

**Meaningful Use Workgroup**  
**Draft Transcript**  
**April 28, 2011**

**Presentation**

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Good morning, everybody and welcome to the Meaningful Use Workgroup. This is a Federal Advisory call so there will be opportunity at the end of the call for the public to make comment. Workgroup members just remember to identify yourselves when speaking.

Let me do a quick roll call. Paul Tang? George Hripcsak?

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

David Bates? Christine Bechtel?

**Christine Bechtel – National Partnership for Women & Families – VP**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Neil Calman?

**Neil Calman – Institute for Family Health – President & Cofounder**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Art Davidson?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

David Lansky? Deven McGraw?

**Deven McGraw – Center for Democracy & Technology – Director**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Charlene Underwood?

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

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Latanya Sweeney? Michael Barr?

**Michael Barr – American College of Physicians – Vice President, PA&I**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Jim Figge? Marty Fattig?

**Marty Fattig – Nemaha County Hospital – CEO**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Judy Murphy?

**Judy Murphy – Aurora Health Care – Vice President of Applications**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Joe Francis? Josh Seidman?

**Josh Seidman – ONC**

Here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Did I leave anyone off? All right, I'll turn it over to Dr. Hripcsak.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Thank you, Judy. Today due to Paul not being here yet and David Bates not being here yet we're going to start the discussion with category five, Privacy and Security Protection for Personal Health Information. Deven, do you want to start that?

**Deven McGraw – Center for Democracy & Technology – Director**

Sure. There were a fair number of comments that got submitted in this category, most of which in my capacity as chair of the tiger team we've heard a lot of this as well, a strong interest in having some consistent policies on privacy and security. A lot of comments about the issue of how you treat data that's subject to more stringent privacy protections under state and some federal law like behavioral health data and HIV tests or AIDS status, for example. Similarly, some of the folks with interest in security weighed in on inclusion of specific security functionalities, the need to deal with privacy and security issues around any patient portal that might get put forward, that's generally the crux of the comments that came in. Again, none of them was unique or new from what was certainly heard on the tiger team and that we either feel like we've dealt with or that we have in the pipeline to deal with.

The tiger team, at the last Health IT Policy Committee, actually put a number of recommendations before the Policy Committee, all of which got approved, most of which have some sort of tie to a functionality in an EHR. So, for example, there was a recommendation that said as part of the security risk assessment that you had to do in stage one and that you should have to do again in stage two you ought to address how you're implementing encryption of data at rest. That's not actually any different from what providers already have to do under the HIPAA security rule, you have to address it, which means you either have to implement it or you have to document why you're not implementing it and you're implementing an equally protective safeguard, if one is reasonable and appropriate and available. The recommendation doesn't enhance the security rule, but we called it shining a spotlight on encryption of data at rest, because there are lots of addressable implementation specs in the security rule, many of them tied to existing functionalities that are in certified EHRs. But given the issues that we've had with data breach and the fact that two-thirds of them are related to lots of data through theft or just plain loss, and none of that data was encrypted in those breaches, it seemed like it was worth using the meaningful use policy lever to draw attention to that.

The one thing that I would raise for a little bit of discussion is the following. With respect to the policy recommendations that the tiger team has made in the past, say, for example, the recommendations that we did on when additional patient consent should be required, which were adopted by the Policy Committee back in September. We have been under the understanding from discussions we've had with the Office of the National Coordinator, that the upcoming governance rule, which sets up the conditions of

trust and interoperability for the Nationwide Health Information Network, was the vehicle that ONC was looking at to try to implement or encourage the adoption of some of those really privacy and security best practices that go above and beyond the baselines that are required, both in federal and state law.

Now, we don't know what that governance rule says yet, so it's a little bit difficult to consider whether in fact the governance rule takes care of implementing policy recommendations that we've put forth, or whether in fact we want the certainty and the stronger incentive for adoption that comes through the meaningful use criteria. So one of the thoughts that I've been noodling over and that we have not, quite frankly, discussed in the tiger team, is whether in stage two, or maybe in stage three where we have a little bit more knowledge, we make it a meaningful use requirement to be exchanging, according to the terms and conditions of the Nationwide Health Information Exchange. It's not exactly a punt, but it ties those two programs together and potentially leverages the meaningful use dollars to encourage NW-HIN participation and adoption of those standards and protocols.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Could you say that again, Deven? It would be a meaningful use requirement, what would the providers and professionals—

**Deven McGraw – Center for Democracy & Technology – Director**

Essentially, they would have to be using the standards and protocols that are a requirement to participate in the Nationwide Health Information Exchange. So I think a lot of people have thought of N-WIN, NEW-WIN, nobody knows how to pronounce it anymore, we haven't landed on a preferred pronunciation yet since we can't use NHIN anymore, I think a lot of people have assumed that that's governance for state HIEs. But I went back to look at the Governance Workgroup's recommendations that the Policy Committee adopted and the definition of governance that ONC has been operating under. It's no longer the network of networks concept that historically characterized the NHIN and is now about a set of standards and protocols, which include adoption of interoperability standards for transport potentially from NHIN Direct, for example, that in fact an individual provider could arguably ascribe to and therefore be exchanging in data in a trusted manner.

Again, and maybe at this stage of the game because we don't know what that governance rule looks like. It's sort of more of a placeholder and an intent to explore tying those two together as a way to leverage the meaningful use incentives to get people to ascribe to policies that are going to be designed to be the ideal for trusted exchange, if that makes more sense than the way I said it before.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

So what exactly would the doctors be doing? They'd be attesting?

**Deven McGraw – Center for Democracy & Technology – Director**

Yes, they'd be attesting, because we don't know what NW-HIN participation essentially means, do you have to sign a participation agreement? It is a voluntary program, ONC has said that all along, and that's consistent with the endorsement of recommendations from the Governance Workgroup by the Policy Committee, that it's a voluntary set of standards and policies, just as NHIN Direct is, quite frankly, that physicians sign up for. Now, whether they have to officially do that through a participation agreement or whether we would ask them to do that by attesting that they are meeting the terms and conditions for participation, I don't know. So I guess what I'm asking for is consideration of an explicit placeholder for looking at the conditions of trust and interoperability that are part of governance of the NW-HIN when those come out and thinking about how we might use meaningful use policy levers to encourage their adoption.

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

Sorry, folks. I'm so sorry I messed up my schedule.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Hi, Paul.

**Deven McGraw – Center for Democracy & Technology – Director**

Hi, Paul.

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

Hi, Deven and George. So I'm catching up, in stage two people may not have to participate in the NHIN and by stage three presumably they would have to. Would that be the time when participation in the NHIN is, in a sense, required for meaningful use and you can invoke the compliance with the NHIN policies?

**Deven McGraw – Center for Democracy & Technology – Director**

I think that probably makes the most sense, since we're looking at what is largely a blank slate in terms of not really knowing what those terms and conditions are, or whether it's realistic to have individual providers subscribing, versus larger network infrastructures only. But I dislike putting that out there even this early, because I think it sends a message to the community that while we've done some things with respect to privacy and security that are largely technology focused in stages one and two in the Privacy and Security category. There are a whole lot of policy recommendations that the Policy Committee has in fact already endorsed and likely to be more that are sitting for a governance infrastructure in terms of how you get those enforced and adopted, and we'll be able to know more details by stage three. But our thinking, I like the idea of indicating that our thinking is that we would tie those two programs together by stage three.

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

It does sound good. And we have not put out a "signal" for stage three yet—

**Deven McGraw – Center for Democracy & Technology – Director**

Yes. So that's my idea.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Paul, did you hear Deven talk about encryption of data at rest?

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

I did not. Unfortunately, I joined when she was describing the tie.

**Deven McGraw – Center for Democracy & Technology – Director**

That's the Policy Committee recommendation that the committee actually did endorse at the last meeting. So in essence the other thing that I think I ought to do to be able to populate this chart so that it looks complete and not empty is to take the recommendations that the Policy Committee did adopt on privacy and security that are meaningful use related and feed them in to the chart.

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

Right.

**Deven McGraw – Center for Democracy & Technology – Director**

And that includes what we call the spotlight on encryption of data at rest.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Deven, can I just ask, when you say encryption of data, what is that? Is that an attestation that I'm encrypting all data? How much of that is certification and how much of that is attestation?

**Deven McGraw – Center for Democracy & Technology – Director**

What you're doing is attesting that you did your security risk assessment including directing how you're going to implement encryption of data at rest, which stops short of requiring encryption of all data at rest. We got a lot of pushback from our provider members because in some circumstances it causes some operational concerns. But we wanted to at least underscore what the HIPAA security rule already requires, which is that you address it, not that you necessarily have to use it. You have some flexibility if it's not reasonable and appropriate for you to implement it.

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

It's a little bit like stage one, which was basically a spotlight on readdressing your security review.

**Deven McGraw – Center for Democracy & Technology – Director**

Right, that's right, assuming you've ever had to do one. I think what a lot of people don't realize is that the HIPAA security rule only applies to electronic PHI, so if you never had an electronic record, you never had to do one historically but you would both under HIPAA and then under meaningful use as well in stage one once you adopt that record.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Okay, so Paul, I'll let you take over. But for right now, Deven, are you going to come up with a proposal for what would go forward—

**Deven McGraw – Center for Democracy & Technology – Director**

Yes, I can come up with some draft language. I think where we've landed is declaring our intention in stage three to have a meaningful use criterion in this category that requires participation in NW-HIN as a condition of meaningful use. But of course we would obviously be reassessing that in looking at the stage three category when we'll also have more information about what the terms of participation are for NW-HIN governance. Then I'll also give you the language from the Policy Committee recommendations on privacy and security that are related to meaningful use that got adopted in the last meeting so you can populate the chart.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

That's very good. So the only downside is that you won't be in there person on May 3<sup>rd</sup> when we look at the whole thing as a Gestalt. We'd have to touch base with you afterwards or something.

**Deven McGraw – Center for Democracy & Technology – Director**

Which is fine, and I'll work to get you that language before that meeting. It shouldn't be that hard.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

All right, thank you. Paul, we were talking about our goals. One is to finish our way through the document that we didn't do in the in-person meeting. A second goal was to re-look at some things, for example, we had handed out homework assignments in the in-person meeting. And a third thing is looking down from above and saying how we can focus based on what the HIT Policy Committee said to us. Christine hasn't had any input, in other words, we hadn't handed out, for example, Josh's summary of where we ended up at the end of it, so she's not prepared right now to reengineer the second category. So we just handed that around and so that's why we moved the agenda around so that we were doing security, then public health. Then care coordination, we put that one back a little bit because David Bates is not on the phone yet.

Paul, that's where we stand. Do you want to talk a little bit about the goals for category two maybe for a second?

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

Sure. Did you cover the work plan for the next month or so?

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

No, go ahead.

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

Okay. This one, as George was saying, was to finish up the objectives we didn't finish, and we basically got through part of two and we did not do three, four, and five. On May 2<sup>nd</sup>, unless we do finish all the categories, but that may not be true if we can't finish up category two, for example, and May 3<sup>rd</sup> we have the face-to-face, and that's where we reconcile our draft recommendations with the rest of the HHS programs like the National Quality Strategy and the ACO NPRM. Then with having our once over through

all of the draft recommendations, we then stepped back, and we had planned to do this and look at how that interacts with timing, both the concerns and various options on how to deal with some of those concerns so that we would have finalized recommendations by the end of that face-to-face that we can present to the full committee. We then know that on the 13<sup>th</sup>, after the full committee meeting on the 11<sup>th</sup>, that we have another hearing that includes a specialist and some information from the field, and after hearing those we would have a May 20<sup>th</sup> call where we finalize the recommendations for the June meeting back to the full committee. Does that sound like it covers it all?

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Yes. Did we not finish category two at that in-person meeting, or had we started category three, Christine and Paul?

**Christine Bechtel – National Partnership for Women & Families – VP**

We finished patient family engagement and started on category three—

**Deven McGraw – Center for Democracy & Technology – Director**

Care coordination.

**Christine Bechtel – National Partnership for Women & Families – VP**

Care coordination.

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

Okay. Do we want to review that part? There was a bit of a problem with, we wanted to combine some things, I thought.

**Christine Bechtel – National Partnership for Women & Families – VP**

We did do that. The problem, Paul, and we talked about this before you got on, is we didn't get any materials to review in advance of this call that would summarize the agreements that we made and the decisions that we made so that we could take a fresh look and step back and do any additional thinking. So my suggestion would be, I'll be on the call on Monday but I won't be in person, Eva will be. I know Deven won't be there at the in-person either, but I think it's very difficult to do any stepping back when we don't have a summary, or we now have just received a summary of what we decided. We had agreed there probably wasn't a lot of value in that, that we really needed to get through the next cut of all the categories, finish patient and family engagement, public health, and privacy and security.

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

Okay, so is it fair on May 2<sup>nd</sup> then to keep that call and then focus on category two, especially since you can't be there on the 3<sup>rd</sup>?

**Christine Bechtel – National Partnership for Women & Families – VP**

That's fine by me, yes.

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

Is that fine with everyone else?

**W**

Yes.

**W**

Yes.

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

We'll consider May 2<sup>nd</sup> category two day. It's an important category and it's important that also we get it—

**Christine Bechtel – National Partnership for Women & Families – VP**

Get it right.

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

—in a clear state, and I think we still continue to struggle ... if there's a clear way to simplify it and yet accomplish the objectives and be more understandable, I think that would benefit all of us, benefit the program.

**Deven McGraw – Center for Democracy & Technology – Director**

Yes. It's an area that Farzad mentioned at the Policy Committee meeting that ONC wanted to double down on. Do you remember that? There were a couple—exchange is another one.

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

Right. So giving some additional thought before next week would be great. Okay.

**Deven McGraw – Center for Democracy & Technology – Director**

Can the typer please mute? Thanks.

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

Did David Bates join us yet? It might be another 15 minutes. If not, we could move to category four, if that's okay with Art.

**Judy Murphy – Aurora Health Care – Vice President of Applications**

I could make one comment on category three. Based on my notes we did make two decisions. One was on HIE and one was on MEDREC. MEDREC, we talked about moving it to core but keeping it at 50%. HIE, we talked about keeping it at core, which is where it was, and keeping it at performing one test.

**W**

Yes, I actually—

**W**

No, we did not agree to that, Judy.

**W**

Yes, we did not.

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

David is going to join a little bit later or very soon, and then we can do that whole discussion. How's that?

**Judy Murphy – Aurora Health Care – Vice President of Applications**

Perfect.

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

Okay. Is Art on?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes. Hi, Paul.

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

Okay. Do you want to—?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

We can work our way through these three areas. I think it's helpful to have the comments from Josh outlined here. Some of them are a little bit inconsistent with the area, so I'm just trying to run through the document, that final comment summary. I think that's the one that we're all supposed to be summarizing, is that not right? Hello?

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

Yes, sorry. The panel comment summary that Judy sent out, yes.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Is that correct? I just wanted to run through what the comments were that we've received. First, in terms of immunization reporting to public health registries, so as it says there, the number of comments were similar, I guess, regarding whether this should remain at the menu level or be moved to the core. Some of the comments beneath it, though, about standards are inconsistent. It says there that ISDS is working to provide that report, but ISDS has nothing to do with the immunization reporting. The most likely source for standards would be CDC and the American Immunization Registry Association, and they've already created those standards. So I'm not sure what this document is referring to. Josh, can you help me there? Was that just an inconsistency in summarizing?

**Josh Seidman – ONC**

Hold on. I'm trying to pull it up right now. I'm sorry. Hold on one moment.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Sure. I'm on page 68. I think in general, as Josh is going through that, there hasn't been that much objection to the suggestion that this remain, that this be moved eventually to a core item. Now, the question is, should it be core in stage two or stage three? Many states of course have limited capacity to do this and the wording that we used this time through, which is different than the original, the final rule, is that we used a term—I'm sorry, just one second. I've got too many things open here. We used the term "if accepted and as required by law" in our proposal, and the stage one term was "in accordance with applicable law and practice." So there was some discussion about this outside, with the CDC in particular, about why we changed that term. Do we have any idea about that, George?

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

First of all, I think in our minds when we were drafting this we thought that this was the most accurate or most precise interpretation of what we intended, but on reading the comments there are ways of interpreting it differently that causes more confusion, and so maybe we should go back to the original.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Okay, so I think that's a simple thing for us to do is just go back to the original phrase. Probably the most, unless Josh has found it and has any comment about it, I think it just might be a typo, but I'd like to spend the most time probably on the electronic reportable stage two criteria. Because the way that we set this up at the beginning it says, "capacity to submit electronic data on reportable as required by state or local lab results to public health agencies," and there's been an immense amount of discussion about this topic, mostly because hospitals have labs and would be reporting it, and that's fairly easy. That's something that they may report out of their LIS, they may report out of the EHR, and we can let that be determined by the hospital.

EPs were not included in this area, and this is something that is of concern because, well, EPs, one, may do in office testing and that's probably going to grow in the years to come, and there would be the missed opportunity to report those things in the near term if we don't include EPs in this criteria. One is that, that we'd be missing the in-office diagnostics. But the second thing is that we'd limited ourselves in stage one to reportable lab results, and there are reportable conditions that do not have an associated lab result. For instance, the occurrence of post vaccination Guillain-Barre, there is no test for Guillain-Barre, or a failure of varicella vaccine when varicella occurs in a child after vaccination. That also is a reportable event but there's no test for it. It's a clinical diagnosis. In some jurisdictions aseptic meningitis may be a reportable disease and it does not have a diagnostic test necessarily cleanly associated with it. In my jurisdiction toxic shock doesn't necessarily have a diagnostic test.

So I think that we made a good stab at it with stage one, but there's a desire to, one, include eligible providers, and maybe we can't do that in stage two. Maybe we should be signaling that this is going to happen from EHRs in stage three, that the providers would need to be reporting, whether it be from an in office diagnostic test or these non-laboratory associated conditions that are reportable. So maybe I'll stop there and see if there are any comments.

**Deven McGraw – Center for Democracy & Technology – Director**

Art, I feel like the IE Workgroup, and I can't remember if you're on there with me or not, these workgroups are all blending together for me, has been having a bit of a discussion on this topic as well. I recall that the thread of the discussion about eligible professionals reporting to public health is centered around the fact that mostly the labs do it. And that the EPs don't want to have to attest to their labs doing it when they don't control whether the labs are in fact doing the reporting that they're supposed to be or not. Is that on the same topic that you just raised or did I miss something?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

That's a third item. I didn't put that in there now because that's a separate thing, but we can come back to that for sure.

**Deven McGraw – Center for Democracy & Technology – Director**

Okay. Then I guess I might be a little confused about what you're suggesting.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

This is about the EHR having the capacity report from an eligible provider.

**Deven McGraw – Center for Democracy & Technology – Director**

Okay, that makes sense.

**Neil Calman – Institute for Family Health – President & Cofounder**

Art, I think we have two problems here. One is that different health departments have different reporting requirements, so things that are reportable in one place aren't necessarily reportable in another place. I think that that's one issue. The second is that you have these different electronic health records that have to somehow figure out not only who they're transmitting to, but what they're transmitting in terms of what the content of that information is. I know that we worked in this area quite a bit with the New York City Health Department trying to figure out what do you do, so there are a couple of different things. We can call out that people need to build at least one decision support that triggers an eligible provider to report a particular condition when they enter an appropriate diagnosis. You can trigger, as we've done, a set of symptom complex kinds of things that basically trigger a provider to think about a potentially reportable disease. You can go all the way through to the point of just basically establishing the electronic health record so that it can electronically transmit the information, or at least print the report in a format that's acceptable by the local health department. I think we should take at least one step down this road, and I'm not sure what you think about what the first step would be.

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

I wonder if this is a little bit like the suggestion Deven had for privacy and security. In other words, it's a super topic but is the industry ready for that in 2013? Is this one of the things we'd signal for 2050 for stage three?

**Neil Calman – Institute for Family Health – President & Cofounder**

I think it's important that health care providers see their role in public health reporting. So even if it's just a matter of communicating to the health department by asking providers to establish one or five or three or whatever decision supports that would trigger providers to send a report to the health department, that's at least a starting point. It requires providers to start to communicate with their health department to figure out who they're sending reports to. The vast majority of providers never send a report, so figure out who they need to send it to, what's reportable in their area. If we're thinking about meaningful use as something that improves quality, it's a pretty simple thing to put a decision support in place that says if you enter this toxic shock as a diagnosis then something that's going to come up that triggers a report. Even if it just says this is a reportable condition in your community, that's a starting point to get people focused on public health reporting.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

That was the second half of my sentence. You snuck in there.

**Neil Calman – Institute for Family Health – President & Cofounder**

I was trying to be smart, you know.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

As a matter of fact that's what we do. So when you get one of these reportable lab conditions it has a link to the proper form, etc., so it's just as you said, Neil, that it's not even that people, one, people do not know that that particular thing is reportable; and two, how do you find the right form? If you really bake it in with the result coming back at you or as you say some kind of alert or popup when you're entering a reportable condition, as Art mentioned. So that's certainly something that, it's almost like our CPOE, where you just wanted to at least have the interaction with the person ordering something, even though it goes on paper for a period of time. Other comments on this?

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

So this is like a new ..., where we're reporting labs but it's a reportable condition so you're changing a little—it's something like demonstrate the ability to report a public health condition or something like that in stage two that gets them started.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

That's a key bit of language that I'm hoping that we can change here, even if we stay without much change that currently it says "on reportable lab results," which is a shortcoming in stage one. That it should have said "reportable conditions including lab results."

**Neil Calman – Institute for Family Health – President & Cofounder**

So two things, one, we would expand the definition on what's covered and also go ahead and say that there is some kind of reminding function, clinical decision support function, that would make available the proper forms and contact information to make that report and then signal in stage three that that would be electronic where available.

**James Daniels – Medical College of Wisconsin – Associate Director**

I just wanted to emphasize what I heard some other people saying, that the reporting of a condition is very different than the lab reporting and a lot of the comments really got at the fact that the public health departments for the lab reports. They're already getting it from the labs for the most part, so there's not a lot of added value of getting lab results from an eligible provider. It really is conditions that aren't triggered by a lab report or additional clinical information about a lab report that's useful for the health departments to get. Just saying eligible providers have to do lab reporting isn't a really benefit for the health department who's already going to be getting that from the labs.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Right. Jim, I—

**James Daniels – Medical College of Wisconsin – Associate Director**

Adding, if we're going to do it, it really should be something completely separate.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Jim, I tried that about two months ago and that didn't work. These are the ones that we wound up with. If we go back to saying something separate, I'm totally open to that.

**James Daniels – Medical College of Wisconsin – Associate Director**

I think just most of the comments for that one were really about how they're already getting it from the lab. So if we leave it like that I'm just worried about the benefits of public health there and that people are going to do a lot of work on the eligible provider side to send labs and there's not going to be a big bang for the buck for that.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

They could say that my lab is reporting. They could attest that my lab is reporting, and their lab then is going to have to prove that to them. That's a condition of the contract with the lab that they're working with.

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

Yes, and there are multiple labs, though. That's tricky.

**James Daniels – Medical College of Wisconsin – Associate Director**

Again, that's already happening. The hospital labs have to do that to meet meaningful use criteria anyway, so are you saying to do that for the commercial labs, that would be for the commercial labs?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Well, whatever labs that that provider might use.

**James Daniels – Medical College of Wisconsin – Associate Director**

Okay. So for the hospital labs we've already got it covered because they're going to have to do that to meet meaningful use anyway, and for the commercial labs most states have laws requiring that. I just think that the bigger benefit from something like this is getting things that aren't—

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I agree with you. The bigger benefit is to address the two things I brought up, the in-office diagnostics, STD tests now can be done in office on urine and someone will make a diagnosis, and just like Neil said, they won't necessarily report it. So that's something that I understand to be missing from whatever patterns providers now use to get laboratory tests through a larger laboratory. So that would be NIST. Then the other point that you brought up, Jim, is the condition, so how do we, and maybe we need to structure this as a fourth bullet or criterion.

**James Daniels – Medical College of Wisconsin – Associate Director**

I think it would end up being very confusing if we just said this same criteria is now applied to eligible providers, because it's going to be such a different criteria for eligible providers.

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

I think Art may be right that this is a different criteria.

**James Daniels – Medical College of Wisconsin – Associate Director**

And I would agree.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Okay then. I'm welcoming that. I had tried several months ago and it just seemed like we were at a point where we were going to move forward with this, and I was trying to tweak the language in the three bullets, but if we can add a fourth I think that would be helpful. I agree with you, Jim.

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

Any other comments?

**James Daniels – Medical College of Wisconsin – Associate Director**

We don't have to ask everybody to do everything that's necessary. Do we have to actually make the EPs do labs also, or can we assume that and just have the new one be that EPs do conditions?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

We have an opportunity to deal with the conditions and the in-office testing in a new bullet. The third item would be, and this I think gets a little back to what Deven was talking about is, do EPs need to attest to the fact that their commercial lab or the hospital lab is reporting on their behalf?

**Neil Calman – Institute for Family Health – President & Cofounder**

I don't know why we wouldn't do that.

**Deven McGraw – Center for Democracy & Technology – Director**

Why we would or why we wouldn't?

**Neil Calman – Institute for Family Health – President & Cofounder**

Why we would. You're trying to force the industry to do something by having individual providers collect a bunches of pieces of paper from all their lab testers certifying, it just adds—

**James Daniels – Medical College of Wisconsin – Associate Director**

I think this is—

**Neil Calman – Institute for Family Health – President & Cofounder**

... providers.

**James Daniels – Medical College of Wisconsin – Associate Director**

... value.

**Neil Calman – Institute for Family Health – President & Cofounder**

We should find another mechanism to force the lab industry to do what it needs to do other than asking individual doctors to gather papers from all of them.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I actually don't think it's anything more than when they set up a contract with that lab they say, are you reporting on my behalf, and the contract says yes and then that's all they need to do.

**Neil Calman – Institute for Family Health – President & Cofounder**

Yes, but they also have to follow safety procedures and do we have to put that in the—I just don't know why I'm going to use individual doctors to force an industry to do the right thing and that—well maybe. I don't know. I'm open to it.

**James Daniels – Medical College of Wisconsin – Associate Director**

If the states are already moving towards that with their own regulations—

**Neil Calman – Institute for Family Health – President & Cofounder**

Yes, see, that would be appropriate.

**James Daniels – Medical College of Wisconsin – Associate Director**

... that might be a better place to make that happen. I think from meaningful use the bigger things are focusing on those non-lab triggered events and some of the things that seem like they were part of the public health button that was started to be described in stage three where it's getting the additional clinical information about those laboratory triggered events. Those are the things that are really important. If we go back to the STD example, the first thing that the epidemiologists need to know are pregnancy status and treatment status. They're not going to get that from the labs. If that's something that they could get automatically from an electronic health record that's a huge benefit to the people who are doing the investigations for STDs and allows them to focus their work on the cases that really need to be followed up on.

**Neil Calman – Institute for Family Health – President & Cofounder**

Plus, putting it in their contract is not really a meaningful use of an EHR for a doctor. It's a little bit out of scope. So would we end up, therefore, with eligible hospitals, either we move that to core or not in stage two, and for eligible professionals we would just do the conditions?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I don't think there were too many objections to moving that to core in stage two for hospitals.

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

This was the lab reporting one?

**Neil Calman – Institute for Family Health – President & Cofounder**

Yes, for hospitals.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Right.

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

Here's the challenge, the challenge is that you have a clinical system that's built to your EHR and then there's a separate lab system that feeds it. The lab system does the reporting and that's managed and that's separate, and there's just overlap sometimes where when this criteria comes in then the EHR also has to do that reporting. It seems like the EHR should do the things we're talking about, like around condition reporting and alerting and let the lab system do the lab system. It's unclear to me why we would want to certify the lab system. It's doing it already. What we really want to do is get the EHR to do what it takes to follow up and manage public health, and that's a challenge. That one comment that we got, many comments came in that the lab systems are already doing this, whether they be in a hospital or in one of the commercial labs. So if it's out there—

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

We've already got—

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

... should be going after.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

... although menu is already in there, so whatever needed to be certified. So are you saying to remove it from stage one?

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

It seems like that's what the commentary is saying and the practice is also that. You refer something to the lab and you expect the lab is going to be accountable for making sure that there's a lab result, STD or whatever they have to report, they're going to do that. It's not an EHR function, that's all.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I don't think we're saying where it needs to happen. In meaningful use stage one we didn't say where it has to happen, just that they needed to report, and if the LIS is going to do that, great. And if an EHR is capable of doing that, that's great. I don't think that we said where it would happen. Are you thinking that we're pushing to EHR reporting, is that—

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

It's just when it comes to certification then you've got to certify those lab systems too. When you get down to that next level it gets really challenging, and so the feedback is, well, the perception is out there I think that the EHR system, again, the lab system will send the results back to the EHR, and the EHR knows it's reportable but does it have to report it too? That's the expectation. That's what's going on.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I think a hospital needs to just say that I am reporting. It doesn't say from where.

**James Daniels – Medical College of Wisconsin – Associate Director**

And they're already doing that. They already have to do that. I think we're all saying the same thing, which is let the hospitals take on the meaningful use for electronic hospital labs for electronic lab reporting and then it's this condition reporting that we're talking about from EHRs. I think we need to really think about what that means and define it very specifically so that public health departments can actually receive the information and EHRs are ready to do it. I don't want us to get into a position in stage two where we put something out there saying now EHRs have to automatically send this information to public

health departments and public health departments aren't ready to receive it, because we guide into that situation previously. I think we need to be really careful about exactly what we're defining that to be and make sure that the public health departments are ready to get it as well.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Jim, isn't it possible that with the phrase "in accordance with applicable law and practice" that if the health department is ready to receive it, great. And if they're not ready to receive it, then they'll probably receive it on a piece of paper. Isn't that consistent with, if they're not ready to receive it, it should not be a reason for that hospital or provider to step away from reporting.

**James Daniels – Medical College of Wisconsin – Associate Director**

Okay, but I just think some of the stage one things that we're trying to deal with now are health departments not being ready to receive a lot of this information and it has caused a lot of confusion with the health department. I wouldn't want to put a stage two out there that's going to put them in exactly the same situation. I'd want to make sure that we did our homework to define it in a way that is really useful for public health.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Sure. I agree with that. Certainly, I live the life of one without enough resources to do all the things that meaningful use would like public health to do. I sympathize with all that. The continuity of care document for a patient, if you have the capacity to receive it into a PHR, that's where we're headed. If you don't have the capacity to receive it in a PHR you can get it on CD, and if you need it on a piece of paper we can do that too. How come we're looking at the capacity of a patient differently than the capacity of a public health department when we make these meaningful use criterion? Do you see the analogy there?

**W**

I'll answer a little bit of that, because the way that the criterion actually gets written, it's a next level down to do a test or to meet that criteria you have to engage with the public health department. When they don't exist, you have to be able to demonstrate or get an opt out capability. So every single vendor, across every single state talks to multiple public health departments and it just gets very complex because even to demonstrate the test you have to do that. So the next level down is where you feel some of the pushback and the vendors all coming to the public health departments say, well, we can't help our customers meet meaningful use because you can't do the test, right, so we need an opt out. So that's kind of the noise you're hearing.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes, but then if public health departments aren't uniformly ready with one standard we can't do anything.

**W**

I think I'm back to the client. Maybe there's a way we can make it more an EHR centered capability that you've been talking about, which isn't so dependent on the health infrastructure. I like the way you're going where it's a signal that that's the way we want to go and the EHR's smart enough to identify those reportable conditions, and if so it enables you to print it out or create the exchange in any mechanism as you've defined it. That makes a lot of sense to me because you're not dependent on the back end piece that moves us in the right direction. But when we get down to the certification criteria as they do a test, that's when it really becomes a problem right now and that's what we're seeing out in the industry.

**James Daniels – Medical College of Wisconsin – Associate Director**

I'm getting a little scared with some of the things you're saying. Just because when you're talking about them being able to print it out and formats or send it electronically—I know when I was running the data entry unit for a surveillance department and different providers wanted to send us their versions of forms that they printed out from their EHRs because that made their workload simpler. None of them looked exactly like ours and with the trained data entry staff that we had it made that work extremely difficult and we actually had to stop accepting those.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

But this is in accordance with applicable law and practice. If the local health department or state health department have a law and practice to receive it, are you saying that we would not be encouraging the EHR to meet that?

**James Daniels – Medical College of Wisconsin – Associate Director**

They're all required to fill out case report forms anyway, right?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

But we know, as Neil pointed out earlier, that—

**James Daniels – Medical College of Wisconsin – Associate Director**

No, they don't do it, yes.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

... they don't do it. The reporting in the United States is actually coming from labs.

**James Daniels – Medical College of Wisconsin – Associate Director**

Right. But if we do it I just think we need to define it in a way that's not duplicative of lab reporting, that health departments are actually getting additional information out of the EHR that's useful. Just getting the same lab report twice is not going to be useful.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I agree, and that is not the intent here is not for us to try to push duplicate reporting. It's about adding value to the public health department through the in-office testing or the conditions that have no associated lab within.

**James Daniels – Medical College of Wisconsin – Associate Director**

I would say—

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

That should be a fourth bullet.

**James Daniels – Medical College of Wisconsin – Associate Director**

... additional clinical information related to laboratory ... events too.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

So that's a whole workflow that I'm not sure that we're ready to define here, and certainly not in stage two. That got bundled up in this interaction with the public health button, and I like where you're headed, I just don't know, is that something we want to signal for stage three, is that what you're saying, Jim?

**James Daniels – Medical College of Wisconsin – Associate Director**

That's the sense I got from the comments too, I think, is that this more complicated, non-laboratory based reporting and clinical information reporting is more of a stage three. I think we need the time to define it in a way that makes sense, come up with the appropriate standards to be used.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

So we'll have to figure this out. First of all, this is George, and we've gotten a reminder that we're not saying our names before we speak. So that's number one. Art, what's a good way to figure this out? Is there work to do over the weekend?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes, I can do some work on this and try to fashion some language, as Deven said earlier, fill in and maybe modify what we have in these boxes on the current matrix over the weekend. I can be in touch with Jim about this and we can work on it together. Would that be okay, Jim?

**James Daniels – Medical College of Wisconsin – Associate Director**

Yes, that's fine, Art, that would be great.

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

I wonder if we can make sure we've covered all the bases. It's almost like a matrix and we've been talking about all four cells at once. Let's make sure we understand where the work has to be done and what we'd expect back for clarification. One is the current criteria for stage one is electronic lab reporting to public health agencies, and we have for the hospitals that they've performed this test and submit where it's applicable. Is that still staying the same? Let's go back to the intent of the whole meaningful use program, the EHR incentive program is to help providers, whether they're EPs or hospitals, do their work for the clinical care and in this case for their responsibilities to public health. I wonder, in the future world, stage three, yes, we can have systems that do communicate and have bidirectional communication with the public health agencies.

In stage two, I wonder if this is like we discussed earlier when we were on the subject of EPs, that we help the providers do the right thing. The fact that they're not reporting is because they don't have the infrastructure to, one, remind them; and two, carry it out in an efficient way. So it's a stage two interim step to say that they should be reminded to carry this out and they can continue to get the information to public health agencies as efficiently as they can ... time. I'm not sure I articulated that in a clear way.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I think what you're saying is going back a little bit to what Neil said earlier.

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

Yes, and applied to both hospitals and providers. In other words, help them do the thing they already, like you say, are required to do, but don't do ... because it's hard to remember and it's hard to efficiently do that reporting. The EHR can, no matter who gets the data in, the lab or the entry and back office lab, it can help remind them, one, this is reportable, and here's how you would connect. Here's how you communicate this information. That's already a big service.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Right.

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

That might be stage two, and the signal, what we can already put in the stage three column is to say and this should all happen automatically.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Right.

**James Daniels – Medical College of Wisconsin – Associate Director**

It's already happening automatically for the hospitals, though, right?

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

Right, and that's part of your point. We're not putting an additional requirement on providers, including hospitals, in stage two. If it's happening it just happens. They're going to know that this is reportable. I guess in some sense it's trying to clarify the confusion that's come across in stage one that will ... why should I have to do what somebody else does. Well, we're no longer saying you have to do it. The EHR has to help you fulfill your requirements to the public health agencies. It doesn't make a statement that it must, "it," the EHR, must be your vehicle just because the field isn't ... for that yet.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

If we can go back to the idea that potentially next week Jim and I come with a fourth bullet for reportable conditions, do we think that—

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

That's a different topic and I'm trying to ... it out so it's clear to you and everyone what those cells are that you're going to ... out. Under the labs, it helps to make the criteria much more that it's done and not that you, either EP or you, hospital, have to do it from your EHR versus your LIS in the hospital case. Do you see what I'm trying to do?

**James Daniels – Medical College of Wisconsin – Associate Director**

But the hospital already has to do it. This is Jim. I'm not sure I understand what you're saying now.

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

I'm not sure, and there are a lot of implications on certification here, Paul, so it's not clear why if we have to do it by state law then why do we need to make this part of meaningful use? I'm a little unclear.

**James Daniels – Medical College of Wisconsin – Associate Director**

Ineligible hospitals already have to do it for meaningful use anyway.

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

Oh, do they?

**James Daniels – Medical College of Wisconsin – Associate Director**

....

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

They—

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

They have to do it by law. They have to do it because the state was ....

**James Daniels – Medical College of Wisconsin – Associate Director**

But it's also a meaningful use requirement.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

... addressed that confusion because ... EHR have to do it or does the LIS do it?

**James Daniels – Medical College of Wisconsin – Associate Director**

I don't think that it's the eligible hospital that has to do it. It just has to come from certified technology ... to the eligible hospital—

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

....

**James Daniels – Medical College of Wisconsin – Associate Director**

... do it.

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

... even though you say the hospital, today you have, in the law it says you have to have a certified EHR. As you expand that then that means that you have to certify all the LIS' in the nation.

**James Daniels – Medical College of Wisconsin – Associate Director**

That's happened—

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

I just don't think we want to go there. There's a lot of overhead for that.

**James Daniels – Medical College of Wisconsin – Associate Director**

That's already happening actually.

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

I understand that, but I don't think that was ever the intent.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I don't know that we can dictate which way the hospital's going to do this reporting, whether it's through their LIS or the EHR. We just want them to report electronically.

**James Daniels – Medical College of Wisconsin – Associate Director**

The eligible hospitals that are choosing to do that as a menu set option this year, some of them are taking modular approaches and having their ... certified. Some of them are taking approaches where they are utilizing the HIE and trying to figure out a certification process for that as well. There are lots of different approaches that they're taking. That's already happening for stage one, so I don't—

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

You're right, Jim.

**James Daniels – Medical College of Wisconsin – Associate Director**

....

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

The only point, again, I'll reinforce that again, this is really early on, and if we can add clarity here where we don't have to go through those complications, that would really be of value if we can really be clear on what our intent is here. I understand, Jim, what you're saying but again we're going to make this nationwide, and the lab systems already report, so—

**James Daniels – Medical College of Wisconsin – Associate Director**

But they don't—

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

... through and certify each HIE and each lab system across the nation is a big deal.

**James Daniels – Medical College of Wisconsin – Associate Director**

I don't disagree with you.

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

Okay.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Labs don't have to report electronically now. In my state only one hospital reports electronically from the LIS, and in New York State I think 300 hospitals report because they went to the effort of creating an electronic system. So this is our window and our opportunity to make sure that there is good reporting from the hospitals through meaningful use. We should not dictate which method is used.

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

I'm fine. It's just that there are ramifications downstream. That's all. We just need to be aware of that.

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

Charlene, would you like to join Art and Jim in this homework off to the side?

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

I can.

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

I think we have—

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

Honestly, I wear the certification hat too.

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

That's right. I think that's important. Let's summarize the off line work. One, I think you're doing with two dimensions for two groups. The two groups are obviously hospitals and EPs. The two dimensions are lab and conditions. So even for labs there are two sides. There's a lab that's performed by the hospital and there's the back office lab that Art talked about originally that's performed by EPs. So in a sense there are two kinds of labs. For conditions it's just different from only lab reporting. Are those four cells the right ones you're asking for, Art?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I think that's right, Paul. Does that sound right to you, Jim?

**James Daniels – Medical College of Wisconsin – Associate Director**

Okay.

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

So that's something you'd bring back to the May 2<sup>nd</sup> discussion?

**James Daniels – Medical College of Wisconsin – Associate Director**

Yes.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes.

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

Okay.

**James Daniels – Medical College of Wisconsin – Associate Director**

If there really are a lot of labs that are performed at the eligible provider then I would say that you have a point for maybe making that criteria for eligible providers as well. But I guess I'm just not aware of that many things that they would do at the eligible provider type that aren't going to be also done somewhere else that public health is already getting informed of.

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

I think that's part of the consideration as you come forward with your suggestions on these in these four cells, and let's not add to the burden, especially if there's no conditional value to the recipient. Also, and this is where Charlene can help as well, is what's the readiness for the different kinds of requirements you might consider.

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

I can help you.

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

Knowing that you have both the option of stage three and we want to maintain our parsimony and not increase burdens and if possible to clarify some of the confusion that we've introduced by the vagueness in stage one definitions, does that make sense? I think it's ... actually.

**James Daniels – Medical College of Wisconsin – Associate Director**

I think that we can work with that, Paul.

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

Okay, great.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

There is the last area, which was syndromic surveillance, and I don't believe that there's too much discussion there. There was the suggestion that, let me just go back to that. Sorry, one minute. This should be moved most likely to core for the hospitals and I don't know whether we do that in stage two or stage three but I think there was significant support for that for the hospitals, and for the providers there was a suggestion that we could keep that still as part of the menu set. Some, as in the summary notes say that this should be removed. I think traditionally this has been more something that's come out of emergency departments and hospitals, but there are areas of the country where ambulatory practices contribute significantly and allow us to make assessments of where we are in our influenza epidemic every year. It seems a bit drastic for me to say we're going to remove this entirely for eligible providers.

**James Daniels – Medical College of Wisconsin – Associate Director**

ISDS is coming up with what the standards are for reporting for ambulatory syndromic surveillance. I think that was a big part of some of the confusion there was there really aren't standards for that. Yet, the few places that are doing it, and, Art, maybe you know more of them than I do, but they're doing it very differently.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Absolutely. It's been organic in nature up to now and it's wonderful that ISDS has stepped up to try to create these with the CDC, these standards that hopefully we'll be able to apply more broadly. I think there has been some confusion. It was great that we were able to include this in stage one, but now as the rubber hits the road there's some difficulty in executing and ISDS should have these standards ready. Now, I don't know whether Charlene has any comment about that in terms of certification for this or whether there has been any review of the people who work on certification around these standards being proposed.

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

I just think there were wrong standards published, so again I'll have to follow up on that. But I guess—

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

There were wrong standards for ED corrected but there are no standards for ambulatory.

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

That caused confusion out of the gate too.

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

Listening to this discussion, it certainly doesn't sound like this is a move to core kind of thing for EPs.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

No.

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

There's even some rationale to removing it as part of core. Let me offer an alternative, can you wrap up this kind of thing to your condition reporting, because in a sense a syndrome could be considered a core condition?

**James Daniels – Medical College of Wisconsin – Associate Director**

No, it's really different.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes, they're very different.

**James Daniels – Medical College of Wisconsin – Associate Director**

And syndromic surveillance might end up being from an ambulatory basis more aggregate count.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes.

**James Daniels – Medical College of Wisconsin – Associate Director**

We just don't know until ISDS figures out their worth.

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

Let's go back to the original comments from the public then. If we haven't decided on whether we have menus or not, this will come up in the timing discussion, so if we no longer have menus it sounds like from your discussion this really doesn't belong here, certainly as core.

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

In stage two.

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

In stage two. And remember part of parsimony is that you'd like to have a few things that people can concentrate on that are ..., but if it's only useful, so most people have urgent cares or EDs that would handle this kind of thing, and do, should we burden the entire EP community with this requirement?

**James Daniels – Medical College of Wisconsin – Associate Director**

I think the comment that I read for this it was pretty clear that for EPs it definitely should not be moved to core.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Is it really a final, final thing that there won't be any menu? This is David Bates.

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

No. On our face-to-face, two of our big paths, one is to reconcile with our other HHS programs like SDO and National Quality Strategy, and another is to come back after we've finished all the draft criteria and look at it from a timing perspective. So it's not a final, final. So at least we can put a stake in the ground that this is not appropriate for core and then we can deal with that at the face-to-face. One option is if there are no menus then to remove it, but if there are menus then that's about as far as we can ....

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

For EP and for ..., or both? What was your—?

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

How do you all feel about EH?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I thought we all agreed this would become core at EH.

**Josh Seidman – ONC**

The comment that came in required moving it to core for EH.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

I'm sorry, Josh. Could you repeat that?

**Josh Seidman – ONC**

The comment that came in from the public supported moving it to core for hospitals.

**James Daniels – Medical College of Wisconsin – Associate Director**

I think that makes sense.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes.

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

Okay. Well, welcome David Bates. Art, does that finish up public?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes, I think that sounds like we have our task to work on over this weekend.

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

Okay. So on May 2<sup>nd</sup> then we'll include that so we'll have two big copies right now instead of finishing to re-look at category 2 and then to do this two by two matrix for lab conditions. Wonderful. Okay, welcome, David Bates, and I think we've teed up the care coordination section.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

There were five things in this area. Broadly, there's a lot of interest in doing some things that relate to care coordination but the difficulty with many of them is that there's something of a lack of standards and I think the comments reflect that. The first of the recommendations was to perform a test of the HIE and that, it seems to me, was broadly acceptable to people. Any comments about that?

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

The one test of an HIE?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

To connect to it. And the definition of that was to connect to at least three external providers in the primary care network, but outside the delivery system that uses the same EHR or to establish an ongoing bidirectional connection to at least one HIE.

**Neil Calman – Institute for Family Health – President & Cofounder**

I like that. I still think that's a good description.

**W**

I'm still struggling with it, in no small part because I think that there's a real opportunity to include the direct standards and policies and services in the certification process. I think you can still say it solves your ... and HIE but I'd like to see us really push a little farther here, and David Blumenthal encouraged us to do that when he saw this proposal. The way that I'm thinking of that is that we have a requirement to use direct and I prefer that that be linked to exchanging some kind of meaningful data. Whether it's a visit summary or care summary or care plan or whatever it is that we can agree on, if we build that into meaningful use then we will have opened up a universe of providers. It will be easier for them to find some larger number of exchange partners in their medical training area, so to speak.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

So what do other people think about that?

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

Again, there's just relative concern on the part as you look across the nation of is direct in town all over the place. So there's conditions of direct, and I'm going to step back, it's also my understanding that we've got, David, some input coming in from the HIE workgroup and some recommendations that could influence.

**Deven McGraw – Center for Democracy & Technology – Director**

Yes, but I think that they were actually heading towards—since I sit on it, actually looking at the summary of care document requirement, which we've already discussed is right now, number one, not core, and number two, still could be met on paper and setting a threshold for the transfer of that to be done electronically. From a direct perspective there are standard Internet protocols, quite frankly, so for you to be able to do direct doesn't require infrastructure beyond access to broadband. Now, of course there are providers who don't have access to broadband and maybe the key is to build in exceptions to this for people who in fact have no Internet access.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes, I agree. Direct isn't a thing, Deven's right, so it's a set of standards and policies and services so anybody can do this at this time, as I understand it, in our conversations with Arien Malec that seems to be the case. So if anybody can do this at this time why would we not use the lever of meaningful use to make everybody's life easier and get everybody on a standard exchange, I'll use the word "platform" even though it's a noun, but at least a standard way for exchanging.

**Deven McGraw – Center for Democracy & Technology – Director**

Right. We don't have to tell people they must use direct. Again, I'm comfortable with the notion that if you don't have broadband access then you really can't do this, because you probably aren't connected to an HIE either for that matter, although you might. So certainly there might need to be exceptions for people who just don't have Internet access, don't have an HIE, and therefore have no way to electronically transmit a document. But beyond that, and that universe is shrinking due to initiatives about broadband extension, that aren't even part of our, or HHS' for that matter, bucket of programs. I think we're much better off to create an exchange requirement that isn't just about one provider, thus, stress the care coordination aspects of it and give people exceptions if they actually physically cannot do this.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes, I agree. I don't see a reason why we would not point to direct because that's the mechanism that gets the standards into the certification process so that all EHRs are capable of essentially using direct.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

But you wouldn't push direct to the exclusion of going to an HIE, would you?

**Christine Bechtel – National Partnership for Women & Families – VP**

No.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

So you're basically arguing for adding this as a third alternative.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes, I think the challenge is that we got really hung up in the in-person meeting on the number and Paul kept going back to some number more than one, but people didn't like three. And I think it should be way more than three. I think the challenge is how we straddle that and whether or not the assumption that if you just build the capability into the system and you tie it to a thing, as Deven talked about, the transition document, I'd like to see something that's even more broadly applicable, whether that's enough to really drive exchange of information or not.

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

Again, on this one it seems to me it's the purview of the Standards Committee to dictate which standards and policies and procedures we followed, whether it's direct or whatever that standard seems to be their purview. I'm more comfortable with the way Deven was going relative to changing this one from a test to demonstrating the ability to, again, I'm not going to use, it's whatever language, the exchange of the clinical summary for a percentage of the population and then let the Standards Committee define what that appropriate infrastructure is. Then we can debate ... or at least one, I think we said last time. But also she had suggested perhaps just using a threshold, like 10% or some number that actually gets the exchange going.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Our discussion, I think what we said was change to establish ongoing bidirectional communication with an external provider, meaning one or more, one being the threshold using direct or HIE, or dropping this altogether and focusing on the use cases where we use this where we don't have a separate objective for this.

**Deven McGraw – Center for Democracy & Technology – Director**

That's right. So the one that's already on the stage one menu is the summary of care document, I think, although I have to admit I'm sort of now working off my memory and not from the document.

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

Yes, you're right, Deven.

**Judy Murphy – Aurora Health Care – Vice President of Applications**

It is summary of care and it's on the core set for the eligible providers.

**Deven McGraw – Center for Democracy & Technology – Director**

Okay. But it also is one that today you could meet by exchanging in paper, so the idea is to set up a threshold for electronics.

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

Right, so it's for each transition or referral, in stage one it is menu but I think we said in stage two it goes to core, as Judy just said.

**Deven McGraw – Center for Democracy & Technology – Director**

Right. Okay.

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

So the transition and referral does open up a broader universe, which I think is good.

**Deven McGraw – Center for Democracy & Technology – Director**

Yes.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

This one, remember we needed more discussion because this is where we got lost ... you need 50% of your transitions of care, and of those 30% had to be electronic, and we were talking about how do we simplify that.

**Deven McGraw – Center for Democracy & Technology – Director**

That's right. That is the recommendation. What you just articulated, George, is what came from the IE Workgroup.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

It sounds to me what we need to do is basically compare notes with the IE Workgroup. It seems to me like there's some consensus for including something about direct and then we have to make the call. Do we even want to have something like this, or do we feel like it's subsumed by something that we've asked for someplace else? Does that sound about right?

**Christine Bechtel – National Partnership for Women & Families – VP**

David, I would just make one small clarification, which is, I think we would not look at whether it's necessarily subsumed but go back and specify that the exchange use case, for lack of a better word, is electronic. Deven's right, at least the thing that we've got here says provide summary of care record for more than 50% of transitions of care or referrals and so we would want that to be electronic or, as George said, some part of that to be electronic.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I think it has to be electronic.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes, I agree.

**Deven McGraw – Center for Democracy & Technology – Director**

I think that's really big. We probably should look at the other parts of meaningful use that are arguably about exchange, but this is the one that is about the exchange among providers that we really wanted to get at in stage two, and it's big.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Right. The other thing that I meant to mention but neglected to was that we do allow some exceptions, I think. I think Deven’s point about that is an important one.

**Deven McGraw – Center for Democracy & Technology – Director**

Yes, if it’s physically impossible for you to do this, obviously we need to give you a pass.

**Christine Bechtel – National Partnership for Women & Families – VP**

I think it would be a good idea for us to do a look back off line and be prepared maybe for Monday to identify the other kinds of criteria that should be electronic, at least in whole or in part. But also then I’m very comfortable with not having a separate requirement for HIE but rather really building it into existing criteria that will deliver value to providers but also really be in line with things like the national effort to improve patient safety and reduce hospital readmissions. This would really support that, so I think that’s good.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I guess I would kind of like to have one, to have a requirement that focuses on this here, because I think a couple of the other things down the road that we’ll be talking about we’re going to end up pushing out and I want to have something that relates to care coordination ....

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes, and the other thing I think we probably have to think about as we do this look back is that the summary of care record, providing that electronically. Just really making sure we get the language right around the transmission of the electrons and what the electrons are, you know, is the PDF okay or does it really need to be some level of more structured or discrete data?

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I think it should be coded and not a PDF.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes, I agree. I think we need to specify that.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I agree that that’s important.

**Deven McGraw – Center for Democracy & Technology – Director**

Or standards set.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Can we then at this point—

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

Going back to the direct or HIE, I wonder if there’s a way to finesse this. Because one of the strengths of this particular one is that you must comply with “standards” which includes policies. I don’t know, Josh, do we know when the NHIN governance proposals might come out?

**Deven McGraw – Center for Democracy & Technology – Director**

The last time I talked to Mary Jo Deering, who is at least one of the persons involved in trying to write that rule, they were shooting for fall 2011. But I’m not sure if they’re on track.

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

Just trying to piggyback again, there should be this overarching policy that governs exchange and that was part of your security and privacy and it still could come back to here as well instead of saying well, it could be direct and it could be this, there should be a set of policies we just refer to.

**Deven McGraw – Center for Democracy & Technology – Director**

I agree. I actually don't think we necessarily need to specify in the criteria that you must use "x" or "y" or "z" necessarily, at least in stage two, but instead maybe we can earmark this as being in stage three you need to be doing it in accordance with. Actually we already said this, it's part of privacy and security in accordance with NW-HIN specifications, but at a minimum I would prefer to define the exceptions as pointing to the venues that we know exist, and if you can't use any of those then we give you a pass. That's a way to incorporate what exists out there, state HIE, NHIN Direct, NHIN Connect, Surescripts results delivery, whatever is your preferred mode.

**M**

David, have we also sidestepped the question about the number if you end up going back to the document and what percent are exchange electronic?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I think we did—

**M**

... a better focus there.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I know that some people would like more than three. I think that there's some rationale for three and we didn't get too much pushback about three. I would rather have three than one.

**Deven McGraw – Center for Democracy & Technology – Director**

Yes, but do we even need to have that if we have the continuity of care criteria set at a relatively decent level, the sharing of the continuity of care document or the care summary?

**M**

That's why I was referring to. Let's just go to what we're trying to accomplish rather than being prescriptive because each one of those prescriptions ends up being both a burden and a documentation burden, etc.

**Deven McGraw – Center for Democracy & Technology – Director**

Yes, I'd get rid of it.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I'm okay with that.

**M**

Good. That would mean committing to measuring the use of electronic exchange to whatever document we end up doing.

**Neil Calman – Institute for Family Health – President & Cofounder**

We want this to be meaningful so we want people to actually exchange with the people who they're currently doing business with in terms of referrals and other stuff like that.

**Deven McGraw – Center for Democracy & Technology – Director**

Exactly.

**Neil Calman – Institute for Family Health – President & Cofounder**

So how do we call that out so that people aren't like, well, I've got to show that I can exchange information and the people that I'm normally referring to can't do this with me, so what do I do?

**Deven McGraw – Center for Democracy & Technology – Director**

Well, maybe that is an exception criteria.

**Neil Calman – Institute for Family Health – President & Cofounder**

People are going to be starting to write, well, the cardiologist who gets most of my stuff can't really accept this yet so I can only do 30% or 35% or whatever. We've got to think about the exception thing so that it doesn't become just an excuse model rather than an exception model.

**Judy Murphy – Aurora Health Care – Vice President of Applications**

I have the same issue with how do we describe the denominator. In other words, how do we know what the opportunity was in order to calculate the percent of what they actually were able to do?

**Neil Calman – Institute for Family Health – President & Cofounder**

Yes, that's why I'm trying to think—

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

It's been pretty hard.

**Neil Calman – Institute for Family Health – President & Cofounder**

It's really going to be difficult to do this at this stage because there's still so much of the system out there that's not capable.

**Steve**

Since we've come full circle, one of the reasons we decided to specify a number of connections is because then essentially it avoids the denominator problem.

**Neil Calman – Institute for Family Health – President & Cofounder**

Exactly.

**Steve**

If you're going to have a connection you might as well use it.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Josh, I heard through the grapevine that you've got some data from, I don't know whether it was from the ... or from some of the HIEs, saying that people were having trouble with denominators in this setting.

**Josh Seidman – ONC**

I have not yet heard that. We haven't heard that here. Where did you hear that?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I can't even remember at this point ... conversations.

**Neil Calman – Institute for Family Health – President & Cofounder**

I can tell you locally here and in New York where there's so much stuff going on there's not one of the specialists in our network right now that are capable of doing this. The extent to which they think they're going to be capable within a year, I don't know. So you end up being at a bifurcation. We can plug into the statewide exchange or to our regional exchange, but a lot of the people that are in our referral network aren't in it. While we can try to create some sort of meaningful way of helping our patients by at least generating the summaries and getting them through our set of providers who actually are capable of taking care of our patients in a different format. Given the choice of being a provider, I want to do something meaningful that helps my patients right away. But yet I still want to be able to call out something in terms of the requirement, because that's what our job is on the Policy Committee. So that's where we came up with the number thing that says let's get the systems doing it and then let's get people using it, at least to some minimal extent which is possible, and then let's look at where we are for stage three at a later point.

**Christine Bechtel – National Partnership for Women & Families – VP**

I may be missing something here, but the stage one final rule for summary of care record, the denominator is the number of transitions or the number of referrals. So folks are having to already figure

out a way to count that denominator, so if we adapt it to more closely focus on, electronically there's a couple of options I can think of off the top of my head. One would be to specify some minimum threshold of transitions that should be electronic but to create exceptions if in fact the transitions or the referrals are going to providers who are not meaningful users. Because if they're a meaningful user they should have the capability to accept it electronically and you would report the number that way. Then another way to do it would be report only, but we've already figured out the denominator, again, if you tie it to a use case.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

The reason that I like this is that it does provide some stimulus for people like the specialists in Neil's community to get going with it. If Neil pulled up his favorite cardiologists and gastroenterologists and dermatologists and says, would you guys consider getting on board with this, they might really start.

**Christine Bechtel – National Partnership for Women & Families – VP**

Right, and if it's a direct piece then it doesn't necessarily require an enormous investment in deployed EHRs, as I understand it. Another alternative might be to have the patient play a role in receiving electronically if providers can't, it's just sort of off the top of my head so it's a little bit raw, but at least if we focus on what the use case is it solves the denominator problem, I think.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

So what do other people think about that?

**Deven McGraw – Center for Democracy & Technology – Director**

I like it, of course.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Paul, are you okay with it?

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

Yes. You're saying denominator is transitions and referrals?

**Deven McGraw – Center for Democracy & Technology – Director**

Yes, just as it is right now.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

But we leave the number of providers.

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

We leave the number at three?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes.

**W**

I don't know if you leave a number of providers underneath it. So if it's already provided care record for 50% of transitions and referrals, you can count that and you can provide the record on paper, but some percent, is it some percent or some number, is that what you're asking, should be electronic?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

What I'm concerned about is the phenomenon in which Neil sends 100% of his transitions and referrals to some place in Boston where none of these people are ever going to get seen. That would fulfill the criteria, but it's not going to help his patients at all.

**W**

Why would he do that?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Because—

**Neil Calman – Institute for Family Health – President & Cofounder**

Because the—

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

... it qualifies for meaningful use.

**Neil Calman – Institute for Family Health – President & Cofounder**

I need to qualify and the people that are in my network don’t participate, aren’t ready to do this yet.

**W**

So you’re going to make a referral to a different state just to meet a meaningful use—

**Neil Calman – Institute for Family Health – President & Cofounder**

No, no, no, that was just being facetious. But basically what would I do? I would need to find new referral resources who can do this in order to meet a threshold criteria.

**W**

But what I’m saying is that the threshold is lower, maybe 10%, and you say not just anybody, and maybe this is where David is going, it’s incorporating the ongoing connection idea.

**Neil Calman – Institute for Family Health – President & Cofounder**

Yes, I think you can do that, but I think you could accomplish what you’re trying to do by keeping the threshold low. I think that actually might even work better than the three. But if you keep the threshold low then you’re basically forcing people to have the capability of doing it and they’re going to use it when they can because that’s going to be a tool that’s going to be very powerful for people to use. So we want people to be able to develop the capability and understand how it works, and I think we can do that by just keeping the threshold low.

**W**

Yes.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

And how low is low?

**Neil Calman – Institute for Family Health – President & Cofounder**

That’s a good question. But 10% is probably reasonable. This is just—

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

David, what are we counting exactly? I want to make sure it’s easily countable.

**Deven McGraw – Center for Democracy & Technology – Director**

It’s the same thing that’s countable now, discharges and referrals. It’s just what percentage of them are electronic versus which are on paper.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

How are we counting referrals, by orders for referrals?

**Judy Murphy – Aurora Health Care – Vice President of Applications**

Which criteria are we doing that for today, because I’m not familiar with that?

**Christine Bechtel – National Partnership for Women & Families – VP**

Provide summary of care record.

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

Yes, and the criteria for that right now, is just for EPs, that was kind of my question. I don't disagree with where this conversation's going, but we have to expand it to be EH, probably say discharge, which I think is fine, but again it's not there right now.

**Judy Murphy – Aurora Health Care – Vice President of Applications**

Yes, we definitely need to expand it for eligible hospitals if it's not there already. I guess I thought it was.

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

This is where that first criteria, "demonstrates a test," overlaps with this care record summary, so those two should be brought together. If we do the test in stage one of generating a CCD or care record summary, then we should be able to execute on that in stage two if we bring them together. But they're not linked together right now.

**Christine Bechtel – National Partnership for Women & Families – VP**

Charlene, that's what we're saying is, all right, you did your test and hopefully you've been doing the summary of care record, some of them will have been because it is a menu option, which I think, Josh, maybe you can help us double check, but I really thought in my little worksheet ... EP and EH. Anyway, so what we're doing is building on stage one by saying, okay, you're already counting the number of transitions or referrals, because the transitions was really the hospital side and the referral was the EP side, so now let's have a percent or a number of those be electronic transmissions.

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

Christine, you're right, but it didn't get translated that way, I don't think. I'm not disagreeing with what you're trying to do, but it didn't get translated that way.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I think we're getting reasonably close to consensus. I'd like to declare victory on this one and move on.

**W**

Okay.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

So let me reiterate what we said, so we'll get the HIE Workgroup input clearly, we'll add direct, we'll add exceptions, and we have to reconcile this with the other measures and I think that there's a lot of consensus about combining it with that. The denominator will be transitions and referrals, keep the threshold low at around 10%, and it has to be expanded to EH.

**Deven McGraw – Center for Democracy & Technology – Director**

Hospitals, yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes. Does that sound okay?

**Deven McGraw – Center for Democracy & Technology – Director**

Yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. So let's move on to medication reconciliation. Here the measure is medication reconciliation is 80% of care transitions by the receiving provider and then we specify a little bit about what transitions are. Before the threshold was at 50% and we suggested going up to 80%. Broadly, there was support for the objective conceptually but there was concern, not surprisingly, about the increase in threshold. A lot of people suggested moving it to core without changing the threshold and there were some requests about clearer definitions, and there were also a lot of comments about aligning things with the Joint Commission's 2011 requirements.

**Judy Murphy – Aurora Health Care – Vice President of Applications**

This is the one I thought we ... but I'll just throw that out there, we got consensus on in the April 5<sup>th</sup> in-person meeting that we would keep it at 50% but we would move it to core instead of menu.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, I think that's—

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

... George.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

What's that?

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

That's correct. This is George.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. Then that's what I would like to do. Does anybody have big issues with that?

**Deven McGraw – Center for Democracy & Technology – Director**

It sounds good to me.

**Michael Barr – American College of Physicians – Vice President, PA&I**

I'm good with that.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Yes, I agree.

**Marty Fattig – Nemaha County Hospital – CEO**

That sounds good. The question I had earlier was about transitions of care, clearly defining that.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. The next one is the summary of care record, which we have effectively already talked about. The next one is a new one, which was the list of the care team members, including the primary care provider, for 10% of patients in the record. People were divided about this. Some people thought it was a good idea to know who's caring for the patient, whereas, others felt that there wasn't a good clinical reason to figure out who the team was. I find it a little hard to defend the second position. People wondered would this help pave the way for care system reforms and care coordination. I personally believe it undoubtedly would. The ... majority were supportive. A lot of commenters felt that they first needed a better definition of a care team, which we of course would have to provide, and not surprisingly even the supporters requested minimal initial data requirements. So that's a short summary. Comments about this one?

**M**

Unfortunately we don't have a way to identify and enumerate all these people uniquely, so in a sense I guess this would be text only basically, human readable list.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, but I think just listing the primary care provider would be a pretty big advance.

**M**

And knowing that one amongst all the systems would be even better.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Right.

**Judy Murphy – Aurora Health Care – Vice President of Applications**

I think if it's simply text only then being able to list the other provider or clinician names that the patient wants listed is, if you type in one name what's the diff?

**Michael Barr – American College of Physicians – Vice President, PA&I**

A question for you: Would this be satisfied by simply keeping track of the primary care physician's name? There's no real numerical value here.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

It certainly could be.

**Michael Barr – American College of Physicians – Vice President, PA&I**

Which would be a step in the right direction for big systems for sure. So I'm not advocating there should be more than that. I just wanted to make sure I was clear about what it does imply.

**Christine Bechtel – National Partnership for Women & Families – VP**

I think that's an important question because I think that is a step in the right direction. But I'd like to see us go a little bit farther since the workflow issue of one name versus two or three or four or however many the patient specifies is like however long it takes you to type a first and a last name, I imagine.

**Michael Barr – American College of Physicians – Vice President, PA&I**

Christine, it might not be as simple as that, depending upon what system the person is in and whether the patient is as reliable as you're implying and whether the person might be seeing three different cardiologists is the one you want to put on the list of team care members. There's a little bit more judgment involved than just simply writing down names.

**Christine Bechtel – National Partnership for Women & Families – VP**

I agree and I understand that. But I also think we don't do any of it today and so even if the patient got the name incorrect or couldn't remember or didn't want to provide it, I don't think there's an issue there. I don't want to see us say with the care team members just PCP and my guess is that a lot of the commenters ask for a little more specificity. So I'd like to see something that basically says it's the best you can do in your clinical judgment in talking with the patient because how else are you going to get the information, right?

**Michael Barr – American College of Physicians – Vice President, PA&I**

I'm agreeable. I just don't want to see a specified number .... I think if the functionality is there that it makes sense for doctors and other healthcare professionals to do this. I just don't want to be too specific about how many and make sure we give them credit for at least recording the primary care physician if they're a sub-specialist, for example.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes, I agree.

**Neil Calman – Institute for Family Health – President & Cofounder**

I've been thinking about how to actually operationalize this. For one thing, there are ways that the electronic health record can be used to do this, so all of our patients who see people other than me as their PCP have a recorded note. If that could create a cumulative record of the people who they've seen, so here's the name of your diabetic educators, here's the name of the nurse that took care of you, etc., and also could accumulate from the referrals that we make out. So each time I refer to a doctor that could be here's your cardiologist, here's the endocrinologist that we referred you to or whatever. I think you could create a system that would capture at least the information that came through the PCP in a way where the EHR could really help you do this.

The specialists, I think, have a bigger problem, in that the cardiologist isn't going to necessarily interview somebody to figure out who all the people are on the team. So we're calling this out but I think it really makes more sense for the EHRs that are being managed by PCPs than for the systems that might be in place in the offices of people who are just doing specialties.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

But don't you think a specialist is going to want to know who the PCP is?

**Neil Calman – Institute for Family Health – President & Cofounder**

To know who the PCP is, yes, but not necessarily want to know who the orthopedist is and who everybody else is.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

But they wouldn't have to do that. The way this is written now if they just wrote down the PCP that would be enough.

**Neil Calman – Institute for Family Health – President & Cofounder**

But—

**Michael Barr – American College of Physicians – Vice President, PA&I**

Actually—

**Neil Calman – Institute for Family Health – President & Cofounder**

Go ahead.

**Michael Barr – American College of Physicians – Vice President, PA&I**

We might want to say something about sub-specialists and specialists actually having to record to the primary care physician as if one exists.

**Neil Calman – Institute for Family Health – President & Cofounder**

Exactly.

**Michael Barr – American College of Physicians – Vice President, PA&I**

So I think that might be a floor, again, with an exception if the patient doesn't have a primary care clinician, a physician, but I don't think we want to do more than that in terms of specification.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Right. I think we want to be fairly general too. People will do it in different ways. We've done this for years. It's a really valuable part of the record. We have a provider directory which is pretty useful, most people aren't going to have that, and we don't put every single provider that the individual saw on this list. We just do it for people that they're likely to see multiple times. If you just stick everybody that anyone ever saw on there, the list gets pretty long pretty fast.

**M**

Part of the value to having the list of the PCP is they want us to know who that person is, but also too ... efficiently communicate information back to the PCP. Are the complications of ... certification criteria including the use of the NPI to identify these folks? That's one of the objectives of that whole process was to enumerate all of it so that we could find each other and communicate with each other.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Yes. I don't know how hard it is to actually find somebody's NPI if you don't know what it is. I'm sure there's a tool to look it up.

**Christine Bechtel – National Partnership for Women & Families – VP**

That's the piece that Micky Tripathi has been reporting on about the provider directories. I'm not technical enough to know where that ... in terms of the role of the NPI, but perhaps we could ask him.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

It's clearly a useful thing. The other side of the balance is that care team members in longitudinal care plans have to be careful not to do too many new things when our mission is to focus. I think this one's

important, though. I would think that coded providers may be stage three given where everything is and that a little bit more vague one would be more appropriate for stage two.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

That’s what I would advocate too. We haven’t gotten to the longitudinal care plan yet, George, but I think we’re going to end up putting that off.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Yes, I’m just worried if we do both of these, then I’m a little worried about this one. But if we’re just doing this one and not doing the longitudinal care plan, then I think we really should go ahead with this one.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

That’s what I think.

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

Two points in terms of coded there will be people in the care team probably who may not be on the provider list, so again you’ve got nurse practitioners and others, so again just consider that, which probably makes us be more “vague” in stage two would be better. The other opportunity, though, is if we start to do these transitions of care documents or exchanges, data about the provider’s going to be included in that, which is going to be able to populate the EHRs with some of that information. So we should be thinking through how we can harvest that in this process, because I think that will be really valuable. Again, if we’re only 10% we’re starting but we start to put a placeholder in there to be able to capture, because you have to know who you’re referring to or who you’re sending the discharge summary to.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Okay.

**M**

This becomes part of the Achilles heel for all of this communication really. Are you suggesting, David, to keep this requirement as really a text requirement to signal people about the ILPD or whatever it’s called, the individual level provider directory?

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Yes.

**M**

Terrific.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

My suggestion would be to keep this would be text. We have a very low threshold, it’s just 10%. It would be coded by NPI in stage three and I agree we should recognize that some providers will be encoded, that’s definitely the case. Do we have consensus around that?

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

The only thing, David, I don’t know that it will be on NPI, or the ILPD may have people in it who do not have an NPI.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

And that would be okay. We should use whatever is more inclusive.

**Art Davidson – Public Health Informatics at Denver Public Health – Director**

Right.

**M**

Right now are we only PCP, or are we keeping it broad and saying—

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

I think you have to have a place for other care team members.

**M**

Right.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

So we’re going to leave it essentially as written. Okay, let’s—

**M**

Well, I guess people are going to ... list of healthcare team members for 10%. Does that mean for 10% you have to have all, I think that’s where the—

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

It’s not going to be that you have to have all. You have to have—

**M**

Maybe you want to just say “PCP” because otherwise there’s no way that people would know whether they satisfy it or not.

**M**

At least one.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

One or more care team members?

**M**

Yes.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Yes. Including at a minimum the PCP?

**M**

Yes.

**M**

Unless they don’t have one and they need an exception for what does it mean—

**M**

Right.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

So we could say including at a minimum the PCP if there is one.

**M**

Right.

**M**

Well then they have to prove that there isn’t one. I just don’t want to make it hard to implement.

**David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine**

Right.

**M**

I think we can say the intent is the PCP would be one of them without having them have to have to attest to the fact that each patient doesn't have a PCP or whatever.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

So that would argue for leaving it the way that it is.

**M**

They just don't know what does a list of healthcare team members mean. Is it—?

**M**

Yes.

**M**

How would you test it?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Isn't somebody else going to define that in more granular detail?

**M**

The only one I worry about gaming the system, this is George, would be if they only put their own name on the list for every patient, because that's obvious, and then they're done with the requirement. Other than that, I think we're okay.

**Michael Barr – American College of Physicians – Vice President, PA&I**

Yes, but actually that might not be such a bad thing after all because if they're in a large practice knowing if that record gets changed, somebody else will at least know that there's a primary care physician associated with that patient.

**M**

It is useful, but it's trivial to implement. Since you know you're seeing the patient any one of your patients can have your name on it, therefore, there's not much to do.

**Michael Barr – American College of Physicians – Vice President, PA&I**

In a practice where patients see multiple physicians and urgent care and all that stuff, it's still extremely important—

**M**

Well, in a hospital, yes, like in a ... hospital—

**Michael Barr – American College of Physicians – Vice President, PA&I**

Not necessarily in a hospital—

**M**

....

**Michael Barr – American College of Physicians – Vice President, PA&I**

... system. Where I work in urgent care sometimes it's very uncertain as to who the actual primary care physician is. There's some merit to it, but I wouldn't make it as trivial as you—

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

George, it's so clinically useful that I think people will start using it.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

Yes, I agree. I'm trying to make it as easy as ..., so I retract my comment. I just want to make it feasible to satisfy.

**Christine Bechtel – National Partnership for Women & Families – VP**

I think part of what we're getting hung up on is trying to jam this into a single phrase. It seems to me that to clarify our intent we probably should be using additional sentences. This document's going to CMS so that they can understand what our intent is but I think if we do a little bit of work maybe off line to just add a couple of sentences for context it might solve a lot of our issue here.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

In 90% of the comments that were made on this call they used the term "PCP." That is our intent. That is one of the high leverage, high value pieces of data. Couldn't we just say 10%, list the PCP ... where available, or something like that, because 10% of these patients have to have a PCP.

**Christine Bechtel – National Partnership for Women & Families – VP**

I don't agree with it in part because I don't know if commonly people, for example, think an OB/GYN is a primary care provider even though the OB/GYN, I guess technically is a specialist but functions as a PCP. A cardiologist is not necessarily primary care, but often functions as a primary care provider. Then on top of that, if we look at all the health reform stuff and care coordination dimensions of it, the most costly and vulnerable patients have about five doctors. So I think my intent is actually a list. It's not just PCP.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

It's very important to have a list, I think.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes.

**M**

Try to get a measurable criteria that—

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Measurement is not the most important thing for this one.

**Christine Bechtel – National Partnership for Women & Families – VP**

Maybe we do a list of patient reported care team members so that way you just need to ask the patient, and if the patient doesn't provide it, it's an NA, because how else are you going to get your list?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

You often know who you've sent people to.

**Christine Bechtel – National Partnership for Women & Families – VP**

True.

**Michael Barr – American College of Physicians – Vice President, PA&I**

I think if the functionality is there and you get people started on it, they will use it. I think over specifying it runs the danger of getting a backlash for something that should be adopted pretty widely pretty quickly if it's done correctly.

**M**

All right, I'll vote for David's suggestion that we leave the wording the same.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. We can provide a little more specificity, another sentence or two, as Christine suggested, and do that off line.

**Judy Murphy – Aurora Health Care – Vice President of Applications**

I agree with that comment, especially thinking about the column that we talked about adding to indicate the significance or why we're even recommending these as good criteria. We talked about that at the in-

person meeting, and that might help everybody hone in on why we're even adding it in there, because it is in fact important, and here's the rationale.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, good suggestion. Now, let's go to the longitudinal care plan.

**Marty Fattig – Nemaha County Hospital – CEO**

Can we back up just a second? I think it's important to identify who's on that care team, especially for the hospital side that list could become extremely long if we look at shift changes. Is it physicians only? Is it physicians and mid-levels only? What is it?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

You can decide.

**Marty Fattig – Nemaha County Hospital – CEO**

To me it would be physicians and mid-levels only. You don't want every nurse on there.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

No.

**M**

But you could. We don't have to be prescriptive about this, right?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, I think you should decide at your institution how you handle ....

**M**

I think the teams are going to have different configurations of people that are important and different institutions.

**Marty Fattig – Nemaha County Hospital – CEO**

Right, it sounds good, as long as we know and make that known to the hospitals. Thank you.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. Let's go on to the longitudinal care plan for 20% of patients with high priority conditions. This is one that I'm very conflicted about, but we got a lot of pushback around it. Most of the comments said, don't include it in stage two, work on developing them properly in CMS or NQF or others do this, consider this for stage three. A few people did support including it, but even they agreed that more clarity is needed and I think I'm okay with moving it to stage three, but underscoring that we need to have work on this. This is a really key part of things if we're going to move to the next stage with ACOs and so on.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes, David, that's my concern about not having some groundwork in stage two. I feel like if we stepped back and looked at the groundwork we already laid in stage one around after visit summary for the EPs and discharge instructions that require some instructions around what the care plan is; that there ought to be something that is possible in stage two, because we're going to have the same problem in stage three. I mean, let's be honest, people are not going to want to do this and they're going to have to do it by then and they really need to. I just don't want to let go of this completely because I think we did lay some important groundwork in stage one and it's really meaningful to patients. It can be another exchange related criteria and even if we step back and looked again at the patient and family engagement criteria, some of those dimensions around ... download. There's an enormous amount of parsimony already established in those criteria that could easily feed a care plan.

**Neil Calman – Institute for Family Health – President & Cofounder**

I've had some conversations with folks about this too. I think that this is really important because without this what you end up giving patients is basically a historical record of what's going on, but I think that from

both the patient point of view and also the transmission of information to other providers point of view it's important to say what's coming, not just what went before. I was thinking of this in a very simple fashion. When we use SOAP notes there's a plan part of the SOAP note, and the way I was taught at least, and I don't know whether ... actually set it up this way, but that the plan consisted of three parts. It consisted of your diagnostic plans, like what further diagnostic stuff was going to be done. It consisted of a therapeutic plan, which was what were the therapeutic plans going forward, and an educational component, which said what do we need to educate the patient about, or what kind of information do we need to further in terms of furthering the patient's understanding of their illness. So we were actually, on our residency we were required to put it down. I started thinking, that's incredibly useful information, both to transfer back to the patient and also to transfer to other providers. So I'm wondering if we couldn't start thinking of it just in terms of something that we do already, which is the plan part of the SOAP note as being something that becomes an early framework for the longitudinal plan.

**Eva Powell – National Partnership for Women & Families – Director IT**

I've been doing some work on this as well and I couldn't agree more, because if you look at the other federal programs, most of which start during meaningful use stage one, we're already behind schedule on the care planning thing because they all include some element of care planning. Just like Neil said, there is opportunity also in the hospital setting in existing processes to build on those, or at least connect those. I was talking to some folks yesterday and it seems like it's pretty standard in hospitals to have as part of order sets a pre-care or a pre-admission planning kind of document and then the self-care as part of the discharge instructions document. But part of the problem in the hospital is that those things are done completely in isolation. If we can somehow work through the criteria of meaningful use to tie those things together, then that would be a huge step towards care planning, at least for planned admissions, which I think is roughly 60% of admissions in most hospitals. So I think there's huge opportunity there that we would really be remiss in not taking advantage of.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

So here I think we're talking about a longitudinal care plan, which is a little different than the plan for the admission. A lot of the comments said things like there are other data and other specifications like the problem list or allergies, and the problems and the allergies are not really a longitudinal care plan. It's a looking ahead thing, as Neil was discussing.

**Eva Powell – National Partnership for Women & Families – Director IT**

Right. I guess what I'm thinking is that that's part of the difficulty of this is how do we get to that long term plan when there are a lot of pieces of that that are yet to be developed? But if we can get everyone in every setting thinking more longitudinally, as Neil said in the eligible provider setting and then in the hospital setting, think longitudinally. If you've got a planned admission, then you need a plan that includes not just the pre-care but also what patients can expect after discharge or expect to do upon discharge for the next couple of weeks. Then ultimately we'll get to that longitudinal plan that is more forward-looking and all-encompassing. But I don't know that it's possible to get there in one fell swoop with one giant step.

**M**

I think even on the hospital side, though, you can basically just to start out simply, building on what exists already. Start off by saying that the discharge plan needs to include what further diagnostic tests are going to be done after discharge, what the therapy is that somebody's being sent out with, and what further educational interventions need to be made. People need to be taught how to use insulin or whatever other things and we could add a referral part. But I'm saying that I think that a lot of the pieces of this exists already. Like, for example, people are putting in orders for these things, so it's a matter of organizing it in a way that's useful to other providers and also to patients themselves.

**M**

For discharge planning, discharge instructions, wouldn't that be specified by the Joint Commission?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I think that will be specified in a different place. Charlene, what are you hearing about this one?

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

The main feedback is pretty much right on target. It is not defined as a standard. The providers pretty much say if you tell us what it is we can feed it. Now, there are some dependencies in the local systems of having, again, this care plan, the shared goal and all those kinds of capabilities in there of having infrastructure in the system today to be able to do that. It's mostly the enterprise systems. I think less so in the ambulatory systems. Again, with medical home that's emerging, so I think there's some development work that's going to have to be done so it can be fed. So if in stage two we can start moving toward what that standard looks like, because it is a shared care plan then I think it's going to be possible to feed them. But I think it's going to be a stretch to get there definitely in stage two and I think we're going to have to work hard to get there in stage three.

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

In some sense the state of health reform, e.g. ACOs, will create the value proposition for this thing and also by stage two hopefully we'll have much more of an HIE infrastructure. So in a sense, although we'd like to have some kind of ... platform in stage two, it's pretty hard to nail down right now.

**Christine Bechtel – National Partnership for Women & Families – VP**

Paul, let me make sure that we understand the timing here. When you look at ACA the medical home demos and things they've started, right, so they're in play. We've got the community based care transition program that started this month and it goes on for the next, like I said, I think five years. We've got the ... on federal payment for Medicaid HACs, the hospital acquired conditions, that starts in July of this year. There's the data for home-based primary care team starts in January. Medicaid and CHPE ... pilot January 2012, and an ACO demo January 2012. So Eva is right, this all starts in 2012, which is still stage one of meaningful use. My concern is that we don't lay some kind of groundwork. It doesn't have to be the perfect longitudinal care plan that travels with the patient forever and ever in stage two, but it needs to be something that is more forward-looking. We're going to have health IT, let's leave aside what's the best thing for providers and patients here. We're going to have health IT systems that aren't going to be ready to meet what these programs are already doing now and coming next year. So I think that's really the challenge.

As I look at the common elements that some commenters suggested, a number of them could be pulled already from the view and download functions for both hospital and EPs in the patient and family engagement section. It's really a question of how do we establish goals of care, maybe look at barriers to care, DME and supplies needed, follow up or specialty visits, which frankly should be able to be pulled from some of the referral information off care summary, I think we've got a lot of it. It's just a question of two or three smaller pieces, right, list the care team members we have. So I'm just trying to think of a middle ground so we establish a couple of elements that by stage three we say, okay, this is stage one, you did that in stage two, and in stage three all we're really doing is pulling it together in one place. Does that make sense?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

That's what I was thinking is that this would largely be, we'd make it really easy to meet, you just have to have a place to put the longitudinal care plan. You would not be too specific about what that looked like. We could certainly ask that it include things like goals and barriers. We would specify some high priority health conditions, like congestive heart failure.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes.

**Marty Fattig – Nemaha County Hospital – CEO**

It would appear to me that this would be something that would be developed by the practicing physician or the physician in charge, and therefore I'm wondering if this really needs to be a hospital objective at all or if that can be developed by the primary care physician or the eligible provider.

**Deven McGraw – Center for Democracy & Technology – Director**

I think ONC we ..., it seemed to me that somebody told me in the last month or so that as part of the standards and interoperability framework that there is a use case for the technical fields related to a shared care plan, and I don't know if that's the same as longitudinal. But I think there's enough that we can just add a couple of pieces, as David has suggested, and be flexible about how we do it

**Josh Seidman – ONC**

I think that there is work being done. I'm not sure what the status of that is.

**Christine Bechtel – National Partnership for Women & Families – VP**

Maybe for Monday we can find out.

**Josh Seidman – ONC**

Okay.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Do you know who's doing that, Josh?

**Josh Seidman – ONC**

I will check on that.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, because I can't remember.

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

On this piece, again, I know the flexibility is going to be key. The other thing, though, is it ties to certainty. I just know how things spin around when we're less clear, so if there's any, I mean, those things that are restructured and know about, we can point to those. These other areas are a bit more ambiguous, and those are exactly the questions that they get. Well, what's the goal? What's the objective and all those kinds of things? Anywhere we can add certainty to this process will help.

**Christine Bechtel – National Partnership for Women & Families – VP**

I agree. I think it would make sense for somebody, I don't know if it's Josh or who, but to off line if we look at the list of the things that the commenters suggested and then maybe get a sense for what the S&I framework is looking at, I think we would have a table with two columns. One is, what's the data that we've already been asking to be collected under stage one or proposed in stage two, and therefore should not be restructured, and what's the new data that we would really need, and then look at those specifically and try to figure out some definitions that are clear enough but offer some flexibility. We can do that for Monday.

**M**

Yes.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Okay. So have we reached consensus around this? George, you were nervous about it.

**George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair**

It's just a matter of timing for me of whether it's feasible. I like the idea.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes, I really do too. Christine, and Eva et al I'm glad you pushed this.

**W**

Our pleasure.

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

I think that wraps up care coordination, Paul.

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

Good. Well, thank you very much, David and group. Let's summarize. I think we've gone through as much as we can today and what we've queued up for May 2<sup>nd</sup> is category two and the public health ... regarding lab and conditions, reportable lab and conditions. Then this extra piece we just talked about ..., we've got to find out what existing work we draw on to specify what would constitute the beginning of a longitudinal care plan. Did I hear that correctly?

**David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine**

Yes.

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

Okay. Any preparation for the May 2<sup>nd</sup> call in addition to what we listed for homework coming out of here? Anything new for category two that we need to distribute before that call?

**Christine Bechtel – National Partnership for Women & Families – VP**

I know that we distributed a timing document. If that's something that's on the agenda for the in-person I'd like to suggest, I have a lot of questions when I read it. It wasn't really clear. The statutory document was very hard to understand, but on top of that I think cleanly laying out the options that we have discussed or any new ones so we can have a second to think about that might be also very helpful. I don't know if that's on the agenda for the workgroup in person though.

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

Timing is one of the main objectives for the face-to-face.

**Christine Bechtel – National Partnership for Women & Families – VP**

Yes. So I think some work around helping us all think through that in advance because this is very complicated.

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

Correct.

**Marty Fattig – Nemaha County Hospital – CEO**

Was a summary of the last face-to-face meeting sent out? This is Marty.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

I think the transcript's on the Web site.

**Marty Fattig – Nemaha County Hospital – CEO**

Thank you. I'll download it from there. Thank you very much.

**W**

Judy Sparrow sent this morning a slide deck that I don't understand the coloration codes, but it does have a summary of the things that we did decide, or at least best understanding.

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

So we can update that with today's discussion going into the face-to-face.

**W**

Yes.

**Marty Fattig – Nemaha County Hospital – CEO**

Thank you very much.

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

Josh, talking about preparation for face-to-face, you were going to prepare a crosswalk of the National Quality Strategy and the ACO and CRM for the face-to-face, right, so that we understand how we are already aligned and how we can realign with some of those objectives?

**Josh Seidman – ONC**

Correct.

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

Charlene, I think you were going to talk some about what's already in place, at least in the ... industry?

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

Yes, and I was going to try and use hopefully some of the conclusions that came out of the document that was shared today as the basis for that.

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

Because that will feed into the timing.

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

Yes.

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

Great. Any other remaining business before going to public comment? Okay, thanks for a healthy discussion. So let's open up the lines for public comment, please.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Yes, operator, can you please check and see if anybody wishes to make a public comment?

**Operator**

We do have any comment at this time.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Okay. Thank you, everybody.

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

Thank you to the staff for the preparation, and thank you to the workgroup for another meeting with a rich discussion, and we look forward to talking to you on Monday and seeing you on Tuesday.

**Judy Sparrow – Office of the National Coordinator – Executive Director**

Great, thank you. Bye.

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

Thank you.

**M**

Thank you.

**M**

Bye, Paul.

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

Bye-bye.