

Certification/Adoption Workgroup
Draft Transcript
April 27, 2012

Roll Call

MacKenzie Robertson – Office of the National Coordinator

Good afternoon, this is MacKenzie Robertson in the Office of the National Coordinator for Health IT. This is a meeting of the HIT Policy Committee's Certification and Adoption Workgroup. This is a public call and there will be time for public comment at the end. The call is also being transcribed so please make sure you identify yourself before speaking. I'll now go through roll and I ask if there are any staff on the line to also identify themselves. Marc Probst?

Marc Probst – Intermountain Healthcare

Here.

MacKenzie Robertson – Office of the National Coordinator

Marc you're here?

Marc Probst – Intermountain Healthcare

Yes, I am.

MacKenzie Robertson – Office of the National Coordinator

Okay. Larry Wolf?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Here.

MacKenzie Robertson – Office of the National Coordinator

Joan Ash?

Joan Ash – Oregon Health & Science University

Here.

MacKenzie Robertson – Office of the National Coordinator

Carl Dvorak? Paul Egerman? Joseph Heyman? George Hripcsak?

George Hripcsak – Columbia University

Here.

MacKenzie Robertson – Office of the National Coordinator

Thank you, George. Could I just ask that everyone mute their computer speakers if they haven't already done so? Liz Johnson?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Liz. Charles Kennedy? Don Rucker?

Donald Rucker – Siemens Corporation

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Don. Latanya Sweeney? Paul Tang?

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

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. Micky Tripathi? Scott White?

Scott White – 1199 SEIU United Healthcare Workers East

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Scott. And Marty Rice?

Martin Rice – Health Resources and Services Administration

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Marty. Is there any staff on the line? Okay, Larry I'll turn it over to you.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I would like to welcome everybody to this call it's been a pretty busy month, I know everyone has been working really hard to get some summary slides put together and that we've been struggling with what to include, what to not to include and even what the format ought to be. So, as we go through the presentations this morning let's keep that in mind. We have a presentation that will be given by Marc and I to the Policy Committee on Wednesday and it should be accompanied by a narrative document as well that can be handed over as recommendations. And presumably we'll get feedback from them hopefully minor tweaks but occasionally not so minor suggestions so that we can get all that wrapped up and turned in ahead the May 7th comment deadline. So, I think that's the stage set for today.

I didn't hear Micky on the roll call. Micky have you been able to join us? Well, why don't we jump ahead then and look at safety enhanced design and we'll come back to definition of the certified EHR technology when Micky gets on. And we've got about 8 minutes, 8 to 9 minutes each to cover these topics so let's be focused and brisk and then we'll have a little bit of time at the end for comments.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay, Joan and I are both here. I'll get started Joan, because I know that Joan has another commitment too so I'll kind of get to the slides and then Joan if you'll add for us? So, in essence there were three design recommendations that were in the NPRM, the first had to do with requiring user centered design principles used throughout the development process and that there would be documentation of the same. The second one would require that standard quality criteria for software development be used and documented and then the final one, which was really a recommendation that was the NPRM requested comment on was the ability to generate a file for reporting EHR safety that's to a PSO and that's reflected on the first slide and then we'll talk about where we landed on each one of those in the next slide, which is slide three.

So, on the first one that had to do with using a user centered design principles, what we said was we favor this recommendation and the reason we favored it is.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Can we have the next slide up?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, slide three, I'm sorry, I'm looking at the presentation not the webcast. Is it up Larry?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It is up, thank you.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay, thanks. So, the Workgroup favored this recommendation noting that it was reasonable first step toward increasing usability of our products. The recommendation recognizes there were appropriate principles identification of eight priorities of risk, as you recall there were eight listed in the NPRM that it clearly focused on the safety aspects of HIT, potentially could increase transparencies for customers and generally speaking was a low burden to most vendors. Specifically, we did want to note however that the safety specifications were not directly defined nor is there a quality measure for the process of documentation. So, although the recommendation was to move forward those are places where it could be the NPRM itself could be better. Do you want to pause there, Larry, first for Joan to add and secondly to get comments?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Sure.

Joan Ash – Oregon Health & Science University

I actually have nothing to add and as I recall from our prior conversation we did not have a lot of discussion about this, I think there was a consensus in favor.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I'm going to take silence to mean consent at this point.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay, then we'll move to number two, which is the concept of using standard quality criteria for software development and again documenting it. Again, we favor the recommendation, reasons being it increases awareness of the value of QA, provides further transparency for certification and customers, and it sets the foundation for future software QA requirements. We did want to note that there was no measure existent to determine the quality of the process or documentation so the recommendation may need to go further and there may need to be further work done in that area but we still favor the recommendation.

Joan Ash – Oregon Health & Science University

And just to note, we didn't think that this would be a terrible burden on the vendors either.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

I'll put that note on the slide so we can add it. Okay, other than that are there any other comments from the Workgroup? Larry or Marc should we consider that consensus again?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

All right. The third one was where they asked for our input on the concept of being able to generate a file for reporting for EHR safety events to the PSO and again we favored the recommendation, believed it will assist organizations in reporting patient safety that is currently and encourage the expansion of that reporting. Certainly, it has the potential benefit of the ability to aggregate this type of data nationwide. The only negative that the group came up with is conversely there could be an impact on the usability of the product because we already have very crowded screens with many buttons and other kinds of data and, you know, can we get this in their without negatively affecting usability.

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

So, this is Paul Tang, I have a comment on this one. Well sort of overall on the three recommendations, I recall that this is stimulated by the IOM report looking at EHR safety and actually this group helped with

the hearing that went into the recommendation at ONC charge and the independent body that turned out to be IOM.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

That's right, Paul, in fact in our original report back to the committee we noted that this recommendation was made in August by you guys.

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

Right. Now, so the first two recommendations are essentially check offs, as you noted they're just a checklist criteria and we don't actually have a specific criteria for what constitutes good usability and what constitutes good QA. Similarly, the third one is just a button, I think it's a very strong first step and so I just wanted to suggest that we...in the previous two you said, well you may have to go further, at least in number that this is the start of a documentation check off but you may need to go further in sort of what's required to have adequate QA and adequate response to information from the field, particularly about patient safety. You might want to consider something like that in the third one too, because this is a reporting function and I happen to think this is a really necessary first step and I wouldn't use that one button on this vast screen as a negative. I just want to balance that.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

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

The other piece of course with the IOM recommendation is that there is a receiver for this report and a way to aggregate and analyze the report. So, I would be interested if the Workgroup thought a little

bit about that and I know you were commenting on the NPRM, which had these three elements, but do you think that there are other things that ONC could do that would further the cause of EHR safety or at least let's say learning about EHR safety, learning more about it?

Joan Ash – Oregon Health & Science University

This is Joan, I think it would be good to idea to add to this what we have added to the others and say that this is a necessary first step but that we hope that it goes further in the future.

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

And is there any way you want to comment on what other, you know, go further in what direction and may or may relate to the IOM recommendations?

Joan Ash – Oregon Health & Science University

Would it be appropriate to mention the PSOs here?

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

You said you have to report the PSO somewhere, right?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, in the recommendation itself, but we could add it here.

Donald Rucker – Siemens Corporation

It's Don Rucker; did we ever come up with a definition of PSO? I think folks; I mean one thing to me is this strikes me as potentially, depending on how it's written, a very, very expensive thing, because, you know, this sort of gets into legal and product liability. I mean I understand the goodness of it, but I think we want to be careful in how it's written because this generates some simply immense expenses for, well the vendors certainly, but maybe even more so for the institutions and, you know, most of these errors are going to be around how an institution configured their content like their orderable's and their templates.

So, you know, there's going to be a lot of...it maybe that we want to do it two-stage process where, you know, at first because there's a tool that goes to the institution because if all of this is dumped into a public entity I think we're going to find a lot of law of unintended consequences and, you know, there will be a natural inclination to buffer these systems with all kinds of stuff that is going to detract from usability beyond just simply having a button on a screen.

Joan Ash – Oregon Health & Science University

This is Joan. I think it could be done in a way, Don, that we could progress towards the ultimate goal of a good deal of reporting and the PSOs are protected. I think that we probably don't need to worry about the legal issues there, they're already protected, and they're already being used as a reporting repository. So there is a history and it seems that at least this far throughout history there hasn't been a problem.

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

This is Paul Tang again...

Donald Rucker – Siemens Corporation

...if I were in Pennsylvania what would be the PSO? Is that the state agency?

Joan Ash – Oregon Health & Science University

The PSO in Pennsylvania happens to be ECRI and it has really done some excellent work and I have not heard that there have been any problems with reporting to PSOs, and it's voluntary, and I think that that's the implication here also is that it would be voluntary.

Multiple voices

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

I could support what Joan said, one this recommendation before you is just getting some information from the EHR, which everybody agrees with in the sense of context is really important to the analysis and what you typically don't get when you get a report just saying, oh something happened is the context, so this "button" is to grab that. The other piece is what Don was mentioning is there some guess that he said there is a certain...he thinks that all errors of a certain type, well the whole purpose of aggregating data is to figure out what are those types and what could be prevented and I think one of the main conclusions in the sense from the IOM study was we don't have enough information now and it's because we don't have both a reporting system and aggregation system, and an analysis. So, there is a lot more that was part of the IOM recommendation that's not covered here, but this is the very first step involving the EHR.

Martin Rice – Health Resources and Services Administration

Hi, this is Mary Rice from HRSA, quick question, you're just talking about being able to report to a PSO not what you're going to report to a PSO, is that correct?

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

And, that's a good point too. I think the idea is to push some buttons and gather the context of like I'm in the ordering screen for medications, etcetera, do you see what I'm saying? Capture what the EHR context is and then there would be some ability to write a text message saying here's what I'm noticing or here's what happened those kinds of things, but often when you just get the text notes sort of like an incident report in a healthcare organization, then the next question is "well what were you doing and what was the context" this is what we're trying to capture as part of the reporting system.

Martin Rice – Health Resources and Services Administration

So, is there any structure surrounding...you know, forget about the contents, any structure around whatever content is going to be able to be built into this ability?

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

Yes, and I don't know whether that was mentioned in the response but there is something called common formats, AHRQ is leading the way in terms of what would be common data you'd want to include in the safety report, it's broader, but one of the types of safety reports to include is HIT safety.

Martin Rice – Health Resources and Services Administration

So, is the structure of it some sort of standardized terminology whether it be SNOMED or whether it be...you know, that's what I mean by structure.

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

I don't know whether anybody else is on the call that is better versed in the common format but that's their goal and I don't know how...there is a taxonomy about the safety incident but I don't know how far it goes.

Martin Rice – Health Resources and Services Administration

Okay, I was just wondering that's all, thank you.

George Hripcsak – Columbia University

This is George. I'm just envisioning let's say for hospitals...I think we need to set up the infrastructure so it can handle whatever is going to be sent. So, having built and running a 7000 user clinical information system I know that you put a field in expecting to enter "x" and the user enters "y", so if you put in this button I suspect they're going to be putting a lot of other stuff besides EHR safety issues. And then you say it's voluntary, but remember in the hospital it's not like you have one provider and their deciding whether to send a report on EHRs, you have thousands of users who are using an EHR, say press a button and something gets sent to some organization outside the institution, so then I start thinking well do we need to have the ability of the organization to review the reports before they go to the safety organization, because there may be things that have nothing to do with EHR safety for example that would get reported another way or for example things that get reported there that should be going to the Attorney General of that state and then the institution is held liable because it was reported to this PSO but never got reported the other way because the administrators never knew about it or whatever.

So, I think it gets complicated when you work in a large environment and you're asking people to report safety issues. So, it has to be thought out well and there may need to be mechanisms that you're not thinking of now, because you're mainly thinking of users using the system correctly.

M

If we had a recommendation as a two-step process where, you know, the initial report is to the enterprise that owns the EMR and then they can forward it, I think that might meet everybody's sort of goals and that would also get at the other reality which is that this stuff isn't going to come out of SNOMED it's going to come out as a log file of function calls which is...you know, I mean these functions are stacked if you're sitting in a modern enterprise software system, I mean there are dozens and dozens, and dozens, and dozens of things that are sort of sitting in, you know, the computer's memory or not in the memory but in, you know, the program stack at the time this happened. So, you know, the schematic printouts of context/state are going to be complicated.

Joan Ash – Oregon Health & Science University

So, this is Joan and I'm thinking that all this recommends is that there be the capability available in the system and then it would be up to the organization to decide whether for example the buttons were activated or not so that this just assures that the capability is sitting there and if it's a large organization would have to put the policies in place to decide where the information would go.

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

That's exactly right. This is the certification requirement essentially for EHRs to be able to gather certain information and to be able to transmit it and I don't who else was speaking, but it would typically go to the organization that figured out how to deal with it either internally or to report it.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, I mean in the beginning it was certainly, you know, as several have said it might be internal reporting but to get the true benefit of it, you know, we would want to in maybe Stage 3 look at external reporting so that we can really, you know, get the benefit of trends and being able to really improve the safety for the patient.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And the scope of this function is what's on the screen at that moment?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

What's on the screen at that moment?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, my sense is that, just like the other two, this is Larry, my sense is that just like the other two that this one is really more directional and saying we have some ideas about what would be helpful but we don't really know and we want people to start and we'll learn.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right and what we would do...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Maybe the recommendation needs to include that there needs to be a way for us collectively to be learning not just from what's submitted to the PSO, but experience of the providers as they use this to the point about many of the things that are going to be reported may have nothing to do with either the EHR or how it's implemented but might be other issues happening at the moment that need to be addressed. My experience with these in the past is people use this as a general "hey something's happening, please somebody deal with it." And the organization needs to make the commitment that something is happening with these, because it could short circuit all kinds of other procedures that are in place, everything from, you know, calls to the help desk, to patient safety issues, to you know, immediate patient care needs.

M

Now as a practical matter is do I really want that as part of the EHR or do I want that as part of my technology system I'm offering to the users? And I don't want one in my EHR and one in my ERPC, and one in my EDW, and one in my lab system and now life becomes really difficult to manage.

Joan Ash – Oregon Health & Science University

Well, one of the positives that we probably should add to our comments is that there is the common format available which would really expedite the ability to do this. So, I would say that as one of the upsides.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, I've added that. You know, Larry, listening, this is Liz, listening to the titter of the conversation, I think the group as a whole still recommends that we allow people to start down this path, we gather data about how it might be better when it becomes more regulated than it is today, meaning this is voluntary today, it may become mandatory in the future and this gives us an opportunity to really create some knowledge about what we can do to make it effective and get to where we want to be.

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

I think that's exactly right, it's a start of having data just to learn.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

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

Adding to your...like you did with the other comment in number two, it needs to go further and we just need to start considering that for example in Stage 3.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right, and I've captured several of the specifics about how it could go further, which is sort of Paul's original request to us, if you think this is a good idea what else should we be doing?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Great, well I'm not even going to look at the clock, because we were way over on this. Do we think we have enough consensus here around those final comments that we could move on? Not enough to generate discussion on Wednesday.

Donald Rucker – Siemens Corporation

Well, I think...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

That's the goal, that's the goal.

Donald Rucker – Siemens Corporation

It's Don, I think if we reference the exact common standards, I'm not aware of what that is, as folks mentioned, and I think if we sort of put in at least that there is some thought that this should not be automatically reported to a PSO or somebody but exists as a thing that the...you know, all the entities or enterprises can parse out before reporting, I think that will work great.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Thank you very much. Okay let's move onto clinical decision support; well let me check, has Micky gotten on the call? Okay.

MacKenzie Robertson – Office of the National Coordinator

I sent him an e-mail as well and I haven't had a reply back yet.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay. Clinical decision support, Don, Marc or Liz, one of you taking the lead on that?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Is Marc still on?

Marc Overhage – Siemens Healthcare

Maybe Liz could do it, my computer just literally died.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Marc Overhage – Siemens Healthcare

Randomly, I didn't even touch it, honestly, but I am going to press the button to report it.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay, hang on a minute, let me get to that.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Well, I'll start us off let's move to the next slide on the screen, thank you.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

There you go, so we've listed here on the first screen sort of the overview like we did before when we just did the safety enhanced design and in essence what we're talking about was replacing the clinical support quotations rule with a clinical decision support intervention and really talking about the specific use of CDS, specifically incorporated with the summary of care record and I think this is where we are going to spend our time, Larry, was we really got into and Don certainly you as well, we got into a lot of discussion about InfoButton and how does that fit and what does that mean and that kind of thing.

Certainly, looking at the capacity for importing or updating value sets related to the impression of CDS voluntary elements, and then really enabling the user to be able to use reference information it really should be patient context-based, and then we take the list from the NPRM itself and the NPRM is clear that it should be for each one as well as any combination of this list.

And that the EHR technology must be capable of generating interventions automatically and it should be when the user is interacting with EHR technology and then finally getting the biographical information relevant to the CDS rule, in other words, you know, are we aware of the provenance of the data. So, that's sort of the overview, let's really talk about the recommendations, I think that's where the discussion will come in which is the next slide. Can we have the next slide please? There we go.

Okay, so the recommendations and Don, I want you to add too, sort of the e-mails we were exchanging last night with Marc, the change to clinical decision support intervention versus rule is a good one and the reason we think that it's a wider more robust definition that doesn't focus on technical implementation, but in lieu of actually what the rule is being used for. It seems that there is a lack of clear best practices in decision support and many ways to provide decision support and there is a whole list there, parenthetically provided, that requiring this relatively early InfoButton as the go to standard is premature and my recommendation is we can either continue there or we can at least go to the next one on InfoButton, because this is, I think, where the most discussion has occurred on previous calls.

The InfoButton information based on clinical context can be incredibly complex calculations and, you know, I think I'll kind of start us, Larry, thinking about, you know, one of the things that I put out last night and I Don, I sent e-mail back, but I have not read your response yet. The InfoButton in other discussions across the Meaningful Use reviewers has really been looked at in two ways, one as a support mechanism from a resource perspective for the clinical decision-maker and secondarily as a piece of patient education. So, we may not need to cover the patient side of this here, but we have to recognize it's really used for more than just potentially clinical support. And Don, do you want to talk about sort of the granularity that you added to it last night that is not reflected here?

Donald Rucker – Siemens Corporation

Sure, yeah, so I think our sort of conversation, I was just trying to recollect our conversations from last week, was that looking again at the broader clinical decision support the NPRM sort of comments on InfoButton seem to be a little bit, based on the assumption that there is sort of some body of reference text from the outside that will come in that had some type of a sort of bibliographic background to it. It is sort of unclear in the document, at least to our reading, whether this would fire automatically or in combination to all of these things which were sort of combinatorial large or be the more classic understanding of an InfoButton, which is the user clicks on it when they have a need. So, we wanted to get some clarification on exactly when that happens.

The other big thing here is that I think some of the best decision support is really around workflow and sort of, you know, we were getting at this earlier with the patient safety conversation about the state, so you're in the middle of some task, there is some very site specific resources that you might want to bring in, that really have sort of like a drug monograph or a disease monograph or something like that, so, really what are the availability of resource, you know, if you refer somebody to a case worker, if you get a consult for something like that, the meeting on that here had some discussions about mandating central line teams to come in and not just letting everybody "place central lines" but having some dedicated central line team, so maybe there would be a work around that. And these are workflow things so we want to make sure in our comments that we sort of expand the clinical decision support concept and that NPRM to be that much broader sense, because that's I think the value that we're sort of all trying to bring into, you know, EMRs, CDS.

So, we had batted around having maybe just a number of examples and then requiring a set of tools so users could build, whether that's let's say InfoButton tool set or rule tool sets, at any rate, that was I think the overall comments as I remember them.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

So, Larry, I think, you know, this is where we've landed trying to reflect what the Workgroup had told us. So, we need feedback, all of us, and also so we need to update this, is this reflective of what the Workgroup believes they want recommended to the Policy Committee?

Joan Ash – Oregon Health & Science University

So, this is Joan, and I think I was the outlier on this in that my understanding was that the InfoButton was something that the user would go out of his way to click on to get some sort of referential information and in that case the workflow is not interrupted, it's the user asking for some information and the fact that there is the InfoButton standard already available it seemed to me like this was another first step in clinical decision support asking that the InfoButton availability be built into the EHR through the certification process, but I think our big problem was we really didn't understand what the NPRM was trying to say and do here and maybe there's someone else on the call who could help us out and explain it.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This is Larry; let me add to Joan's comment. It feels like we have two or three conversations going on here. One is about clinical decision support broadly comes in many flavors and as Don was saying often affects workflow in ways that may be completely transparent to the user, you know, we have clinical indicators that say you ought to order this consult and so it shows up in an order set or it shows up somewhere on the screen, and maybe completely integrated into the workflow and is not a pop up alert it's completely integrated in or we may have some things that are sort of the classic pop up alert things. So, we're looking broadly at that and saying we want people to be looking broadly at how to use automation to provide better care. So, I think that is sort of like one set of conversations.

There is another piece which we haven't talked about but was commented on in her intro here, which was that the NPRM is asking if there's a tie in to care summaries here. So, I'm assuming that there is some notion that there may be ways to facilitate the reconciliation process of information coming in from a prior site of care or there is some way to help analyze that data. I don't quite know what the thought process was in asking this question, but it sort of seems like, you know, a specific piece that got kicked out in terms of patient summary.

And, then the third piece is this whole discussion about InfoButton where I think we're combining our own lack of clarity about exactly what's being asked for with various ways in which the information is presented to users and needs for things like when you present something that is an expert opinion being able to document who the expert is and where the opinion came from. So, I'm hearing multiple threads through this and I don't want to see it lost in the InfoButton which we seem to be doing a lot.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Recognizing those other areas we're looking at as well.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

So, Larry, given that to get to a recommendation, I mean, how do we move forward? Because, I recognize and respect the time that we've got here, I think that maybe what we...I mean if we don't have anybody that can give us further clarity about the use of InfoButton and those standards, we had the same discussion in the standards meeting frankly, there is much confusion about it. So, how do we get from the confusion to where you need to be or do you ask for clarification from the Policy Committee? How do you want to do that?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think that part of our feedback and our comment could be, there seems to be broad confusion about this.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

That may be our own ignorance, but at this point we're confused of what you're asking for with InfoButton.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

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

This is Paul Tang. I wonder if there's a organizing principle, so one of the challenges InfoButton represents one kind of decision support and one of the ways we approached this from recommendations for Stage 2 was to say instead of saying "oh you have to have a rule or you have to have a resource retrieval system, etcetera" the many kinds of decision support, we gave attributes, there were 5 attributes and that would be consistent with the NPRM instead of saying this is a support rule let's call it a decision support intervention.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

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

And let both the vendors and the users decide what's most appropriate for them or a particular kind of intervention they're trying to make, but list these five attributes or capabilities so that EHRs can fire a rule for a kind of user in a situation, you know, don't tell them about the medications when they're in the middle of a chart review. At the right place, at the right time for the right person give them information that's relevant to this patient, this decision and there were five attributes. Those were the kinds of things we said and just make that happen and you can still do and relevant to five priority areas, those kinds of things, but give them a lot more flexibility yet build the capability, a flexible capability into the EHR, that was the original thought and maybe basically is that one way of approaching this is go back to that thought instead of picking on one thing predominately.

Martin Rice – Health Resources and Services Administration

This is Marty. It sounds to me that this InfoButton is nothing more than a mini query on an area that you're working on, does that sound right?

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

I believe that's true. So, in a sense when you said area you're working on basically it is a request for information, usually from an information or resource database, knowledge-based that is relevant to this patient's context.

Martin Rice – Health Resources and Services Administration

And the ability to build a query that if you're working in the medication screen that you could pull some sort of little query that it's associated somehow with, you know, a capability that you can find out something surrounding that topic?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah and what we've said all along is it should be patient context-based and then you are right, then it would be context specific to the clinical activity you were engaged in. Is that your question?

Martin Rice – Health Resources and Services Administration

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes, okay.

Martin Rice – Health Resources and Services Administration

I mean if we can build some concepts around that, you know, InfoButton doesn't mean much to me because it could be info on anything but maybe the capability to be able to develop a little query on the area of concern that you're working on or the form you're working on, I don't know.

George Hripcsak – Columbia University

This is George. I agree with Paul. First there is the decision, do we want to sit here and design the interventions or not, now remember this is a Policy Committee not the Standards Committee. So, if we're going to do InfoButtons I think we've got to do rules and talk about say ardent syntax now in HL7 and then talk about care plans and talk about those standards. I mean, either we're designing the decision support or not I don't think it make sense to pick one particular decision support and go deep on that, especially for the Policy Committee. So, I think if the Standards Committee wants to say if you're going to do an InfoButton then please follow the InfoButton standard that's better for the field, if you're going to a rule follow that standard and so forth. But for the Policy Committee and that's why Paul ended up with, well does the Policy Committee really about, it's the criteria, at least at this point, instead of enumerating because we've been there talking about this for three years, instead of enumerating all the types just say here is what we expect decision support to accomplish and how.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, this is Larry. So, maybe it took me a while to do the obvious, so InfoButton is an HL7 concept of context or where knowledge retrieval, so I think we're sort of struggling as a group with our lack of knowledge about that as a specific standard and our desire for it as a concept and so maybe that's what we should talk about is that the concept of context or where knowledge retrieval is a great one and the confusion around what InfoButton is suggests that it doesn't have much attraction in our world as a standard at this time, but it might be a good one to advance, we just don't know.

Joan Ash – Oregon Health & Science University

Well, so this is Joan, I think that there must be some way we could support the idea of using the InfoButton standard, I mean that would be a very positive step and then as Paul was saying couldn't we support a flexibility in the availability of decision support?

George Hripcsak – Columbia University

I still think, this is George, that it's not our business to promote standards exactly it's to use standards that we need and what standards is the Policy Committee supposed to be suggesting, usually doesn't suggest any standard, it leaves that to the Standards Committee. So, if we want to start promoting standards then I have a list of standards that I would like to promote.

Joan Ash – Oregon Health & Science University

Well then we could certainly push flexibility.

George Hripcsak – Columbia University

I mean, I'm just trying to put it...well, let me put it this way, I'm pretty sure the Meaningful Use Workgroup on the same day, at actually the same instant is going to be suggesting that we not enumerate all the types of decision support and that we follow the...you know, that we do a set of criteria. I have no objection, I mean remember we're one of the originators of the InfoButton standard so I'm highly, highly supportive, I'm just looking at, you know, is that what we're supposed to be suggesting to the Policy Committee?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

So, at the end of the day, so there are several things I think we are agreeing that we agree with the change to the concept of clinical decision support intervention versus rule, right? And that we support the concept of patient context-based clinical decision support, I mean, although we may suggest that there is a lack of clear practices but actually getting into the standards for how you would do it would not be included. So, even our suggestion around broadening the certification criteria potentially belongs to the certification group, the standards group or not? I mean, in the past the certification criteria review and

expansion has taken place after the Policy Committee, you know, to determine what they wanted to accomplish and the Standards Committee said here's how you can measure that and certify it in product using these standards, etcetera. That sounds more like what's going on here, Larry and would sort of guide our revision of these recommendations.

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

Right, and so the "InfoButton" is just the context where it is one of the attributes of an InfoButton and in fact that's one of the five attributes that we had originally specified as desirable in the CDS intervention.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

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

So, these are all captured and I'm not sure why we got drilled down on one area and in fact the NPRM had this one area called out too. So, I think one of the messages, it seems like we are all in agreement with is the different kinds context that are important, remember this is all about workflow, if you make the right thing to do trivially easy that'll happen and that is done by it being the right patient, the right context, etcetera, and those are part of the attributes and I think our message is we still think that's a good approach, it provides flexibility and allows for innovation without specifying you must have "x" whatever "x" is.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I'm hearing we should focus on the attributes here and not specifically around InfoButton as a standard and that there seems like there is pretty good agreement, the context of where information retrieval is a good thing to have.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes.

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

Well, when you said that I think you inadvertently said, well you must have that, that's the catch. So, if you're doing...if information retrieval is one of the CDS interventions you'd like to invoke then it should be context aware and by the way there is a standard for that. If you choose a rule than there are other standards, but we're following these attributes and the important one here is context aware, but we're not saying you must have, we think you must have context aware information retrieval that's just one of the kinds of interventions you could have. That's the nuance, but I think it's an important one and it seems to have come out in this discussion.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Well, and I think the other one that has come out clearly is focusing on the attributions which said not the mechanisms and if we use that as a guideline these recommendations can be streamlined.

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

Correct.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Do we have enough consensus here to move on?

Joan Ash – Oregon Health & Science University

I'm fine with it, this is Joan.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Me too.

Donald Rucker – Siemens Corporation

Yes, this is Don, I think so.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay let's do it. Now let's see if we can make up 10 or 15 minutes on the next few, good luck to all of us. Okay, so let's have the slides for other healthcare settings. Okay, let's go onto the first content slide. Okay, so there is a bit of draftiness to these slides, so this initial piece up here that says policy objective actually gets repeated on the next slide, so ignore it on this slide.

So, the NPRM asks for comment on what to do about other healthcare settings and would certification process and criteria be helpful? So, I've put up some of example settings to try and set broad context of the range of providers here. So, we have ones that classically are talked about under the banner of these other intelligible healthcare settings, the post-acute, long-term care settings, behavior and mental health. So, I started asking people, so who else are we not including and various folks sort of put their hands up to say there are other people who provide care and maintain medical records, but they're not the kind of usual settings you think about. So, it's everything from pharmacist giving immunizations to dialysis centers, to camp and school nurses providing, you know, on-site care, to wellness programs. So, there are a lot of people collecting information. So, we should think broadly when we think of other settings.

And some of the importance here is that they're very different in...well they all are and want to be part of a better connected health care system and then all the rest is sort of variable, the time they spend with the individual can range from moments, you know, in an immunization setting to weeks, months, years in an assisted living setting. So, it's really quite variable. The physician presence is really variable. Many of these settings make very good use of non-physician staff to provide high quality care and do a lot to create teamwork and so they're creating a particular kind of care process and workflow activity.

There are various levels of regulatory requirements, some of these are very highly regulated with formalized assessments that have to be done for everyone who is receiving care, they're a part of the payment process as well as part of care and quality process and others have sort of minimal regulation, that is kind of the context for this and the other, I guess obvious context is they were explicitly or implicitly excluded from the Meaningful Use incentives in the HITECH Act. So, let's move onto the next one. Next slide please.

So, the first comment I think is that there is a real desire to exchange care summaries and so this was the notion of, so what are we trying to do here? So, this notion of a policy objective. Reduce the time and cost for ineligible providers to acquire and implement the new health information technology to exchange information with other health care providers. So, you know, a lot of words to say there's lots of value in exchanging information with providers. There seems to be a pretty good consensus that care summary using the consolidated CDA to coordinate care would be a very good thing, it doesn't resolve all problems. There is a lot of work including stuff happening under the S&I Framework that define what needs to be in that summary document, but the ability to send and receive consolidated CDA seems to be rising on everybody's wish list.

And so, in the certification criteria there are a couple that specifically approach generating and receiving care summaries, and then doing something to incorporate them into the record. So, those are things we want to encourage and to use the existing certification process and certifiers to allow people to test their products that meet these criteria and, you know, using the existing modular certification process that shouldn't require any new mechanisms. So, in some ways a very lowball recommendation here to increase awareness and ability for people to get their products stamped as able to do exchange. So, any comments about this recommendation or this comment?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

It works for me.

M

Me too.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay, let's go on. Next slide please. So, the NPRM also asks in a variety of ways for what about other things that we should be doing? So, I put these under the heading of setting specific criteria. I feel like there should be some kind of policy, objective, statement on this slide as well and in my mind it's got two pieces, one piece speaks to concerns I'm hearing about unfunded mandates that there's a lot of nervousness that if certification criteria were put forward, even if it was voluntary, it opens the door to it not becoming voluntary. So, can we just keep quiet on all of this stuff? The second is sort of the sense that was put forward back in the very early days of ONC before there was the HITECH funding that having certification criteria actually encourages activity in the marketplace and provides some directional intelligence and helps purchasers have better insight into what it is they're buying.

And so, I think there is some support for a voluntary certification program. And there has been some experience of vendors producing products that are targeted for spaces other than eligible providers have gotten certification, three of them, three of the CCHIT Program and of those three two got modular ONC certification for some of their features. If we look broadly at this HL7 has a pretty long history of an EHR functional model going back to those early days of ONC asking for guidance on what should be in an electronic health record. But, they've also developed over the year's specialty profiles that go into more niche needs of different care settings. And that some voluntary certification has occurred. So, there is some activity in this area, I think it needs to stay voluntary and we should acknowledge that it's happening, but I don't think there is particular value in pushing it in one direction or another. So, any reactions to this comment? Well okay.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

I'm thinking that means it's okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Very good. I think that was the last slide is that right?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Great, let's move onto our next topic then. Accounting of disclosures. Marc are you still there? Micky have you picked up? Would you like one of us to walk through the slides?

MacKenzie Robertson – Office of the National Coordinator

This is MacKenzie, Micky said he's on vacation and has very limited service. So, I don't think he'll be joining today.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay. And I'm guessing Marc's silence is that he had to leave as well?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay, let's see if we can walk ourselves through the slides. So, there is a brief statement of context of this for accounting of disclosures and maybe before I get into this, does anyone feel like they are sort of an expert on this and would like to walk us through these?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

You're on Larry.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay, I guess I'm on, thank you Liz.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Sorry.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

No, that's fine. So, I'll read the slides out loud for us. So, the first piece of the question is, accounting of disclosures, should this be moved from optional to mandatory certification criteria? How does this align with the current HIPAA privacy rule which was issued as a proposed rule, I guess, but we don't have a final rule yet? I guess those are the main two points there. So, Marc and Micky identified some benefits of doing this. Let's move on to the next slide.

Okay, so this I guess is really the substance of the discussion here. So, it appears to be two different concepts put together here, so we have the HIPAA privacy rule that it's not as a technical requirement but is a capability to be able to report disclosures, it's often done manually and various descriptions of intent need to be presented around the disclosure. So, the question then really is that there is a shift towards...is the audit language in HIPAA morphing into moving into the disclosure reporting? And that's both a sort of technical and a policy question of audit trails, the right vehicle for collecting information. Do these really represent disclosure as we don't have a final rule yet or are we jumping ahead of ourselves by trying to put in place mechanisms to address a potential based on a preliminary rule?

And then concerns that the audit trail itself today doesn't capture enough information to really be helpful in assessing disclosure. It's not clear that the kind of audit trails we have actually lend themselves to the kind of enhancement that might be necessary. Earlier there has been discussion about potential...so is the use of audit trails with potentially huge amounts of data really addressing the desire when someone says I want to know who has been accessing my record and whether those accesses are appropriate or not. And where that fits under the banner of normal operations and care or where it represents actually disclosing information to other entities sort of the essence of what does it mean between use and disclosure. And potential privacy issues for the individuals who are providing care and suddenly they are being identified in documents about what they're doing with no particular reason for their being included other than if they did provide the care.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

So, Larry, looking at these two slides, is there is a conclusion that one can draw as to whether we are recommending this is mandatory or not? We've certainly pointed out the pros and cons, but are we going to try and answer the question?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, that is a really good question, I mean, my sense is that there is a strong sense of where we're recommending against this, that this looks like overkill.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, in reading it that's the same sense I get and the fact that we should wait on...and look to HIPAA, but I certainly don't want to speak for the group, I'm drawing that conclusion from reading the pros and

cons on these two slides. And as we heard in other areas the desire to wait on HIPAA, but that may not be the consensus of the group.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

We've beat everybody into submission from the first two.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Well, maybe that's a question you need to turn back to Marc and Micky.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

To say, you know, based on the information presented we believe the answer to the first question is "no" and assure ourselves that this is what they intended to be communicated.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

I mean, you could actually...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Let's push that, so if that is what they're recommending, if they're recommending "no."

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Is that consistent with the other Workgroup members feel? I should rephrase my question. I'll take silence to mean we sensing that "no" is the recommendation and we'll take this back to Micky and Marc to wrap it up and focus the slides to say that.

George Hripcsak – Columbia University

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Great, let's move on to disability status.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, can we have the slides up for disability status? I felt like this was an instant emersion in something for me. So, let's move on.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, Larry, I was going to say, this is a long presentation, oh, no it's not, it's not too bad, there is additional material, okay, never mind.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Sorry, I tried to stop after a couple of slides. I couldn't help trying to share what I've been learning.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

I understand the passion is coming out, it's a good thing.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And I sort of felt like, and maybe this is a problem with the slides and we need to figure the balance obviously around InfoButton we spent a lot of time trying to sort through background.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, for me disabilities status was a learning phase, what is it, where are we in the world, how mature are the standards and so it's hard to sort of focus on the policy issues when I felt I didn't really know what the topic was in any kind of deep way. So, maybe we can get these more focused as we look at them.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, let's go onto the next slide. So, my take on the NPRM questions were that they're looking at EHRs to record disability status and most of the discussion of disability status actually is on the flip side as abilities, so functional assessments, behavioral cognitive and other assessments and they're assessing things around which, you know, sort of like assess someone's vision, their vision is not so good, it is or isn't corrected with glasses, their hearing isn't so good, it is or isn't corrected with hearing aids, you know, and then clearly as those are sort of examples many of us are familiar with, they are very technical clinical documentations about how...not how necessarily good or bad your vision is, but what it is, right? How good is your acuity, are objects squished or not when you look at them? So, a lot of clinical information going with a very high level thing that people often report about themselves. How is this handled in the EHR and where are the standards for this?

And so, the discussions I think seem to be mostly around how helpful can this be in providing appropriate care? And how can it be used to collect information about potential disparities in delivering care and care outcomes. And then some thoughts about how this does or doesn't fit into different parts of the chart, and where there is consensus are readiness for widespread options. So, let's go onto the next slide.

So, I think there are three comments here. So, the first one talks about, so how does this fit in terms of criteria and where does it go in the record? And my sense is that while HHS has started including a variety of things in national health surveys, that the questions used in the survey don't really fit well with the medical record. Also, things that we're putting a lot of things under the banner of demographics, and I think that one of the reasons that's done is historically the demographic section has been very highly coded and therefore you could use it for reporting and for analytics and you could assess disparities based on the data that is in demographics whereas a lot of what's in the rest of the clinical record has historically been poorly coded and so it's been tough to use that data to do anything with and I hope we're moving into an era where we're beginning to get information out of the rest of the record and that you don't have to push things into demographics just because that's where it is.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, I would say that when you talk about doing this as part of routine registration information if we can't get into the CCDA we're going to have trouble because you're talking about the collectors of the data are non-clinical persons.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

And, so then we get into the potential of the value and completeness and blah, blah, blah of the data. I mean, I agree with you and I hear what you're saying, you're saying this is more universally a place where we go and it gets communicated outside of our organizations, therefore it would be available for integration into transition of care, but if we think about what we're using in the world of Meaningful Use for

transitions of care in terms of clinical summaries and CCDA, somehow we need to tie it there I think, because again when you say routine registration I get very concerned about the quality of the data.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And, so, yes, my reason for talking about building this into routine registration was just to raise that issue, Liz, so thank you.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I also think there's another piece here, which is patient reported survey type information.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right now when I walk in I get handed a clipboard of tell me your medical history, but it seems like it wouldn't be such a stretch to have, you know, this is more of a real survey.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Who are you and what do you value? What are your concerns for the care you're going to get?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

You know, it could be patient reported information.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And maybe even methods that support the patient doing it on my own time rather than making me fill it in at the registration process.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right, which plays more into the policy ramifications around the fact its self reporting and the patient involvement and all those sort of things that we should be leaning too anyway.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, maybe that actually needs to be broken out into two bullets so that it's actually clear that I'm talking about two separate things here. This notion of patient collected survey information and the notion that we maybe overloading the registration process and therefore we should be thinking about if it's appropriate for clinical documentation that might wind up on a problem list or within other assessments.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right, like initial assessment.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, exactly.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

The only other comment I had on this slide, Larry, was I wasn't sure from a policy perspective that we would...you have the standards on the next page, so I'm not sure that HL7 belongs here. I think, you know, I think you could just say consider approach to recording clinical documentation and it would be appropriate.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay, good, thank you.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes, and you've already got the care summary document. So, the only thing I would ask on the next comments, on the status of standards, in order to comment, we say these things have been established and I don't know if this is appropriate to the Policy Committee or if it goes back to the Standards Committee, but one of the things we often talk about, not has it been established, but what is the utilization, you know, the penetration in the actual real world.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, next slide please. Okay, so you're right I talk about when these were established mostly because I don't know about adoption.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right, so maybe one of the questions needs to be here are the standards, the question needs to be put back to... and response is, you know, further validation on, you know, current utilization or...because again, you don't want to limit yourself in terms of innovation in moving the bar forward because it doesn't have a huge acceptance but there if there is zero acceptance that's a different problem.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right. Also, I guess one of the reasons for putting this out here is my sense is all of this is relatively new.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And, so I'm concerned about baking into our technology things that we're still sort of shaking out, but I want to get them in so wider spread use.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Well, yeah, I mean, I think in all candor, except for rehab units a lot of this stuff is not at the level that you would hope it would be at, frankly.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes. So, I think that is our conclusion.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

This is all new.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

So, that kind of leads to your conclusion, which is “yes” and when you say included in Stage 3 on your next two slides...just do the next one.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes, let's move onto the next slide.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

So, are you talking about not even introducing it as menu or anything of that nature in two, simply moving it to three and then would it be...and maybe that's too deep, too granular, but sometimes we do the opposite, we say rather than have core this time can we start with menu.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

And maybe you just leave it silent as to how to get in Stage 3, you just simply say this is important and we should certainly include it in Stage 3?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I guess that's what I was struggling with is I don't know what I'm recommending should be menu item for Stage 2.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah. If you want to get started, I mean that would be the quandary.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yeah, I do want to get started it is important.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes.

George Hripcsak – Columbia University

This is George. I have the same style of comment all the way through the morning, we have talked on the Meaningful Use side about cost benefits and so once again there are many things we want to get started, is this one of the ones that has to get started right now? In other words, I can imagine many areas of medicine that we want to push forward as functional status, the one that deserves an objective even a menu objective right now. So, the problem is each time you talk about one of these topics it is an important topic and we do want it to go forward, it's kind of like when you put extra check boxes in every doctors note and you're doing like a, you know, who is the interpreter and what's the pain management and eventually you have 50 check boxes for every doctor's note, because each of those is independently important and your mechanism to make it go forward it to add a check box. Here our mechanism is to add an objective. So, is this 1 out of 20 objectives put it that way for the nation? And maybe it is but that's the question you should be asking.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, so HHS I think in the last few weeks released their latest report on health disparities, right? So, if you will, this is all in response to health disparities and that is on our priority list of things to be looking at. So, I agree with you George, I'm sort of, you know, relative to priority is this more or less important than some of the safety things we've been talking about, is it more or less important than communicating care summaries to follow the patient as they see different providers? I also feel like we're missing the folks on our committee who are most likely to comment about this as a priority.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

I was going to say, one of the things you could do though is in lieu of pushing it to menu, the only reason I ever suggested menu is if you want to start with baby steps, and I do hear the concerns, and believe me on the provider side I have the concerns about timing and everything else, then you may need to say it should be included and you could remain silent and not go to menu for Stage 2. I mean, depending like you said on the...we are doing this we're just not communicating it to other organizations. Do you follow me? Your concept is that we need to not only be doing it and doing it better, but we also need to have it part of the communication to other organizations in transitions or care. Is that correct?

George Hripcsak – Columbia University

Mine, George's?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Whichever, yeah, both of you.

George Hripcsak – Columbia University

Well, I wasn't specifically saying...I'm saying that that's just another thing we're working on I think, not that this one...like I think that this is something we should be collecting and using.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

George Hripcsak – Columbia University

I'm just saying is this one of the top 20?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

George Hripcsak – Columbia University

For Stage 2, I think recommend inclusion in Stage 3 sounds fine.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah.

George Hripcsak – Columbia University

It's just that do we want to make a menu item? Do we want to recommend a menu item in Stage 2 for this, I'm not sure. Well, first of all, you know, ethnic group and race that's in there, this is expanding that to include these important areas. In other words, we are partially addressing disparities, but I admit that this is not required now.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right, I know that functional status is a big deal on continuity of care because those are often the things that you need to know about when someone is going to be receiving care in terms of all of the support stuff their going to need.

George Hripcsak – Columbia University

Okay, very good, so, I agree with that too, whether that is Stage 2 I'm not sure, but I agree with that.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Right. So, that's the link to the transitions of care piece, you know, the fact that when...you know, I have hearing loss and if I can lip read really well, it improves the patient interaction if we know stand in front of me and face me when you speak, but, you know, it's not an underlying disease process that we're trying to treat here. So, my sense is its important; we want to tell people it's important, there are standards on their way, we should acknowledge that and we should signal that we expect this will be in the next round.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

It sounds good.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Is everyone okay with that?

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yes.

M

It sounds good.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay. Next slide. Okay, so this was a specific request from the Policy Committee, it's also in some IOM reports on health disparities and the latest HHS disparities report. So, gender identity and sexual orientation. HHS says they're planning to include this in their health survey process starting next year. There is some work on standards for use in clinical assessments, but I don't think that that work is done. In fact, I know there is some IOM meeting in the works for this summer to talk about it some more. So, I think this should be addressed, but again, I think we're moving this into the future rather than doing it now.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

I agree.

M

I agree.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Great. Okay. So, we're approaching 10:00 o'clock, sorry 11:00 o'clock Eastern, maybe we should take a quick look at what we still have to cover.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, I have a request for the group and that is on the EHR technology price transparency and the reason I have a question on it is I was actually taking off in a plane before the end of the call and the slides that I sent to you I concluded, from what I heard and read, that the group was not recommending that this go forward at this time. But, I need a confirmation on that. I'm not at all taking away from data portability or definition; I am just worried that this meeting is the last one we have before the policy meeting. Do you want to give me some input?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, Liz, I'll jump in, my sense is we were saying getting a list price on EHR technology is a lot more complicated than getting a list price on a car.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And we thought that the intention of trying to provide transparency was a good one but it wasn't clear that we knew how to do it.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Right, I mean, I've said that and I added a slide with questions, you know, Don and I worked on it, I added a slide with questions and I can clean up the rationale, what I was really looking for was, did we come to a consensus that we would not recommended it at this time?

Donald Rucker – Siemens Corporation

I think we certainly identified, I mean I think we certainly...this is Don, I think we certainly identified, you know, what the components are, the installation of these things, the implementation, sort of the total cost of ownership which is really the economic thing of import here is almost...is in a very large degree much greater than "the list price" and the many ways utterly disconnected. There is also a big difference I think between some of the more arguably standalone potential office space PMR systems, I know the concept of Wal-Mart was mentioned versus the enterprise, you know, the enterprise situation, you know, where you're putting this on top of a...you know, you're putting pieces into a very complex environment at a minimum I think there should be a new...

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, can I make a suggestion? Don, why...I mean I will flesh out a little more of the rationale so that Marc and Larry will have talking points and I'm going to go with this as consensus that, good idea, it's got much more complexity than one might think and just the questions themselves make it very clear that it is much more complex than simply putting out a list price and based on the complexity and the value, that although we think it's an interesting idea, the answer is we're not recommending it. I mean, I really think...and you can tell me Larry, maybe we don't need to land the plane, but I felt like we should landing the plane with either do or do not recommend it and then the Policy Committee can certainly make their own collective decision.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I agree with you. I think we should make the recommendation not to do it and have the discussion happen.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Don, are you okay with that?

Donald Rucker – Siemens Corporation

Yeah, I think that would be...there is so much stuff to do here I think that to get EMRs sort of more widely adopted just seems to me to be...

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

And then, Larry if that's our recommendation, I mean can you...because still need to talk about format, I'm thinking that we could give you and Larry, I mean you and Marc just some very brief talking points on it or you can send me an e-mail and tell me what you want.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I think that's fine, just give us the talking points.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

The recommendation with the talking points.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

So, Don I'll exchange e-mails with you on it.

Donald Rucker – Siemens Corporation

Yeah, I'll send out...I'll resend out...I just found it here in my outbox, what I sent a while ago, I assume because I just it, Liz to you.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Yeah, well what we did was we started with our document and then Mike added to it and you added to it, and I mean I edited it, so we can certainly just use that as their talking points but the recommendation will

be no. And then Larry what I want to know is the document is a couple of pages long, what I wanted to know is did you want to try...you know, like we did with others...do you want us to try and pull that down to one or two comments or do you want to just have the talking document?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, I think we can have the talking documents and maybe a slide that just says...you know, a slide with the summary points.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay, Don, so...

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I want to simplify getting ready for it next week.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

If you send the talking points to Marc, to whomever, the whole group as far as I'm concerned, and then we're just going to need to synthesize two or three critical succinct points that they can say on a slide. Do you want me to take a whack at that or do you want to do it?

Donald Rucker – Siemens Corporation

It would be great if you could do it.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

This is Mary Jo, could I just ask for clarification, because I was distracted for just a moment, so in other words what you'll present next Wednesday will be a very brief slide deck that contains at a high-level all of your recommendations or will it only have some talking points and your comments or recommendations themselves will be in attachments?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

My plan, Mary Jo, is that we will have a version of today's slides for each of the topics so that the full committee will have sort of a one-page briefing and then specific recommendations coming out of the Workgroup.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, but they'll all be pulled together into a single deck?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Into a single deck.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Right, great, how much time do you think you'll need to get through this?

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Hah.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Now, remember they've also got the entire Meaningful Use NPRM to get through before you.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

I understand.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

It's going to be a long day.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

It is going to be a long day and we're starting a whole hour early.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Well, half hour.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

A half hour earlier, excuse me, okay.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Well, I was hoping you might be able to do it in under an hour, like if I put you on at 2:00 o'clock.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Yes, put us on at 2:00 o'clock.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Okay, good. Okay, good, thanks a lot.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay, I know we need to go to public comment, I think...I was just looking for if each one of us gives you a slide or two with a recommendation, I'm just trying to figure out what work is next, because I know we have a very short timeframe, I'm sorry, but I've sometimes very...when I have short timeframe.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, we had our discussion today on the slides, most of the authors were on for the discussion. So if you want to tweak and focus the slides based on today's discussion that would be great.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

And, if you get me those I probably will not work on them over the weekend, I'll do a little bit this afternoon and then picked them up Monday.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Okay.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, anything you get to me by Monday first thing would be fabulous.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

All right, thank you.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

So, let's quick run through, so we had data portability we didn't cover, but I think there is a good argument that the standards are nowhere near rich enough to have standards-based data portability for the complete contents of an EHR today. So it's an interesting notion but we're not there and Micky did a great job discussing what certified EHR technology is. It seemed like we were all comfortable living with the definition, so I'm going to leave those two without further discussion unless someone wants to jump in right now.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Sounds good.

Public Comment

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay, well let's get public comments.

MacKenzie Robertson – Office of the National Coordinator

Operator can you please open the lines for public comment?

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comments at this time.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Well, thanks everyone for your work, for hanging in there, we're almost to the finish line. So, to Liz's question, yes whatever kind of summary updates you can get me by the beginning of Monday would be great, I'll have an integrated deck that I'll get out to all of us late Monday and barring anybody screaming we'll send it off to the full committee on Tuesday.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Sounds like a plan.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Okay.

Elizabeth Johnson – Tenet Healthcare – Vice President Applied Clinical Informatics

Everybody have a good weekend.

M

Bye.

Larry Wolf – Kindred Healthcare – Senior Consulting Architect

Bye.