the National Coordinator

Operator, can you please open the lines for public comment?

Public Comment

Operator

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 and Women’s Hospital

Okay, so I just want to thank every-, everyone and, and, ah, next time we will, ah, go through the rest of them. We got, got quite a ways today and then we will, ah, focus on prioritizing and consolidating. All right, so thank you.

Marty Fattig – Nemaha County Hospital – Chief Executive Officer

Thanks, David.

Michelle Nelson – Office of the National Coordinator

Thanks.

Charlene Underwood – Siemens Medical – Direct Chief Technology Officer, Government & Industry Affairs

Bye.