**QMTF Notes from 07-21-15**

**Appropriate Use Criteria (AUC) for Radiology CDS Discussion Notes**

**Discussion Points and Points to Follow-up on:**

1. Mixed comments on CDS implementation:
	1. Some recommended building tools directly into EHRs at point of care/ordering
		1. Build into the vendors system an open source tool that all vendors could adopt.
	2. Some recommended caution building into EHRs since updating within EHRs is difficult:
		1. Discussed that if it’s an open source cloud instead, the EHR community can talk to it when AUCs change rather than going to EHR companies to get everything changed –users would then be able to go to the primary source in the application within the cloud.
		2. Recommend using cloud-based implementations of AUC and CDS since clinicians want to know the tools they are using are up to date – there will be disruption if the tool is not up to date, accessible or properly maintained.
2. Concerns were raised about data driven processes that need to occur to do the kind of checking discussed in the proposal:
	1. How would tracking work with provenance information?
	2. Are there any examples or opportunities to input patient preference in decision making?
		1. Should there be methods of explaining why the guidelines were not followed – ex: patient preferences?
3. Concerns were raised with who is providing decision support and updating it for accuracy:
	1. How should this be handled?
	2. Who should provide actual CDS rules?
	3. What standards should be applied and what capabilities should be required for CDS rules to be accepted by CMS?
4. Predictions about when CDS may be ready for use:
	1. There has been discussion that some of the standards that are currently in production may be helpful but also might be overly specified.
		1. It was recommended that perhaps instead of a full standard for the decision support, we need to accept an API that can somehow use a standard that helps you connect what it’s asking for to the order.
		2. Or have an embedded feature in the EHR that is linked to URL or cloud where results can then populate EHR fields.
5. AUCs capture and analyze data at the point of care but may not aggregate and report data in ways that give meaningful performance feedback over longer periods of time:
	1. Optimal implementation of AUC with CDS would result in a learning experience within normal work flow for the ordering physician/EHR user.
6. Regarding how to best roll out AUC into clinical practice: starting with a comprehensive library or individual AUC, or a slower roll out focusing on a few priority clinical areas?
	1. Recommendations for a slow roll out to show early wins and successes going through barriers of implementation, but also cannot be too slow due to short time constraints:
		1. Processes still need to be solidified – CDS analytics, care algorithms
		2. There are still issues to be addressed such as whether there should be the same or different implementations across settings (eg, emergency room vs. outpatient office)
		3. Part B providers practice in many different settings; the degree to which a uniform set of criteria would be applied across multiple settings might result in more consistent delivery of appropriate care.
		4. Easier access to information across settings would reduce overuse in some cases.

**Recommendations for ONC and CMS:**

1. Encourage a standard based in the cloud when there is a stable standard to use. Provide governance and guidance as an intermediate step while standards continue to develop and mature:
	* ONC needs to think about how they can ensure there is some kind of consistency and repeatability around the rules for this capability so that there is not a lot of variability of how this is being implemented.
		+ Need to agree upon who should be establish the rules.
		+ ONC should establish who EHRs, AUC developers/AUC authors should be working with and connecting as AUCs are developed and implemented going forward.
			- * Need to consider the history of AUC development most AUC in use today were not developed with EHR implementation or certification standards in mind.
				* AUC developers have focused on review of evidence-not electronic implementation.
				* AUC in use today have been 10 years in the making.
		+ ONC should consider extending CDS certification criteria to be consistent with what is working today (b/o short time frame for implementation, and long lead time to develop AUC; don’t want to have to rework existing AUCs), while encouraging standards development.
2. Don’t limit to outpatient only.
3. Establish governance to remove EHRs from silos since there is uneven behaviors among vendors:
	* Establish clouds to be on same standards of interchangeability
	* EHRs need to be required to speak to a standardized cloud architecture and have certified outputs.
		+ Clouds needs need to be on the same standards of interchangeability and have the ability to run applications so that information can move across platforms.
		+ Data needs to be in a standard consumable format so that EHRs can consume it using the standards they’re adhering to.
	* Encourage vendors to be more open to third party data to prevent workflow disruption.
	* Address obstacles that limit data fluidity that are present because of privacy and security concerns about clouds.
* ONC needs to certify that technology is authentically pulling and providing data through surveillance – certify analytics are meeting necessary standards for achieving clinical goals.
* AUC rollout should be a slow process to show early wins and successes going through barriers of implementation but not too slow because of short time constraints.