

**HIT Policy Committee  
Meaningful Use Workgroup  
Transcript  
June 12, 2013**

**Presentation**

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thank you. Good morning everybody, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there is time for public comment built on the agenda. The call is also being recorded, so please make sure you identify yourself when speaking. I'll now go through the roll call. Paul Tang? George Hripcsak?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks George. David Bates? Christine Bechtel? Neil Calman? Art Davidson?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**  
Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks Art. Paul Egerman? Marty Fattig? Leslie Kelly-Hall? David Lansky? Deven McGraw?

**Deven McGraw, JD, MPH – Director – Center for Democracy & Technology**  
Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks Deven. Marc Overhage? Charlene Underwood?

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

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks Charlene. Mike Zaroukian?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks Mike. Amy Zimmerman? Tim Cromwell? Joe Francis? Greg Pace?

**Greg Pace – Deputy CIO – Social Security Administration**

Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks Greg. Marty Rice?

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Here.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

Thanks Marty. And Robert Tagalicod? And any other ONC staff members on the line, I can see Michelle, so I know Michelle will be joining in a minute? Okay, with that, I will turn it back to you Art and George.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Thank you. And thank you everyone for joining this morning. Before we get started, I just wanted to ask George a question, because I thought Paul would be on the line today. The goal today is to create the final recommendation that would go back to the Policy Committee in July, or are we talking later. Do you know?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

This is – our goal is to set the category for recommendations that will go to the Policy Committee, yes.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Is it in July or is it in –

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

This is MacKenzie; we're planning for the draft set for August and then the final set for September.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Yeah.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Okay, I just wanted to check the timing of that, thank you. Okay. So I think everybody should have the slides, I don't think we'll take as long as it's projected on the current schedule, but we'll see. So after the Request for Comment and the comments that were received that Michelle summarized, the subgroup met and we came up with some recommendations that I hope we can review today. If we'll move to the – yeah, we have the slide up there now with the – there are seven items on this list. It was originally about ten and we're down to seven after the application of the concept of consolidation. And you can see there that we have several registries that were merged, several items on this list were considered potentially future stage and I'm glad to see that we may actually put one of those, the case reports to public health, in the certification only category as a recommendation to the Policy Committee.

George, before we get started with the details, is there anything else you wanted to add here in an overview sense?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

No, not really. I mean we've been just going through category-by-category and so, I'm looking forward, I agree with you, we may not take up the full time, but let's have a good discussion.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Sure. Okay, if we could advance to the next slide, please. And this first slide, I'm just going to look at it on my own machine because it's a little bit small for me. The immunization registry, this is 401A and there was not really that much change in our deliberation after the Request for Comment. The main thing that we did here was just change the threshold from a higher threshold of 30 percent down to 10 percent for patients who received immunizations from the EP or EH during the entire EHR reporting period. And I really feel like we're in need of feedback from, and the committee, the su – the workgroup, subgroup felt that we needed some feedback from Stage 2 on ongoing immunization registry reporting before we could make this firm commitment. But I think we're due to get that by the end of this year, at least the beginnings of that.

So here again, we find that one of the problems is that many states are in different states of readiness, and that some immunization registries are well down this path and others may be less so, and some may be incapable of really taking on the task of bringing in thousands of providers. But I know that from discussions with my public health colleagues in the immunization programs around the country and the American Immunization Registry Association AIRA that states and jurisdictions smaller than states are currently working to gear up for this effort and intend to put forth the best possible public health response to Stage 2 requirements. So, I don't know that there's too much difficulty anticipated with this in the long run. They are getting up to speed and understand that this is a great opportunity offered by Meaningful Use.

So the final recommendation would be the capability to receive a patient's immunization history supplied by an immunization registry or immunization information system and to enable healthcare professionals to use structured historical immunization events in the clinical workflow. So that means that they have to be able to send back the information to the EHR and the EHR needs to be able to somehow represent that in the workflow process. And as I said earlier, you would need to document that you could do this or had done this on a lower threshold than we had originally set, which is 10 percent.

And again, the certification criteria is that the EHR is able to receive and present a standard set of structured, externally generated, immunization history and capture the act and date of the review within that practice. Any questions about this? Any concerns about the low threshold? I think we thought it was – as we've seen in most of the work so far that you set a threshold and people seem to blow past it. So even though we went down here, we wanted to give practices the opportunity to begin to institute this, but we anticipate that it'll probably go way beyond 10 percent in full practice.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

So this is Mike Zaroukian, I would like to ask a question and maybe express a concern from a primary care physician perspective. So as I'm taking care of patients and I look at this, it reads to me mostly like what a certification criteria would be. In other words, between the registry and my EHR, my EHR has to be able to accept the registry information, which I applaud and I think it's great and will help all of us. I don't know what I would actually need to do as an eligible professional to meet the threshold. Am I actually documenting something about having received and reviewed it? Am I simply attesting that yes, my system is taking this in? And I think to your point, it's really true this either will work or not, and if it works, we will, of course, be able to get all these data and so whether it's I guess automatic or a manual review and acceptance of these data into our EHR I think would be part of the issue. So I'm a little confused if I were trying to do this in my role as a primary care physician, what would I actually be doing to qualify for this measure?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Thank you for that question. That's a good question. So, you're sitting with a patient with your EHR and it's a kid, you need to find out what shots to give. The query would go out to the state registry or the jurisdictional registry wherever you are and it would retrieve the shots that are known in that registry for that child. And you would be able to see it and the EHR would say the request was sent to the state registry or jurisdictional registry and it was – this information was received in the process of care. So, if you give out 100 shots in a month, you would have done that on at least ten.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

But the question...all right, the question is, do you have to check a box that says, I reviewed the history?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

No, I think that at the bottom it says that capture the act and date of review within the EHR practice and that's a – that is in certification, so, you will have to do that – you'll have to go out and look for it, but the EHR is capturing it, you don't need to check a box.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

So it's not clear –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

You have to look at it. You have to go to the screen that has the information on it – if the EHR has it but you don't look at it.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Umm –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

For example –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Well I – the EHR has to somehow represent that to the clinician. I guess – so you're saying the EHR could look it up and just get parked somewhere without ever getting into the workflow.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well I'm not worried about it; I just want to know –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

No, I think Mike's worried about that.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

– it's not a certification criterion so you have to do something, for vital signs, when we had vital signs it was you had to record the vital signs. So that was an act that a doctor was doing. What's the act that the doctor is doing here? The health record is doing it. So, I think it's like when you're sending something, generally a feeling the doctor's pushing a button that says send it. Whereas – but there are some of our objectives are kind of – like ability to view and download and we ask how many times a patient does something. So I think we just need to clarify if we're asking the doctor to do anything or just asking the EHR to do something.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right. And again, I'll just expound a little bit, and that is, in an ideal world, I don't query the registry. In an ideal world, the system automatically when the patient comes in for their visit, queries the system if necessary the night before, more or less like pharmacy fill history, and does all the work I would otherwise need to do. So I don't click a button to query because number one, I shouldn't have to and number two, I'll forget. And so what I'd really love to do is in the process of automating my workflow habit of looking at immunizations to see what to do and using clinical decision support to look for deficiencies or opportunities and provide them. I'd like the EHR to have already worked with the registry to update it with the latest information and then use that to provide me with decision support about what the child needs and then if they need an immunization, or in my case adults, if they need an immunization, go ahead and give it. And if they don't, I would still like credit for the fact that I reviewed and made sure that their immunization history was up-to-date, even though an immunization was not required.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So I totally agree with you that this should happen automatically in the background. And now – and I think in clinical workflow we would use the data, if it comes in, if it's presented, you would be able to make a decision based on what came in from the night before. So how would you word this differently to express that the data were used.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

So, great question. So number one, if we therefore said, I'm not going to check a query button – I'm not going to click a query button to go do it manually because we agree we want to get it automatically. But what I can do is have some kind of an indication that I have reviewed their immunization status that part of certification criteria is such that in order for this EHR to be certified in the first place, it must be presenting me with the data that I need to review. In that case I would expect it to do it 100 percent of the time with all of the registries capable of providing that service, and that I can actually get Meaningful Use for reviewing that in a certain percentage of my patients. And that's where I think the threshold is such that you may well have to ramp that up because docs may not be in the habit of reviewing those on a regular basis during a patient's appointment, and that's the opportunity to really make a difference in quality and outcomes.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So would you say that during the clinical encounter a check box –

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**  
No.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**  
– is marked?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Well – so I would just say some indicator that an – so trying to marry the combination of goals here. So one goal that we have that I share is making sure we can get information from a registry. The question is, if that's the goal that only needs to be a certification criteria.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**  
Right.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

If we actually expect doctors to do something with it, that's a Meaningful Use measure that relates to an EP and because the Stage 3 objective and measure right now does not read as – to me, as a provider, as I actually have to do anything. I right now just have to make sure that the certification criteria are being met and somehow attest that yup, I'm actually getting them. So I'm looking for the action item, if you will, in the measure that I would need to do and we could discuss that whole process of, do I actually have to do a review and if so, how do I document that it's been reviewed. But that's not yet in the measure that I can see.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Right, so maybe we could add the word after rec – documentation of timely and successful electronic receipt of this – receipt by the EHR and review of vaccine history. Would that – so that documentation now falls on – a review falls onto the clinician, not on the EHRs certification ability.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

This is George. I would go in the other direction. I don't think we need more check boxes for everything we come up with that makes sense for doctors to do. So I agree the objective's ambiguous and therefore problematic, but the answer is not to have a check box for every objective, all 20 objectives that doctors have to do. So it may be that, in fact, certification criteria would just say that the system is able to do this, it doesn't say that you're getting any data from the health department. So what this objective could do is say we have to actually get data from a percent of patients who receive immunizations, they had data downloaded. Now the fact that you can attest to this by pushing a button in your EHR and it comes up and says look, you gave this many immunizations, and of those, this many people had data downloaded on the same day, I'd be happy with that. I don't think we necessarily need the check box.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right. And so this is Mike. I agree and actually, if we anchor again, on what is the objective and measure here, this is data sharing, right, so this is not necessarily a clinical quality measure per se, or a delivery of care type of a process, it's making sure that information needed moves back and forth. So unless we're going to create another measure related to actually doing something that moves the needle on getting patients immunized, I would very much anchor indeed on that issue. And then I would say that the EHR could generate the report that says, which I think is to this point here, that yes, information not only for certification do you have to certify that you can do it. But in practice, there's evidence of a report from the EHR that information did come from a registry into the patient's chart for "X" percent of patients that were seen during that period.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
Right, that's what I would do.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So, it's an attestation for the measure and a certification criteria for – that reports can be received from an IIS is what we're now suggesting. Is that –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

It's not an attest – it's a measurement of how many – for how many pe – it's just that the provider doesn't do it, the EHR measures what percentage of the time when I ha – of patients who had an immunization, what percentage of those had a download from the health department, from the immunization registry and that's the percentage I'm going to report and it has to be more than 10 percent.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

And I would ev – and this is Mike, I would even argue it's irrelevant to whether the patient's getting an immunization during the time period, it think it's –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So we have to decide – right. So that's something we have to decide. The problem is that, like what happens if there's no information on that patient in the registry? Does that count towards or against it, like you did a download and it said "no match," does that count towards your thing or not?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Does "no match" mean no data or does "no match" mean I couldn't identify the patient?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well it could be either one because there's "no data" because they don't have the – if they don't – if they never received immunization data on this patient it may not be in that database, so it would be a "no match." They may not be able to tell the difference.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**  
Right.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Yeah and again, I think with a sufficiently low threshold that might take care of that issue but I think you could also exclude that from the denominator if the registry reports a certain value of "no data," etcetera and the EHR can capture that.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So this is an open question. I – we narrowed it by saying anyone who receives an immunization and that was our attempt to narrow the denominator. I think 10 percent of all patients to get a record from the health department is a huge thing, and you want to aim for something like 1 percent or a tenth of a percent.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

So again, it's a great point. I think the key question, and we've talked about this in our other subgroups and that is – and Paul and I have, and that is the issue of, do we want to prove that the systems are capable of doing this or is there an actual threshold that matters? Because I think for those of us who are docs, if our systems can do this, we're not going to not want them to do it and we're not going to be trying to achieve a certain threshold; if the data can come, we're happy to take it and then do something with it. So if this is a proof that the systems can do it, for certification criteria, and that it actually works in practice then if we have any number of them that are actually coming across in a way that is deemed to be reflective of the success of this data-sharing process, then I think we're good. I don't know that we need a particular percentage.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

I forget which objective we made the switch for I'm blanking now.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

The switch for what?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

For going from a percent to a number.

**Leslie Kelly Hall – Senior Vice President, Policy – Healthwise**

This is Leslie, we did it in I think education and we did it in language, I think, in other areas, and we just said you needed to do it once.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So Mike I think you bring up a good point that it is about proving that the EHR can do this at first and if we – when we get to the 402 – 401B, the one that is the clinical decision support. Maybe that's the one where it really will drive practice based on what recommended vaccines should be given. And that's where you may want it to have it more in the clinical workflow that there is a threshold there, rather than just did I get the information, I don't need to check that off, I don't need to even do anything more than say that it happened.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right, docs will value the fact that this has been a requirement that registries and EHR vendors and everybody has to work together so that these data come to us, we would love that. Then you can hold us accountable for the clinical quality measures around it, we don't need a measure to prove that we've actually received it. You may need a measure to make sure that that exchange happened and if we can grab it from our EHR as a report that shows that an irrefutable indicator that the registry talked to our EMR and gave it data, even if it reports no information, we know that it works. Then we can work on the issue of more and more robust information that's being exchanged. But it meets the goal and spirit of the rule.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Thank you Mike. Are there any other comments from other members of the workgroup?

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

The only other comment, and I don't recall this one – this is Charlene. Did we consider this as one of the aspects of clinical decision support when we were working at that clinical decision support in quality and would that have any impact. I mean, I'm fine with the conclusion, it's just a report of the percentage that was received by the EHR and not a physical requirement by the physician, so I think that's fine. But did we have, this is just for full disclosure, do we have an element of this kind of clinical decision support under immuniza – or checking this type of information?

**Leslie Kelly Hall – Senior Vice President, Policy – Healthwise**

Charlene, this is Leslie or, this is Leslie. We could potentially piggyback off of the existing standards that are described to go to any expert system, a clinical decision support system, a research related system or public health. I mean, we could piggyback off that standard. So, that would be one way to look at harmonization, how is an expert system, like the public health immunization record compatible, so that we could work towards some common efforts for certification with the EHRs, and really go a long way fast.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Right, so I just –

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

So this is Michelle. So Charlene, just to answer your question though, the next objective or one of the next objectives that Art will talk about is about integrating immunizations into the CDS objective, so –

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

All right, okay, that – it was. All right, sorry. I was –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

I think that – why don't we continue with this discussion. So I'm going to ask us to advance to the 14<sup>th</sup> slide, the last slide in the deck.

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

So I just want to confirm what I heard though for this objective. So was it decided that there would still be a measure, but it would just be a report. So it's more than certification criteria, there is actually a measure for this one?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Right, but the EHR is capable of doing it and the provider has little to do there, other than to use it in the next measure that we're going to talk about.

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

Okay.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So at least one query result was received by the EHR within the reporting period.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So, are we okay with – so I think this is back to Michelle's question, is there a measure there? The EHR can generate this and now George you're suggesting it should be only at least one.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well, I was just going by the other one.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

And this is Mike. I would just add the issue of that it's turned on, that that capacity is turned on for the entire reporting period. Because we could turn it on and off and only have it work for 20 minutes, and –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Yeah, that's –

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

– so as long as it's on for the whole period and then we let the EHR report, then that should be good.

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

Well, I think I'm hearing two different things there. So the certification criteria, which I think in Stage 2 or, they're starting to work on for Stage 3 is the ability to track whether something was enabled for the entire reporting period. So that can be a certification criteria and not a measure.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

I've seen a history though where it's a measure – so the EHR – the criteria that I'm reading says that it has to be able to receive it, it doesn't mean that it's enabled necessarily. So, help me with that if you can, but I've seen in other measures where it looks like you not only just had to have it available and have that functionality, you had to have it on for the whole period. And that was the measure, in part.

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

So for Stage 1 there was – so for formularies for example, that – but we're trying to move away from that and have the certification criteria available so that vendors have to have a way to report that something was enabled for the entire reporting period.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

So if that's true for certification for Stage 3 for this, we can leave it out and then just have that same threshold.

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

Okay.

**Deven McGraw, JD, MPH – Director – Center for Democracy & Technology**

Well, wait but why would you need a measure, this is Deven, if you don't have a Meaningful Use objective, you just need certification criteria, you don't need a measure.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

That was kind of my original argument, yeah, I agree.

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

So that's what I'm hearing and I just want to confirm that that's what I'm hearing, it's just certification criteria to have it enabled for the entire reporting period?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

No, you must use it once. The measure is to use it once, plus it has to be on. So it has to be on for the period and you have to show that it queried at least once.

**Deven McGraw, JD, MPH – Director – Center for Democracy & Technology**

But I guess that's the argument George –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**  
(indiscernible)

**Deven McGraw, JD, MPH – Director – Center for Democracy & Technology**

– don't we need a measure that says use it once? Aren't there enough incentives in Meaningful Use measures that we wouldn't need to add this as a sort of check the box use it once kind of thing? That's what we're trying to get away from.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

But most people can't do this because there's no health depar – I mean, having it – like we could get rid of the objective, so that's an option, but if we're keeping the objective, turning on the – just a certification criteria – this is not something that's already running that we're going to now get rid of the measure. This is something no one's ever done and they're not going to do if they don't have to do it.

**M**

Right.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

We have the one where we send data to the health department, but we don't have one where we send data from the health department back to the provider. So if we just put this as certification, no health department ever has to implement this.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right. This is Mike. If we go back to my early comment, this is the whole difference between making sure the capacity is there, making sure it's turned on and then making sure it works. And so that whole notion that we had to do in Stage 1 where we had to test to make sure it was actually working, even if it failed, that was at least a test and we only had to test it once. One could argue that a measure could be important that allows us to be vigilant with our vendor and our registry to make sure as an organization or as a practice that our report is not coming up with a zero and we don't do anything about that, in terms of interacting with our vendor or the registry. That might be reasonable.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

I think that what we're de – we have a concept of start using, which we often do when it's a new thing and it's going to be hard for the nation. One way to do this is to pick a small denominator and then on top of that, pick a small threshold, like 10 percent. A different way to do that is to pick some number, like we try 10 and 15 in one, but some number that ensures it's actually not just capable of doing it, but the health department, in this example, is actually sending data to every doctor who's getting meaningful use who picks this objective if it happens to be menu. So, we're just deciding is it better to pick a small denominator and a low threshold or count the number, which could be anything from 1 to 25. But we do want it to be a measure, if it's just certification, then I don't think any health departments need to implement it.

**David Bates, MD, MSc – Senior Vice President, Quality and Safety – Brigham & Women's Hospital & Partners**

How about if we pick – this is Dave Bates, how about if we pick some number like ten, I think it is very important to ensure that it's actually working, because it's not working anyplace that I – that I know of.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So David, are you saying ten or 10 percent?

**David Bates, MD, MSc – Senior Vice President, Quality and Safety – Brigham & Women's Hospital & Partners**

I like – 10 percent would be okay, but I also wouldn't object to the idea of an absolute number –

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

And this is Mike, I agree – I'm sorry, go ahead.

**David Bates, MD, MSc – Senior Vice President, Quality and Safety – Brigham & Women's Hospital & Partners**

– is the idea of people having to tick boxes for ever and ever. I think Michael and I probably feel the same about that.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right. So if it works, we won't have to do anything. Charlene and others who do this sort stuff will create these great tools for us –

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Right.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

– and we'll just have it recorded in our EHR and we'll have our own detection system, because it is a measure, to know hey, is it working or not. If it works, and we don't – and it's not based on how many immunizations you do, although you may make it only required for people who do immunizations. Since it's not based on how many we're actually doing, it's proving that the data sharing process happens and it'll be way more than ten for people who have any data in a registry. And if we allow for even information that proves there was a talk between the registry and the EHR, even if there were no results, we're still proving that the system works and that's okay too.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Okay, so then it seems to me, since we were having trouble defining the denominator, should it be people who receive immunizations or all people. It might be better to go with at least 10 query results received by the EHR within the reporting period, that's the measure part of it and it was turned on for the reporting period, which might be more certification or whatever, that's okay.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Perfect.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

– that as a final result.

**M**

I like that.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

This is Marty Rice. I've got a quick question. Since it's a functionality of the EHR and I'm kind of unclear of how we need to – if other things are not working and it's part of certification, there should be something that technology sort of pushes out to the clinician to let them know that it isn't working, not for the clinician to really notice something isn't working, it puts a burden back on them. So, I'm kind of not understanding if it's just strictly a functionality, why do we need to even look at it? You need to do something if it's reported, but the system should self-report if something's wrong. Just my two cents.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right. So this is Mike, let me try to operationalize that, because I definitely agree. So I would be hoping that in my EHR, just like I could do a pharmacy fill history or whatever, I would, as I go to review my immunizations, I'd get some kind of information about the status of the system having talked to the immunization registry and when was the last time that was successfully completed and the like. And if I go through all 12 of my patients for this morning, and there's no data, no data and the last date that it was queried was somewhere in the distant past or never, I know it's not working, and I didn't have to go check to see if it's working, I just had to do my usual workflow. Then I could contact my IT person or whatever and say, hey, there seems to be something wrong here, and they can investigate it. And that's even before I run my monthly or whatever reports on whether I'm meeting the measure. So it's really – every patient needs that information, so.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

This is George, so that's a reasonable question, how do we do this for lab results, how do we do this for radiology results? We didn't really design it into the certification criteria, because if you're not getting – although we are doing, now, after the fac – now later on what we're doing is closing the loop on getting lab results. I guess I would say that this is a brand new thing in getting the health departments to start sending data was our goal for Stage 3. We could make it in the certification criteria so that there's a display of the information and that's where the doctor would say – or eligible professional would be – I guess if it's blank, they don't really know that the query occurred or not. So it might be in the certification criteria that they'd have to actually say whe – the quer – the display should tell you whether the query occurred or not, how about that? That would be nice. In other words, you could tell the difference between no immunizations and don't know.

**Martin Rice, MS, BSN – Deputy Director, Office of Health IT & Quality – Health Resources and Services Administration**

Yeah, the burden shouldn't be on the clinician for all the functionality of the EHR, it should be on the system to be able to transmit that information invisibly back to them. It should be kind of like a no-brainer.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well that's why the display has to say whether it got to the health department or not, so the EP knows what they're looking at. This is not an attestation for meaningful use, I just mean for functionality for clinical care, you should know, did I get something back from the health department or I'd never asked.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right. So I think – this is Mike – I think these are some of the methodologies that I would like to leave to vendors and practitioners and whatever to innovate around. And so again though, I think the key issue is, if we can expect registries to send information, EHRs to receive and record them, and to be able to generate a report, to David's point, about how many times was there evidence that the registry talked to the EHR about a patient. And if we get to ten or more instances where there was a successful communication, regardless of the results of that outcome, then they will have met the regulation, and of course, certification would have already established that they can receive and present the standardized set of information. So theoretically, we're not retesting that process.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Okay so Art, you ready, that sounds good, are you ready to –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Yeah. So I'm going to have to listen back over this and see if there's some tweaking of the certification criteria that we might do. Michelle, did you capture that?

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

I think so, so I'll share with you what I heard and you can validate.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So, I was going to – since we were talking so much about immunization, I'd just like – I think it might be helpful at this point just to jump to the 14<sup>th</sup> slide in the deck, which is the one around clinical decision support. And, I'm not clear now, after this discussion, it just says implement 15 clinical decision support interventions. I don't know what that would mean, whether for the other clinical decision support interventions, you have to do anything more than just say, I implemented them. Rather than, in this last discussion we kind of gave up on a measure, we're putting it more on the certification criteria and is it just a measure that I have a CDS for immunizations or is it that I have used it in clinical care?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Well, this is part of a broader decision we've made where we've actually – we're now in our third iteration of trying to get decisions support in –

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Right.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

I don't think we want to start putting use measures on top of this right now, on top of all the other 14 measures also. So our goal was to consolidate, right, and so to try to make this decision support for immunization like the other decision support. So I would vote to keep it consistent.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So it's just the triggers that are being tracked.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

It's that implemented an intervention.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Right. So does that fit with what you were saying Mike earlier?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

I think so and I'd love David's view on this, too. But part of where we are in the process, and David's done great research in this area, is some clinical decision support is great, some is not so great. Some needs to be tweaked more. We should get started in using them and use our experience to get better with them. But exactly how we use them and what we should be held accountable, in terms of how we're using them, I think is less of the issue, but rather, if they're helpful to some of our other goals as we look forward to health reform, etcetera, as we try to meet clinical quality measures, they'll get used more and more. So I'd much rather see at least at this point that we have enough of the right kind at least, domain and specialty in areas that can be used, so that there's more and more availability and then let the clinical quality measure performance, etcetera, at this stage, at least, dictate whether and how they're used.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So on this 14<sup>th</sup> slide, I'm sorry, let me just look back to see if – yeah, you're on that – very small, as I said, for me. It says the ability to track the CDS trigger, so I could get that, that's easy for us to see as a certification criteria. But then the next one is, how the provider responded to improve the effectiveness of the CDS intervention. So that means that you have to track what you did as a consequence of seeing the recommendation in the CDS, is that what that's saying there George?

**David Bates, MD, MSc – Senior Vice President, Quality and Safety – Brigham & Women's Hospital & Partners**

Yes that is what that's saying. This is David.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Right, so then the CDS shows a recommendation for an immunization and then we have to somehow have the EHR say that the clinician did that or didn't do that.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right.

**David Bates, MD, MSc – Senior Vice President, Quality and Safety – Brigham & Women's Hospital & Partners**

Correct. And it's quite straightforward to do that, the vendor just has to put in a flag for – saying, a suggestion about this immunization came up and the person either paid attention to it or they did not.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Yup, so we do this all the time. And the reason for overriding can be required or not required and all that. So what we're – what I see the Meaningful Use group's trying to do here is to make sure all EHRs can do that, which I think is definitely wise, but not yet hold physicians accountable to any sort of particular performance against that. Because clinical judgment is a huge part of whether or not one does or doesn't do some of these, and we're not yet ready to say, is there a particular clinical decision support that should always prompt a certain action.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Okay. Good. So, is there any more discussion on this last slide we jumped forward to, the one that is now labeled 113, which includes immunization, clinical decision support? Great.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

I guess my only question, and I don't have a strong opinion and I just would ask other folks is, as we think about eligible professionals across all specialties, do we feel like it will be easy enough, regardless of specialty, to find two categories where providers in that specialty will go, yup, those are good areas for me to have clinical decision support? Or might we need to include some other options?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So that's a bigger issue than this –

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Yup.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

– workgroup, subgroup presentation.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Okay.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

I don't – we might take that up in another call with Paul.

**Deven McGraw, JD, MPH – Director – Center for Democracy & Technology**

I think it was already discussed at the last workgroup meeting, I think we can revisit it again, but to Art's point, it's not for discussion today.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Yeah, and as long as it was discussed, that's my main point is to make sure that there was a conversation about it and you settled on something. That's fine, because I'm new to the group, I understand.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Thank you Mike.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Sure.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So then, we'll return to the fourth slide, which is electronic reportable lab results, 402A. And this one, the only mention here was that there needs to be an updated implementation guide that strictly enforces LOINC and SNOMED, but this is relatively unchanged from Stage 2, and I don't know that we need to spend any time reviewing this, unless someone has a concern. I don't know that Marc Overhage has joined us yet, he's on the Standards Committee. I think that'll go to the Standards Committee for review, is that right Michelle?

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

Yeah, I think that's right, we'll just pass it over to the Standards Committee. That was really comments that we received and I don't think there's any reason to discuss this.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So if we move to the next slide, which is the fifth in the deck, this is case reports, 402B. And this is an area that is under a lot of investigation right now, I just came from the Council of State and Territorial Epidemiologists meeting in California and the great effort there to try to help work on this and make it possible to do this case reporting from an EHR. And the certification criteria now states the EHR uses some external data to prompt the end user when criteria are met for case reporting, a date and time of prompts is available for audit. And – I'm sorry, just a second – the standardized case reports are submitted to the state and local jurisdiction and the date and time of submission is available for audit and this could be similar to standards used for other areas like 209.

I believe that the work of the S&I Framework around these structured data capture that Doug's spoken to us several times about, is hoped to be a mechanism that might support this certification criteria, that the EHR is capable of doing this structured data capture, an active effort within the S&I Framework. Any comments about this from the group?

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Again, the feedback we've had on this one from the vendor community is again the variation, even among local health departments, relative to the availability – in terms of what you had to report. So again, I think – my concern is just the degree of variation in terms of responding to this in the vendor community. If there's a standard that's one thing, if there's going to be a lot of variation because of this, I would – I hesitate that –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So I think the way that the S&I Framework and the public health community are looking at this is that the EHR is capable of representing some structured data capture process, whether it's CDISC or it's some other method, and that the request goes out for a form and then it's represented. And the form could be modified to address the particular needs of a jurisdiction based on – some states and jurisdictions have 58 reportable diseases, others have 65 –

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**  
Right.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

– and we're not going to get away from that, we're not going to change state practice.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**  
No.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

But the fact that you could go out and get a structured data capture form is what the EHR is going to be certified for is the hope. That is not acceptable to the vendors?

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Um, I mean, we're certainly – it's just the readiness – doing all this stuff that's being asked, I'm going to be honest here, and then the readiness of the other end to actually work with us in accomplishing that, be it the jurisdictions. I mean, so you just came from the meeting, they just – this is a two-way street and those pieces – I mean, it's just like with the labs, they have to be ready to accept the stuff in standard form, the same thing for the health departments. So, we've done a lot of work around immunization registries. I agree that this would help, certainly improve the percentage of cases reported. I just – to put that on the docket with everything else is just a lot.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Oh, this is George. Remember, this is not on the docket with everything else, it's a future stage. So I don't want to spend too much time –

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Sorry, I thought it was Stage –

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

– discussing one that, yeah. So Art, like what we did is we sa – on the previous one we had certification plus a little bit more, the 10. This one, because we said immunization is super important, this one we backed off and said certification only, but it's also for future stage. So, we have time to figure out if this is going to work or not.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Okay.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

I'm sorry George.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

I would just leave it as it is.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

– as is and keep that effort going, because I was thinking one more thing for Stage 3 was where I was getting –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

No, this is future. Yup.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Okay.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

We can move on the sixth slide please which is 403, which is syndromic surveillance. And there's really no change here at all and I think that the states are moving along to be able to receive the data, the CDC set up this BioSense 2.0 site and hospitals are being recruited to submit there. I think that in Stage 2 we'll learn a lot about this, but there's not any change for Stage 3. Any comments? Okay. Thank you.

So this next slide, the seventh slide is the one that we spent a fair amount of time on. So in Stage 2, we had the cancer registry and then in Stage 3 now, we're sort of merging several registries together into a registry objective that talks about two registries that someone would participate in or some organiza – an EP or an EH. So here there was concern about the definition of mandated and voluntary, so we explicitly stated what those were. As you can see on the slide, a mandated jurisdictional registry would be one that is required by law, regulation or order, and those include cancer – for the EP, so we have two slides, the seventh and eighth slide, the one that's up on the screen now is the EP one. And that one is one that includes cancer registries, children with special needs as an example and early hearing detection and intervention.

The next slide is identical to this, except that it's with reference to the eligible hospitals and there are certain registries that are slightly different for hospitals versus EPs, in particular, healthcare acquired or associated infections. So we clarified here what the meaning of mandated was or is, and then we've also given some examples of some voluntary community-based registries are those encouraged but not mandated by the jurisdiction or those willingly joined by the EP. So some entity – an external entity, could be an accountable care organization, it could be a public health agency, it could be a professional society, it could be a specialty community, maintains a registry, and those registries, some examples here were hypertension, diabetes, body mass index, devices and/or other diagnoses and conditions. So here we're now taking what in Stage 2 was several – two different registries, the cancer and the specialty registry, which were separate, and now combining them into – in this consolidation process is recommending that we combine several of these into one registry objective.

Here the operational issue is that we identify – is that the current effort in Stage 2 around registry activities requires the public health agency to onboard and give credit to an organization that's submitting data to a registry, and that registry, like the cancer registry, immunization registry, syndromic surveillance. But there is no such onboarding process for some of these other organizations that someone or some eligible professional would be participating in. So, I don't know if CMS has got a plan about this but it's something that we want to call to their attention is that there needs to be some equivalent process for those agencies that would receive data to a registry that acknowledges that they are contributing to the registry. The eligible professional is contributing to a registry at the accountable care organization or a professional society, because public health agency is incapable of providing that acknowledgement. That's one issue. And then the last thing is that we don't really know whether this should be a menu or core item for eligible professionals, and I'd be interested to hear what the clinicians think about this, that are on the line. Mike or David?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

So this is Mike. I was on mute, I'm sorry. So in terms of menu or core, I – at least from my perspective, I'm a little nervous about what Stage 2 looks like in this regard. I like the work that's been done in terms of the rewording, it actually looks clearer to me and more straight forward. In terms of menu or core, do we feel like we'll have enough experience from Stage 2 about how this goes to be able to say?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Well, it would be wonderful if we had some feedback from Stage 2, we will probably be providing this information to ONC and CMS, as I understood from earlier in the call, sometime in at least by September, and that's still too early. CMS and ONC may be making at least providing a notice of proposed rulemaking sometime in the early part of next year, I guess. Is that still the plan Michelle? Do you know?

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

There just hasn't been a timeline set yet for the NPRM, all that has been said is that there won't be an NPRM in 2013. I might suggest though, I mean perhaps we could leave a note or something that – because the way that it has gone in the past for almost every measure except for syndromic surveillance is that if its core one year, then the next year its – I'm sorry, if its menu one year, then for the next stage its core. So you would assume that it would follow the same precedent, unless the experience just doesn't reveal that it is – that people are ready to do that.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Right and so actually –

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

And that assessment might be made by CMS anyway.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Exactly, so I would say core unless it's discovered otherwise and CMS can make it menu.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Okay.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Because once we say its menu, CMS can't really make it core very easily, but if we say core, they can make it core or menu very easily, I think, right Michelle?

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

Right.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So then, I have a question though, Art. This is George, sorry. We now are good about our definition of mandated versus voluntary. However, we no longer use it, because everything is just either that one or that one, so, I'm not sure we need – we could just say in the objective part, we could just say mandated or voluntary – mandated jurisdictional or voluntary communicates registry, to have a long list of examples. Because in fact the measure and certification, everywhere there's a choice, you always say mandated or voluntary and it could be two mandated or two voluntary, according to the – right? It's not one of each –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

No, no, it's either – could be either.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So we could probably reduce confusion by just saying – I think we should mention the word mandated and voluntary, because otherwise people will say, well what happened to it, it was in Stage 2, did it disappear. And we'll just be clear that it could be either mandated or voluntary, but we don't need like a number 1 and number 2 anymore. Michelle what do you think?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Well I think, the reason why we explicitly put these here because people in their comments back in the RFC said, what's a mandated and what's a voluntary, so we felt there was a need for definition. Are you saying you don't need the definition?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

We don't – they wanted to know what mandated and voluntary was because they had to do one objective for mandatory, one objective for voluntary. We're now blowing that away and just saying, do whatever you want with any registry you want. They don't need to know the difference since we're going to tell them it doesn't matter what the definition is to them anymore is what I'm saying. There are no longer two objectives, you have to do one of each. We not only defined it, we eliminated the need for it. But I think people will get confused if we completely drop the term, because then everyone's going to ask, well do you mean mandated or voluntary, because we already introduced it in Stage 2, I guess. So, I think –

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Yeah, so this is Mike. I would say I agree with that, on the one hand. I agree also with simplifying it and taking it out, but the nice thing about the rules that CMS has published these additional clarification sheets, there's an easy place to put either in definition of terms or in the additional information part of the these information sheets that come out. So we can make the actual measure briefer and the definition of terms or the additional information, provide that detail so that those people who are still wondering what happened to the mandated or voluntary can see that we do have a definition for them and we may not have needed to insert them in the rule. Or if we did insert them into the measure, they're defined in more detail in those other sections.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Yeah, that's a good point. We should put these definitions – CMS should publish them for Stage 2, so people know what to do today –

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

That would help.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

And then for Stage 3, we can mention it as – you can just say, what we're talking about is either mandated or voluntary registries, for example, all of these, and have the list. And then, you could leave mandated or voluntary, I guess in the measure, just because people, as I said, will be wondering what happened to it. So that's why I was asking Michelle your experience with keeping – making these things clear.

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

Yeah I think that makes sense George. So I'll work on fixing the language and we'll share that with Art and we'll share back with the rest of the group.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

I think that makes sense, just as long as the definition's somewhere. Now I understand what you're saying George, it's in the measure it doesn't need to be there, and even in the certification criteria it doesn't need to be there either.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Right.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Okay. I agree. Any other comments from the group? Okay. So this issue about who will give that acknowledgement we'll have to...it's going to have to be dealt with in Stage 2, because the onboarding process for public health is with reference to immunization registries, it's what's referenced to syndromic surveillance and to electronic laboratory reporting. It does not deal with any of these other items, cancer registry or other specialty registries. So, at some point CMS may have to provide some guidance or rule about that, how to say that that has been dealt with or has been addressed or that you've achieved that measure.

The eighth slide, the one that deals with the eligible hospitals, 404, 405, 407 EH objective, it's essentially the same. Except that there are – as I mentioned earlier, the healthcare associated infections is included here as hospitals have a mandate in some states to report to the National Healthcare Safety Network, NHSN, which is a CDC platform for receiving reports on healthcare associated infections and that is, as I said, mandated in many states, but not all. So that's the only difference in this slide from the previous one. Any concerns about this slide? And I think the same logic that we used on the last slide, that George recommended the change to remove a few of the words in the measure and the certification criteria would apply to this as well Michelle.

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

Okay.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So I think we can move on to the next slide, which is – well this is just the background, the mandate – it says mandated registry, 404, this was the cancer registry objective earlier and now we've defined that as a mandated one. I don't think there's any concern on this slide. Any comments about this.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

No, I think we did it.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Yeah, we've done it and then the same thing with 405, I don't think there are any comments here, we've covered this. Let's see, that's the tenth slide. Now the eleventh slide is the 407 – I heard some comments about this at this meeting I was just at in California about healthcare associated infection reports and as I said, there's this national platform to receive this at the CDC. But not all the – and this may be getting back a little bit to some of the concerns that Charlene was raising, not all the states have the same requirements about this –

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Right.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

– and I don't know that an EHR can actually send a completed message, and there's a lot of work that goes into sending healthcare associated infections, a lot of infection control work that is review of charts, this is not some automated process. This may be – it seems like this is a parallel effort going on to the NHSN that cannot be fully completed by an EHR, it might be able to get a portion of the data. But not all of the data because there's so much careful clinical review and abstraction of charts that goes on in addition to just saying, here was some surgical site infection, there's way more here than that. So, I'm not sure whether CMS has an idea about what HAI reports should be like, whether CDC does and whether we even need to deal with that at this point?

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

So Art, that's – this is George. This is a good point, because what we did is we consolidated it into the merged objective, right. And we included it under mandated jurisdictional registries and you're asking the question whether it makes sense for this to be a mandated jurisdictional registry for HAI from say CDC or something, because in fact, it doesn't re – it's EHR isn't enough. So I think our decision is whether it should be in that list of examples. Remember, not having it in the list of examples doesn't exclude it. So I think in the list of examples it's probably okay, but if you wanted to, you could take it out of that list, but if someone did set up an HAI registry that would count as one of the two of the merged objectives. So we're still okay there.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Yeah.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

And it might be a voluntary one of some society, the ID Society wants to set something up, but it's not quite as extensive as what you're talking about where you do the root-cause analysis for the infection, but just get what you can from the EHRs. That could be a new project that's not mandated for all we know. So I think our new consolidated objective is flexible enough to handle all that and the question is, do you want to include it in the list for the EHRs mandated jurisdictional registry, leave it as is, or do you want to take it out.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Well I think that that the HAI community would really like to keep it in, so I'm not going to take it off that list. They were pretty vocal and passionate about trying to include this in their testimony to our group earlier.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Okay, good, so we'll leave it in.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So, probably just leave it in. Yeah, okay. Any further comment about this slide, the eleventh slide? And we're cruising along pretty well here. The last item is something in the future stage, so, won't be spending much time talking about this, about adverse event reports, number 408. And we just had this proposal for the future stage and I don't think the committee needs to spend much time in review of that. So, the last item is the one that we covered earlier, this consolidated item where we took the immunization CDS and placed it within 113 and we discussed that earlier in our call. So I think we've gone through all the slides, but I welcome any other comment or suggestions that we might discuss at this point.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

So, this is Charlene. This is kind of relevant to this topic, but goes again beyond. Again we got the email kind of in terms of support of unique device identifier, which again could correlate into this whole area around adverse event reporting. Where does that fit into the discussion in terms of our consideration of that? Is that a future stage? Is it something – because again, that's just an identifier of that kind of device so we know if there's an issue, we can track it. Do we consider it here as part of the population public health or is it – I know we talk about it under consumer a lot?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

So, yeah, I did speak with Walter Suarez from the Standards Committee over the weekend at this meeting and he brought that up as well. We hadn't really considered that as part of our population health efforts, the device identifier. Was that considered elsewhere Michelle?

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

Yes. So we were going to follow up, I didn't have it prepared for today's call, but there was a new objective proposed within David's group, so subgroup 1. So I don't know if there's something that we want to do with that objective or if we want to do it here, but I think we might want to wait for a different conversation when we're more prepared to talk about that. But –

**David Bates, MD, MSc – Senior Vice President, Quality and Safety – Brigham & Women's Hospital & Partners**

Yeah, let's do it as a different conversation.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Okay, but it should relate – I'm just trying to connect the dots here a little bit, because –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Well it would relate more to the previous slide about adverse event reports –

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Right. Well I was looking at 408, so...

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Okay. Right.

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

David, maybe I'll follow up with you on the next full workgroup call, that'll be the first thing that we discuss.

**David Bates, MD, MSc – Senior Vice President, Quality and Safety – Brigham & Women's Hospital & Partners**

Super, thanks.

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

Thank you.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

I mean, this could go in steps, it could be first that something is captured, the UDI is captured clinically and then at some future date, we're able to actually report on adverse events related to the UDI.

**David Bates, MD, MSc – Senior Vice President, Quality and Safety – Brigham & Women's Hospital & Partners**

Exactly. Which – the adverse event report would include the UDI.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Right.

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Right. Okay.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

You okay Charlene?

**Charlene Underwood, MBA – Senior Director, Government & Industry Affairs – Siemens Medical**

Yup.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Okay. Any other comments or concerns?

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

No, you did a great job.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Well, we got through it. Thank you, great comments, especially about that immunization discussion, which I want to thank Mike and David for putting a little more realistic clinical spin on it. We don't need another check box.

**Michael H. Zaroukian, MD, PhD, FACP, FHIMSS – Vice President & Chief Medical Officer – Sparrow Health System**

Thanks for the great discussion, it was good.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Thank you all. Michelle, our next – is there another Meaningful Use Workgroup meeting coming up.

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

Yeah so the next full Workgroup meeting is on June 24, I believe, and so we will go through subgroup 3 and if we have time, we'll go through subgroup 2 as well.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Okay, great. And I guess our next meeting is then in the beginning of July, as the Policy Committee.

**George Hripcsak, MD, MS, FACMI – Department of Biomedical Informatics – Columbia University**

Great and now we'll be going to public comments, right Art?

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Yes.

**MacKenzie Robertson – Federal Advisory Committee Act Program Lead – Office of the National Coordinator**

So operator –

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Operator, can you open up the line for public comment?

## **Public Comment**

**Rebecca Armendariz – Project Coordinator, Altarum Institute**

If you would like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press \*1. Or if you are listening via your telephone, you may press \*1 at this time to be entered into the queue. We have no comment at this time.

**Arthur Davidson, MD, MSPH – Director, Public Health Informatics – Denver Public Health**

Thank you. And thank you again to the committee for the excellent discussion this morning.

## **Public Comment Received During the Meeting**

1. In relation to "On for Entire Reporting Period": I assume the policy intent it to keep EPs or EHs from turning off a function. My concern, especially after speaking with EPs that are being audited, is that there may be a software update or other external reason the functionality was inadvertently turn off or even 1/2 or one day before it was realized. This would mean that the EP is no longer able to achieve MU. I would recommend that a definition of "entire reporting period" be made that would allow for such events. Say that entire reporting period is 95 percent of the reporting period. Even for EHs that are open 24/7 this would only be 18 days that the feature could be off.