

**Meaningful Use Workgroup  
Subgroup #1 – Improve Quality  
Transcript  
June 5, 2012**

**Roll Call**

**MacKenzie Robertson - Office of the National Coordinator**

Good afternoon, everyone. This is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful use Workgroup, Subgroup #1, Improving Quality, Safety, Efficiency and Reducing Health Disparities. This is a public call and there will be time for public comment at the end. The call's also being transcribed, so please be sure to identify yourself before speaking. I'll do roll now. David Bates?

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

I'm here.

**MacKenzie Robertson - Office of the National Coordinator**

Charlene Underwood?

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

I'm here.

**MacKenzie Robertson - Office of the National Coordinator**

Thanks, Charlene. Marty Fattig? Michael Barr? Neil Calman? David Lansky? Paul Tang? Eva Powell? Are there any workgroup members on the line? Are there any staff on the line?

**Josh Seidman – Office of the National Coordinator**

Josh Seidman.

**MacKenzie Robertson - Office of the National Coordinator**

Thanks, Josh.

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

Michelle Nelson, ONC.

**MacKenzie Robertson - Office of the National Coordinator**

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

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

Thanks very much. This may be a relatively quick call given the people who are on.

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

And Charlene has to get off early.

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

Exactly. Our intent today has been to go through what we talked about in the past. We've actually been through all the core objectives. We wanted to review those and then reflect on anything that might be perhaps more overarching or things that we had not included previously. So basically, this is a time to consider new ideas.

So that's really the plan. It's a short call. We'll go to the public comment period at 1:25 or earlier if we're done sooner. We really did the last time get basically through the stage two comments.

Charlene, thoughts or reflections after the last call?

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

The only areas that David, I thought we did a good job in terms of covering the topic areas. I think we looked at some of the patient safety stuff around smart comps and those types of things. I'm not sure that we hit on that. Where I see potentially infiltrating some of the quality stuff is things from the other workgroups. For instance, on the patient engagement workgroup we spent a lot of time looking at considering how to make decisions based on patient preference. One of the items – and Paul's not here so I'm going to say what he said – we considered under clinical decision support was in stage three moving to where we could actually include patient preferences as clinical decision criteria. That was certainly one of them. So that's one area.

Another area that we touched on, and this came from care coordination, is again, we're starting to evolve to, if you will, some additional use cases under care coordination. Where that's starting to gain some traction, if you will, is as you start to look at actually thinking about when you do a transition care, treating that as an order and being smarter relative to the information that gets conveyed to support that order. So we're struggling with that.

I guess my point is, as we bring together this finding from the other groups, they're probably going to come back and reflect into what some of our criteria are. I think the same thing in public health. Again, gathering the right data necessary to support some of the various initiatives in terms of public health depending on what direction that goes I think could also play into some of our criteria.

The biggest area that I think is maybe one of our challenges is, again, looking at what our criteria are and seeing, perhaps, where there are emerging measures that might do a better job of driving the data capture, perhaps, rather than actually having to make them a criteria. For instance, the smoking cessation one. I know the AMA in that group kind of said, "Okay, we already capture that and measure it, so why are we including that here?" That's probably the other venue we have to consider in terms of looking at stage there. It's more going to be, I think, inputting the stuff from the other areas and then ... emergence of what's happening on the measurement front.

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

I think it's a really important point around doing the crosswalks with some of the other groups. We'll clearly need to do a lot of that.

One area that we touched on last time that was not there as much as it should have been which you did not mention just now was registries. I agree with you; I think that's a really good suggestion about including something around preferences in patient engagement. That seems like a good idea.

Could you say a little more on the care coordination about treating things as an order? I didn't fully follow that.

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

Today, on the transition of care we send the CCD, a care records summary or whatever we're calling it now, a summary of care record?

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

Yes.

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

So this was to kind of say well, if we think really think it through and for instance, it's almost like a referring order – and there are some transactions out there that actually do these referrals – if we can actually communicate out the order for a transition of care, if you will – I want to refer someone, I want to admit someone, that type of thing – and there's data that sometimes captures what that case is - there's actually a transaction out there that does it – then it almost starts to become a closed-loop process incremental to the discharge and transition of care record. In addition, you're going to add the order in. The purpose there is so that we start to close the loop in terms of doing referrals. That was kind of where the thought process was coming, and coming up with ways of better making sure that those transitions of care also happen and they don't get lost in space, which many of them do.

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

So if you're sending me a patient and I'm the long-term care facility, you'd send me a CCD but you'd also send me something like an order that I would have to respond to and you would know that I got it. Is that basically the concept?

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

Yes. That seems ... pretty good. Again, I'll have to get it vetted certainly from our workgroup, but again, a concrete something that addresses clearly the need of what we're trying to accomplish. I don't know if that would come back and influence what we include in orders or how we think about orders, but it really does ...

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

Yes, yes. That sort of thing is a big issue with referrals, too. One of the various harder things to do is after you've sent a referral it's hard to know whether the patient then actually got seen. There are a lot of dropped balls there.

I've just been sort of scanning through, also, our document, the planning document, which included where we were with various things. Our comments are summarized there. There are a couple places where there were comments. For example, for the safety protocol for IVs there's a note about possibly surveying patients, whether they'll want that, and the ability to detect a long duration of a typically short-term medication. The question was whether people have a good approach for dealing with medications that are typically short-term. I think this is something that's still being worked out. We personally, for example, have it for some things, like antibiotics, and the way we do it is we set things up as a default duration that's shorter for certain drugs. You can't do it totally by class. Sometimes it's for drugs within class. Charlene, do you know what the norm is around this?

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

No, actually, I don't know that. We'd have to ask that question.

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

Right, right. I mean, steroids are a classic one and occasionally, patients get in trouble because they're started on a steroid and they somehow escape the monitoring approach. It was intended to be a short-term thing and they take it for a longer term. Yes. I mean, I don't think there's a place that I could point to where there's a knowledge base around this.

Then around the coding of medication allergies to better support drug allergy interactions, we were going to have the Office of the National Coordinator basically get some more data about the standards for reactions. Do you have anymore information for us about that?

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

No. Sorry, David.

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

That's alright. I'm sure that there are lots of things to do. Is that Michelle?

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

Yes, it's Michelle.

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

The next note was about disparities. We talked about the vital signs and some specifics. Our thought was because that's going to be in summary care we may not need it as a separate objective. I think that's the case. Um, OK, next one was on ...

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

David, just kind of on that, I was at one of the HHS Websites and there was a lot of data that's trended out there even by disparities now. Do you see adding a lot more categories in terms of this area?

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

No.

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

There seems to be a lot out there. I know it's not perfect, but there's a lot of data out there.

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

No, no. I think we're pretty good with what we have.

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

I was going to say, it's like I'm not sure how many more variations. I'm sure you can look at a lot more variations.

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

Yes, yes. Well, you could start to do things like once you have people's preference information, look at that, but that's a ways off.

The next question was around advanced directives, and that's another place where it would be helpful to have some more information, either about standards or states that have a specific approach around this. This one is important enough that I think it would be a reasonable thing to, for example, consider having a hearing about.

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

Yes. So Michelle, do you know what Paul and George have done on that? I know we discussed that one.

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

Yes. I actually wanted to ask this group for a little bit more detail about what you were looking for from the hearing - maybe it's not this group, I don't know - but just to kind of get that moving.

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

The concept would be to ask people how they’re representing information about advanced directives, whether there are specific standards that are being used, what variables are being included, and then whether that’s accessible, for example, through decision support.

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

Charlene, I’m just asking, but you know how we did the listening session for your group? Do you think that’s something that could be done through a listening session rather than a full hearing?

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

Definitely. You might need a couple. The issue we always see here is a variation by state, and these are legal documents, and that’s why we can’t really get too prescriptive about it. It would seem like there would be a subject matter expert that we could certainly pull in that could talk to us about that.

In terms of talking with customers, most vendors support capturing an image and allowing people to access it as part of their system to keep it really simple because of the variations, but what we really don’t know is there are few providers out there, I think, kind of what David said, that are starting to actually take the data to be able to act on it. I don’t think that’s the current state of the field, so we don’t know what that space looks like and we don’t know if it’s because there’s so much state variation in their legal documents that people don’t want to do that or is this something that should be part of the care plan?

So I think we have a lot of questions on it, but I certainly think we could start with a listening session and determine if we need to expand that to a larger hearing. I don’t know, David, what you think, but those are the things that we always hear.

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

No, I agree. I didn’t know that the listening session was an option. I’d be highly supportive of doing something less intensive and seeing whether we could get there that way.

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

So I’ll follow up with Paul as well because I know that he was interested in this and suggest that first and then see where that takes us.

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

That sounds good.

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

David, what we did is we had about hour-and-a-half listening sessions. We actually had three of them for care coordination. One was the current standard, and that was a whole topic. One was kind of what are people on the ground doing. Then one about what the future thought would be. So it kind of got mixed at the end of the day, but they’re about an hour-and-a-half and they’re pretty easy. The presenters bring their presentations and it works really well. They were, I think, efficient for everybody except for the staff, who got the presentations maybe at the last minute. They did well. That was kind of the format that we used. It seemed to really work well.

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

Sure. That sounds quite good to me. The next comment is about the decision support rule. I’m having trouble seeing the comment. There was a question here about whether to require the core 15 and/or add those checking for relevant medications. I think I would add renal dose checking for relevant medications. That one is pretty well established.

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

Would that be additive?

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

I think it would be additive because not many places actually have it.

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

Yes.

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

Now, on incorporating clinical laboratory tests, that one, we had a question about what ... data for rural areas is showing. Do you have any more information about that? You may not?

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

No. I'll follow up right after the meeting. Sorry, David.

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

No, no. That's okay. The next one I think is fairly self-explanatory. The next issue was for imaging results. We wanted to see what emerging standards there might be. That, I think, is really a down-the-road sort of thing.

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

Yes. So that, before making a recommendation, that would be one that would be really helpful to have the information. Nobody else besides ... I think has that. There's not any place we can go to look it up.

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

Let me ask the question. I've been out looking at this ... generated data hearing, but I've been out looking at all the mobile devices and stuff.

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

Yes.

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

For instance, there's a ton of stuff. They have contact lenses with sensors on them. They have stethoscopes with Bluetooth so you can hear them anyplace. Do we care about capturing any other types of data in the EHR, like sound or anything? Is that even relevant to consider?

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

I guess the way that I look at it is there are so many types of things that we might want to capture that it might be better not to try to specify all those things and to instead, perhaps, ask that records be able to accept, basically, patient-generated, if it's expressed, using some of the specific standards for these devices.

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

Yes, yes.

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

Those are pretty well laid out, as I understand it. I mean, I’m thinking more useful in the near-term will be the glucometer data and some of the data from the smart scales and so on. Is there a requirement like that someplace? I can’t think of one. I think we may have just kind of left this out. Michelle, can you think of one?

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

No, I can’t.

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

Or Josh?

**Josh Seidman – Office of the National Coordinator**

No.

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

I mean, I think for 2015 it would be good to have some sort of recommendation signaling that we would like the record to have available the ability to begin to do some of that. Charlene, what do you think? Is that something that would be acceptable?

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

Charlene, you’re muted if you’re talking.

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

I came back on. I’m sorry. I fell off. I guess, David, the only point is as you were talking about images, do we just want to expand that concept to other data types? That was always ... That’s kind of where I was going with this.

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

Did you hear what I just asked you?

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

No, no. I missed that.

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

So what I said was that I think it would be useful. We’d probably need a different recommendation than for images because images are such a broad category, but some sort of requirement to be able to accept other data types from devices if it’s represented using a very limited number of specific standards.

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

Yes, I’m good with that.

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

Good. Charlene, other things that you would like to bring up?

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

The only other question I had, the one I was thinking about from our last call, was where did we ever end up on this electronic notes area? I’m still on the page of needing that immediate

discharge summary because I think that would just transform things. People would really figure out how to do it then.

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

Sure. I’m trying to find that one.

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

It was proposed in the ...? We don’t know where it’s going to land.

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

Did it make it into the ...? I thought it got left out of the ...

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

I’m forgetting if it was one of the ones that was actually included or one of the ones at the end that they said they weren’t including.

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

The ... was excluded because physicians are already doing it. We said that may happen in the ambulatory setting, but much less so in the acute care setting, you know? I just called out the ... case ... If we could just get that discharge summary start to move at discharge in some way. It’d seem like by stage three we could get those out. It would just provide great value. Even if we could only do the discharge summary, period, that, I think, would be a tremendous thing to transform in stage three.

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

Right. I thought we captured that, but I’m looking for it now.

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

Yes, it was discussed during the last meeting.

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

So we have it?

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

I think so, yes.

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

Yes, it is actually within the electronic notes. Yes, it was not included as an objective in the ... but they did ask for comments on it. So we don’t know where that will necessarily land. To Charlene’s point, her comments about the discharge summary are on there.

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

Good. Staff, anything else that you would like us to cover?

**W**

No.

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

Anybody else join? Well, I think we’ve basically come to closure.

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

David, I think you have a great set to go forward with for the committee, for the largest group.

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

I think there are a bunch of suggestions that will be helpful, too. So Charlene, thanks so much for being on today.

**MacKenzie Robertson - Office of the National Coordinator**

Should we open it up for public comments?

## **Public Comment**

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

Please do.

**MacKenzie Robertson - Office of the National Coordinator**

Operator, can you please open the lines?

**Operator**

Yes. We do not have any comments at this time.

**MacKenzie Robertson - Office of the National Coordinator**

Thank you.

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

So thanks very much, everybody. We’ll see many of you tomorrow. Take care. Bye-bye.