Meaningful Use Workgroup
Draft Transcript
December 15, 2011

Operator
All lines are bridged Ms. Deering.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Thank you very much. Good morning. I am Mary Jo Deering in the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Meaningful Use Workgroup. I'll begin by taking the roll. Paul Tang?

Paul Tang – Palo Alto Medical Foundation
Here.

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

George Hripcsak – Columbia University NYC
Here.

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

Michael Barr – American College of Physicians
Here.

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

Christine Bechtel – National Partnership for Women & Families
Here.

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

Arthur Davidson – Denver Public Health Department
Here.

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

Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)
Here.

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

Joe Francis? David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

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

Greg Pace – Social Security Administration
Here.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Latanya Sweeney? Rob Taglicod? Charlene Underwood?

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

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Amy Zimmerman? HHS Staff present?

Josh Seidman – Office of the National Coordinator
Josh Seidman.

Allen Traylor – Meaningful Use Policy Analyst – Office of the National Coordinator
Allen Traylor.

Lauren Richie – Project Manager, Performance Measures – National Quality Forum
Lauren Richie.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
And have I missed anyone? Okay, Paul over to you.

Paul Tang – Palo Alto Medical Foundation
Well, thank you very much Mary Jo. And thank you all for participating in this call pre-holiday. I want to start out by one thanking Allen and I know Josh wants to make some words too, but thank you so much for all of the hard work you've put into both the HIT Policy and the Meaningful Use Workgroup in particular, and most recently on this massive review of the AMAs document regarding the specialty input, but thank you so much for all of your help and best wishes on your new job.

Allen Traylor – Meaningful Use Policy Analyst – Office of the National Coordinator
Well thank you, Paul, I really appreciate it. I've really truly enjoyed the work, working with this committee and I'll continue to follow your work as you guys move forward.

Josh Seidman – Office of the National Coordinator
Yeah, and this is Josh. I just really want to give my thanks for all of Allen's work. Sometimes people may not know behind the scenes everything is getting done and Allen has been an incredibly important part of the support over the last 2 years for the Meaningful Use Workgroup. So, everybody may not know how important he has been but he's really been invaluable to our team.

Paul Tang – Palo Alto Medical Foundation
Thanks very much.

Neil Calman – The Institute for Family Health – President and Cofounder
Hi, it's Neil Calman I just joined.

Paul Tang – Palo Alto Medical Foundation
Thank you.

David Bates - Brigham & Women's Hospital & Partners
David Bates I just joined also.

Paul Tang – Palo Alto Medical Foundation
Great, thank you David. Okay, a brief overview of the agenda and what we want to accomplish for this Workgroup. We're going to hear from our two small Workgroups, small groups, one is on the clinical quality measure and the other is from the specialist, remember that these are two things, these were two hot issues that came out of our hearing and so we wanted to drill down a bit on that and get some feedback and some draft recommendations for consideration by this wider workgroup, uncover any other plans we might have, let's say for hearings, other information gathering kinds of activities, and then although I was thinking we were going to talk about work plans, I had raised some timing question with Farzad and had not heard back yet.

Maybe Josh knows, but originally our plan was to meet up with the 2012 timetable for Stage 3 and working backwards and getting 18 months, you know, and it's less than 1 year of clearance time for HHS, would put us in the middle of 2012, and we would have to our recommendations. That seems early, but as you know, it does take quite a bit of lead time, not only for development of a new functionality that might be included in the Stage 3 requirements, but also getting it developed and getting it implemented in the provider groups.

The other thing that's coming along with Stage 3, and David Lansky might have something to say as well, is the push towards more meaningful quality measures and a lot of the concepts were introduced and proposed back, probably I think in the middle of the year when David Lansky's Quality Measure Workgroup put forward their recommendations and that is sort of in the process.

So, some of the things that we're asking for or at least we're thinking about as dates, we have a much longer lead time and that is why we wanted to get it out as soon as possible by trying to update our timeline with Farzad and I don't know Josh whether you want to comment with the Secretary the new finalization of the start point for Stage 2 with the early adopters, they really followed up our recommendations to move the early adopter Stage 2 date back to 2014. Josh, do you want to add anything to that?

Josh Seidman – Office of the National Coordinator
I mean, all I'll say is, you know, there will be, you know, additional detail when the NPRM comes out about the proposed timeline going forward.

Paul Tang – Palo Alto Medical Foundation
Okay. And the Secretary had already announced that the timeline for that one was February. So, that may be one when we get that information or at least the proposed timeline, then we may have to adjust our work plan and plan around that. So, anyway, I sort of moved that agenda item up. I wanted to sort of frame our timing and I think we do have more time than we thought probably to be able to do a good job with Stage 3 and that's important because it's probably going to look significantly different from the pattern we have done with Stage 1 and 2. Okay, any other editions to the agenda?

All right, why don't I start out with an update from our Clinical Quality Measures Small Group and that was just sent out this morning, a summary and what we did was we based it on the hearing, as you know that was probably the most popular thing to comment upon at the hearing, so we did a couple of iterations. We had already presented to this group once before and in fact, we gave a summary of the hearing to the full HIT Policy Committee. So, we've taken the input from the hearing, we've taken the input from this group and both committees and put together this revised set of recommendations, a lot directed towards

sort of philosophy and principles, and some directed towards the Quality Measure Workgroup, which I think is going to be meeting pretty soon.

So, the preamble sets it up as this is, you know, where did we get this information, what was the public feedback and then talked about our intent to line up with the CMS, the new CMS programs and health reforms, those are things like accountable care organizations, medical homes, reporting of requirements, et cetera. Keep it aligned as really the public wanted us to with the new changes and sort of signaling the changes in the payment system and value base purchasing. Everybody has been talking about aligning the quality measures specifically.

So, we re-endorsed, I'm just sort of walking through the high points of these 6 recommendations, we re-endorsed the core and menu selection category domains that the Quality Measure Workgroup had proposed. We sort of re-emphasized the alignment with one of the things called out in ACA is this measure application partnership that is hosted by NQF and Christine, at least, is on that and so we're trying to stay very much aligned with that to keep these quality measures harmonized. So, it's a lot easier to harmonize them at the front end than try to reconcile them on the back end.

As part of our understanding of the challenges that the organizations went through in qualifying for Stage 1, certainly reporting on quality measures was one of them, and a lot of vendors chose to hardwire their calculations in their certified systems. A couple of things that happened then, one is it is hardwired and so any tweaks, whether it's because of a difference in interpretation or even an error made in its calculation, that causes a new release and that causes a lot of new work for the provider organizations.

The other thing is, well gosh when a vendor decides how they're going to calculate it that may or may not fit in the workflow of the individual organization. It would be nice to have a way to evolve both add new measures and to evolve existing measures in a way that's not nearly as disruptive as it currently is. So, a major part of the recommendations from the small group is that there become, in the sense a CQM platform in which you can just make changes in your measure plug-in in a sense. You plug these measure definitions into this platform and you can plug new measure plug-ins into it or tweak some existing ones and hopefully this will be at a systemic level, meaning nationwide.

So that's the direction we're heading and got a lot of favorable feedback on that. We would want to notify the HIT Standards Committee as early as possible so they can start thinking well how would you do this technically. Clearly this would be a change and fortunately we do have 4 or 5 years before the Stage 3, but we want to try to get that signal out as early as possible.

The third recommendation is incorporating patient reported data. This is following the lead of the QRM Workgroup. So, that requires more thinking. How do you get patient reported data into your system in a way that protects the confidentiality of the individual, yet gives providers that sort of near real time feedback? But that's good work in the sense of both the development side as well as the measurement side.

Fourth is continuing on the theme of measures that matter to patients and how can, I the patient, know how I would be treated in a healthcare organization. And so the notion of delta measures, which again came out of the QRM Workgroup as well, is how does an organization treat individuals and what percent of the individuals in that person's panel are improved, for example? Versus do you just look at the average population meeting a goal?

The fifth one has to do with using the demographics that we required in Stage 1 to start stratifying the results, and I think there is a question should it be a small number or a proportionate number, I think, actually, I would even edit this now to just say sum and it's sort of up to the discretion ultimately of the Secretary how many, but I don't know that you need to have the stratified for every measure, but there is the ability and that's really what we always suggest is when we use a word, even if it's for a single measure, that automatically means that the system has to do it according to the certification criteria. So, the notion that some measures are you can with your certified system produce this in a stratified way is important. A similar thing for the information exchange. Clearly people are going to need for accountable

care organizations to combine data across business entities and we need better support of that from our EHRs.

The next one has to do with this whole notion, and we heard a lot about this in the hearing, that most organizations do their reporting outside of the EHR just because EHRs are more designed for patient oriented transactions. And that caused a little bit of a bind, because the qualification criteria ask people to report out of their certified EHR. So that actually would either cause people to have to certify their reporting mechanism or use the hardwire calculations in their EHR. So, we were suggesting that as long as you subject the method to an audit, that the organization and providers should be able to use non-certified systems to generate the CQM reports as long as all the data comes from a certified EHR. And similarly, this is a reaction to the response to the hearing data that, well gosh vendors not only had to certify only 9 out of the 44 measures as being reportable, they weren't required to even make sure that they were accurate against some standardized test dataset. So we're recommending that this be something that be fixed or addressed.

So, that is like a high-level overview of the recommendations that we had out of our small group. I want to welcome anybody in the small group to comment on that or for the Workgroup discussion before we advance this on to the Quality Measure Workgroup and HIT Policy Committee. Comments, questions?

Neil Calman – The Institute for Family Health – President and Cofounder
Paul, how does that list that you just ran down relate to the stuff that that we were e-mailed this morning?

Paul Tang – Palo Alto Medical Foundation
It's the same.

Neil Calman – The Institute for Family Health – President and Cofounder
I'm confused. Well, there's 8 items on there.

Paul Tang – Palo Alto Medical Foundation
I thought I did 8.

Neil Calman – The Institute for Family Health – President and Cofounder
Okay. So do you want comments on individual items that you went over?

Paul Tang – Palo Alto Medical Foundation
Sure, sure.

Neil Calman – The Institute for Family Health – President and Cofounder
Is that what you're looking for?

Paul Tang – Palo Alto Medical Foundation
Well why don't we organize ourselves and do it one at a time. Presumably, there's nothing new on number 1, sort of re-endorsement and alignment.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Paul…repeat them again, this is Charlene, I'm processing multiple e-mails.

Paul Tang – Palo Alto Medical Foundation
Okay. And apologies for that. So the first one I'll just sort of highlight it, the top one, basically we re-endorsed the domains that the Quality Measure Workgroup came up with and their notion of core and picking at least one from each of the domains and saying that we should align with those that are aligned quite well with the National Priorities Partnership and we're asking for further alignment with the MAP Measure Application Partnership. That addresses the alignment parsimony…So the second one has to do with the CQM platform, which will be a technology development project, but it's, I think it's the number one thing that people were concerned about. And certainly if it existed would introduce a lot efficiency in the overall system. Comments? Questions?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Paul, this is Charlene, on this one we actually, I have really two points to make on this one. Number one, I think, and again, I've been kind of communicating with Marc Overhage on this because I know he was on your committee okay again there's the concept of having a place to be able to add new measures to, again, makes a lot of sense and it's kind of a development strategy. So, to some extent, prescriptive, but we're certainly not objecting to that as a strategy, however, and I think this was discussed in the Workgroup quite a bit, being successful is really dependent on the measures that are actually selected, and I don't think we want to constrain the measures.

So, even if you import a new measure, there's an implication that the data to be able to support that measurement has to be captured in the workflow, so therefore, it's easy if you have measures, you add new measures where the data is already collected and collected in a way that's necessary to calculate the measure. However, if you add new measures where it's outside the scope of, if you will, what's in the platform, new data flows have to be created and measures outside of what's normally captured in an EHR have to be created, the data is not standardized, all of those types of issues, there's additional dependencies that have to be met to make this successful. And I think that needs to be clarified in the recommendation and it's my understanding that was pretty heartedly embraced and acknowledged in the discussion.

Paul Tang – Palo Alto Medical Foundation
That's such an excellent point, Charlene. Can I just expound on sort of the vision of how things in the world might work? As you know, in parallel NQF is moving toward e-measure specification even as a requirement. So, in the future, sometime in 2012, probably towards the latter part of 2012, there will be a requirement that measure developers must submit an e-measure specification if they use data from an EHR. Over time, you also know that there is this thing called the quality data model.

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

Paul Tang – Palo Alto Medical Foundation
Over time, and maybe what happens is you have this platform and you start off with only a few measures that qualify as you described, Charlene.

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

Paul Tang – Palo Alto Medical Foundation
But over time more and more, because it would be in everybody's best interest, everybody from the providers, the creditors who then would be able to get this information in a more timely basis, etcetera. You would want to encourage the development of e-measures that fit the requirements you just enumerated and the data elements and the metadata about those data elements would be stored in this quality data model. So, yes, I think the caveats are you're saying clearly not all measures could even fit the requirements of being a plug-in, but if it exited, then hopefully that would be inducement to have more and more measures to test. Does that make sense?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Yeah. I just think those caveats, I think we have talked about them, there are other dependencies that have to be met. We've got a vendor that actually tried to build one and the measure specs didn't work, the data couldn't be found, all those kinds of things were the challenges that they faced.

Paul Tang – Palo Alto Medical Foundation
Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
So, those just need to be clarified in the recommendations and dependency.

Paul Tang – Palo Alto Medical Foundation
Exactly. Okay. Someone else was going to say something?

Neil Calman – The Institute for Family Health – President and Cofounder
Yeah, this is Neil. Two things. One of them is I think that, and pardon my ignorance on this subject, but I want to make sure that we're capturing the issue that we've talked about multiple times, about the measures being reported in ways that are actionable by the providers and not just sort of looking at sort of the external reporting kind of issue. And for that, I think what we want to do is make sure that we're not just developing a platform that allows the quality measures to be reported, but allows them to be used. And so there are two things about that. So that's one point. I don't know how to put that in so that it's more explicit.

And my second point is that I think that we should specify that irrespective of the definition of the quality measures, all of them need to be reportable, stratified by any of the required demographic characteristics. And the reason for that is because that really dictates a lot about the types of programs that people put in place. By geography it gives you opportunities to, you know, to work with populations and, you know, we've talked about the fact that there is not a lot in our requirements that really deal with population health. So, I think we should specify the fact that those are required and I sent this morning a list of the new sort of demographic capture requirements from HHS, but I think even beyond that, you know, we ought to be able to report on these patients and measures, and stuff like that for specific populations.

Christine Bechtel – National Partnership for Women & Families
Yeah, Neil its Christine. I agree and one of other things I think we need to call out explicitly is data collections around sexual orientation and gender identity, and this is what the IOM recommended in March, that Meaningful Use begin to collect those standards and I know the Office of Minority Health has been doing a lot of work on this. The National Center for Health Statistics has been doing some data collection through like phone surveys, but IOM suggested we incorporate it into Meaningful Use and I think that's a great idea.

Paul Tang – Palo Alto Medical Foundation
So, let me take both of those recommendations. So, Neil, recommendation number two, the CQM platform was actually intended to address the issue you talked about, actionable QMs because then some of the plug-ins could be QI, it is not explicitly stated but I certainly can add that to that. And then the second one that you and Christine talked about is in number 5. One, is we can also make sure that the implication is that once you require that some be reported out and stratified, that basically turns into a certification criteria so that is all, but we can make that explicit as well.

Neil Calman – The Institute for Family Health – President and Cofounder
Yeah, I read 5 as a requirement that is at least a few of the CQMs should be required to be reported out, stratified, and what I was combining sort of number 2 and number 5 in saying that we should have the ability to do it for all, but I don't want to lose 5 as sort of a requirement that for some it should be, you know, sort of required.

Paul Tang – Palo Alto Medical Foundation
Correct. So, I'll make it explicit, one, we're creating the certification criteria that EHRs are capable of doing this and in addition 5 is saying and some of them should be spelled out.

Christine Bechtel – National Partnership for Women & Families
Yeah. And also, you know, say again, and I know I've mentioned this before, but I think it was on e-mail, that I think that for number 6 where it does say a small number should use information exchange, you know, we're a lot less advanced I think in that area, but we're much more advanced for number 5 in terms of reporting out disparity variables, so I just still don't love the reference to a small number. I mean, I agree that it's some and it's maybe not all and I think Neil's suggestion helps us, but I just think optically we ought to be more advanced than that, given the work we've already done in Stage 1 and hopefully in

Stage 2. So, I would go back to a proportion or, you know, whatever, but I just don't love the small reference.

Paul Tang – Palo Alto Medical Foundation
Yeah. That's why I was proposing change to some.

Neil Calman – The Institute for Family Health – President and Cofounder
Yeah, that's good.

Christine Bechtel – National Partnership for Women & Families
Oh, yeah.

Paul Tang – Palo Alto Medical Foundation
Okay.

Michael Barr – American College of Physicians
This is Michael Barr, just a quick comment on that particular one. It also has to be clinically relevant.

Paul Tang – Palo Alto Medical Foundation
Correct.

Michael Barr – American College of Physicians
The number is not appropriate or even to best scale; it's when it's appropriate to stratify by patient characteristics. It may not always be so.

Paul Tang – Palo Alto Medical Foundation
That's part of why I'm saying "some."

Michael Barr – American College of Physicians
Oh, no, but some implies a number without any criteria associated with it. So, you know, that's why, I understand not all, but I think some also doesn't give the idea that it has to be relevant to the particular measure.

Christine Bechtel – National Partnership for Women & Families
Michael, could you just help me understand a little bit more about it, do you mean like in circumstances where you don't have a significant number in the denominator or the numerator to report or what do you mean by clinically relevant?

Michael Barr – American College of Physicians
I mean it may not be, I don't want to get bogged down to it, but it may not be necessary to stratify by a disparity demographic or clinical severity of illness. It may just be a measure that applies to everybody so why would you need to stratify it?

Arthur Davidson – Denver Public Health Department
This is Art. Wouldn't you just want to be able to stratify to find out if it's true or not that you don't.

David Bates - Brigham & Women's Hospital & Partners
Right. Often you do that. This is Dave. Although, the primary report might not be stratified and, in fact, typically is not.

Paul Tang – Palo Alto Medical Foundation
So, go ahead.

Neil Calman – The Institute for Family Health – President and Cofounder
Well, I mean, you're first going to do a report but then if you want to understand its relationship to any of the demographic characteristics then you report it stratified. Is that what you're saying?

Arthur Davidson – Denver Public Health Department
That's what I was saying.

David Bates - Brigham & Women's Hospital & Partners
Yeah.

Neil Calman – The Institute for Family Health – President and Cofounder
That's what I thought you were saying, yeah.

George Hripcsak – Columbia University NYC
Paul, this is George, when we say report out, are we talking about report to CMS, which was the original purpose of the CQMs or do you mean in the user interface to the doctor?

Paul Tang – Palo Alto Medical Foundation
In number 5 it's to CMS.

George Hripcsak – Columbia University NYC
So, if this is a recommendation to CMS.

Paul Tang – Palo Alto Medical Foundation
Correct.

George Hripcsak – Columbia University NYC
They should ask for it stratified.

Paul Tang – Palo Alto Medical Foundation
Correct.

George Hripcsak – Columbia University NYC
By patient characteristic. It is not a recommendation. And then of course everything follows and you have to be able to certify that it's possible.

Paul Tang – Palo Alto Medical Foundation
Correct.

George Hripcsak – Columbia University NYC
I understand that but it's to CMS, all right.

Paul Tang – Palo Alto Medical Foundation
And then number 2, to talk about Neil's issue that he raised is we want one of the reasons for having this flexible platform is so that individual organizations can use quality improvement things on things that are of high priority in their local situations. So, this platform just gives us a lot of capabilities.

Neil Calman – The Institute for Family Health – President and Cofounder
So I would suggest, Paul, that we relook at the preamble.

Paul Tang – Palo Alto Medical Foundation
Okay.

Neil Calman – The Institute for Family Health – President and Cofounder
Because the preamble sort of, you know, and maybe that's what sort of threw me off the first time. I'm just re-looking at it now. Maybe we should really clearly specify in the preamble that we're looking at 3 objectives, at least 3 objectives for quality measurement, you know, reporting for the purpose of the programs that you mentioned accountable care organizations, medical homes and others.

Paul Tang – Palo Alto Medical Foundation
Yes.

Neil Calman – The Institute for Family Health – President and Cofounder
Public, you know, public reporting, which is what we're talking about, and also internal use for quality improvement within organizations.

Paul Tang – Palo Alto Medical Foundation
Okay.

Neil Calman – The Institute for Family Health – President and Cofounder
And maybe specify those and that not all of the recommendations below are relevant but offer those things.

Paul Tang – Palo Alto Medical Foundation
Excellent point, that's a really good point. Okay. Anything else on number 2?

Josh Seidman – Office of the National Coordinator
This is Josh, I'd just say that the issues around this are something that ONC and CMS have been working on and, you know, do intend to work on with the Health IT Standards Committee's Clinical Quality Workgroup that is working on the very technical standards around e-measures.

Paul Tang – Palo Alto Medical Foundation
So maybe this is the kind of thing, I am glad they're already working on it, that we may want to bring to our thinking to them fairly early to make sure we're in line and make sure we give them enough heads up, because this is going to be tough, as Charlene was saying.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
And Josh, this is Charlene again, I think the vendor association, again, these are not recommendations for Stage 3, they were more on point in terms of what needs to be addressed, but I do know that HINTS has also done some, you know, root cost types of analysis in terms of how to make this improvement. So we'll forward those to those committees.

Josh Seidman – Office of the National Coordinator
Yeah.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Those are the dependencies I think we're talking about that need to get sorted and we still have a gap if it's a new measure that's added that's not in the context of, you know, the current workflow or the data is captured, you know, from a patient. We've got sort through some of those things.

Josh Seidman – Office of the National Coordinator
Yes.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
And that is where I get a little nervous, but we have to have those discussions.

Josh Seidman – Office of the National Coordinator
So, I think we're pretty well aware of the vendor input. Jacob Rider, who is now at ONC.

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

Josh Seidman – Office of the National Coordinator
Is leading a lot of this work.

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

Paul Tang – Palo Alto Medical Foundation
So, maybe we can talk offline about how do we try to get a critical mass of thinking around this to go forward with strategies, almost like a, because we have to consider the vendor development time, the standard specifications, the user needs, the whole actionable that Neil points out, it seems like there is a group of kind of perspectives that we need to get in the room to know even what we know and don't know to move forward. It's a big task. Okay, so it looks like we're, a lot of people like that direction, we just have to figure out how to get this moving and implemented in the next few years. Any comments on number 3? I think that is basically supporting the QM recommendations and basically getting into the certification criteria.

M
Yes.

Paul Tang – Palo Alto Medical Foundation
I also thinks that still needs some work in terms of, you know, what is it, how do you incorporate it, you know, how do you make it synonymous so people can, all kinds of things. Anything new on number 4?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Paul, this is Charlene, back on 3 again, patient reported data could be reported outside of an EHR, so for instance if there was, you know, a health information exchange that was community centric, that's the piece that makes it challenging. I think it is where does this data get reported from. And then it aligns to that certification.

Paul Tang – Palo Alto Medical Foundation
Correct.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Because you want to be open to capturing that in a lot of different ways.

Paul Tang – Palo Alto Medical Foundation
Right.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
So that has to be thought through. I don't even have a recommendation for it.

Amy Zimmerman – Rhode Island Department of Health & Human Services
This is Amy and I joined the call late, I'm sorry about that, but I agree that one needs to be thought through, because I think there are, depending on what the requirement is in terms of where people want to capture their data, there are so many choices that assuming that patients will want to put their own data into multiple different EHRs, I just think that this requires a lot of thought. I agree.

Paul Tang – Palo Alto Medical Foundation
It does, I totally agree as well. The one question when we think about how do we move this forward, do we have a sort of a summit working group or do we have a hearing with the different perspectives?

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise
Hi, this is Leslie. Sorry to join late and the newbie, but I do think this is worth a subgroup working on.

Paul Tang – Palo Alto Medical Foundation
No, I'm talking about actually 2 and 3, both of these things require major development, major standards.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise
Right.

Paul Tang – Palo Alto Medical Foundation
I almost think that there is a multidisciplinary workgroup that includes vendors and operationally, Josh, do you have any advice there? You know, we may want to, maybe we could have the chairs get together and see if we can convene this cross committee work group?

Josh Seidman – Office of the National Coordinator
Yeah. I think that makes sense.

Paul Tang – Palo Alto Medical Foundation
Okay, we'll talk about it more offline, but clearly these are huge payoffs, but also a lot of new work that has to be done.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Paul, the question I would have on 3 is if I gather this measure development process is happening to support 2, if a measure that uses patient collected data was necessary, would that be caught earlier in the process, and that it would be looked at in terms of what the source of that data is? Wouldn't that just be considered part of that process? And then the tradeoff would be made could we capture it or not and is it valuable or not?

Paul Tang – Palo Alto Medical Foundation
I'm not sure I'm following you.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Is it upstream a little bit, that was all kind of thinking it through?

Paul Tang – Palo Alto Medical Foundation
Which is upstream?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Well, to be able to accomplish 3, is it really part of the process that we need to put in place for 2 in terms of like when those measures are defined and, you know, if it comes out the accountable care process, the map process, then we need this data, then there's an analysis that looks at where you can you can get the data, right? And then there's a value that's made in terms of could we get it not, right? And then it starts to flow down through the process. So, it wouldn't make it through accreditation until we made sure we could get it, you know, and the infrastructure was in place, I guess is kind of what I was thinking.

Christine Bechtel – National Partnership for Women & Families
Paul, its Christine. The folks that I know who are doing this are the folks up at Dartmouth and Jean Nelson and John Lawson and others, and I think I mentioned before too that ONC has a pilot going with a beacon up there and I think that's right and Dartmouth around the electronic collection of patient reported data and how it gets integrated into EHRs. So, it we're not totally sure about the landscape on this we might ask them to brief us on a future call.

Paul Tang – Palo Alto Medical Foundation
So, I'm wondering if we used the strategy of, I think there's a whole lot we need to sort of level the playing field in terms of information and maybe there's a very rich hearing where we just understand one, some of these issues, two, what work is going on, and then we go into probably an all-day, and this is a combined group, an all-day post hearing workshop where we try to understand the issues and then figure out how to deal with them and what would have to be done in order to prepare for such kinds of a requirement and it may go beyond Stage 3.

It sounds like there is a lot of interest. We need to learn a whole lot more, all of us get on the same kind of awareness and knowledge platform so that speaks more towards an informational kind of hearing and then start working on that. And then it may get passed off. So, let's say this is a good idea, these are the thing that have to be worked out, these are the stakeholders that have to be at the table and then some

other group, I don't know, whatever group it is that's already in the private or public sector continue work on that, and we continue to signal these are sort of the goals we have in the Meaningful Use Program, and of course that still can extend beyond Stage 3. Okay, good discussion. Number 4, this is the delta measures.

Neil Calman – The Institute for Family Health – President and Cofounder
Paul, this is Neil. In the way you described it when you were going through it, you kind of, you described it as sort of one of the ways in which measures could be reported in a manner that was digestible by the public.

Paul Tang – Palo Alto Medical Foundation
Yes.

Neil Calman – The Institute for Family Health – President and Cofounder
So I just didn't want to confuse those two issues. Because I think delta measures have multiple uses not just for that, but also as an alternate way of looking at quality.

Paul Tang – Palo Alto Medical Foundation
Yes.

Neil Calman – The Institute for Family Health – President and Cofounder
And second of all, I think maybe we should call out something about patient reported measures if that's something we're expecting. So, that's why I suggested maybe we put something in the preamble, but also, we haven't really talked about which of these kinds of things might be conducive to that and maybe that's beyond the scope of what we should be talking about today, but at some point, we need to be thinking about the different uses of the measures.

Paul Tang – Palo Alto Medical Foundation
That's a good point. I can include that in this description and as you alluded to, we're sort of passing this off to the Quality Measure Workgroup.

Neil Calman – The Institute for Family Health – President and Cofounder
Right.

Paul Tang – Palo Alto Medical Foundation
David Lansky, anything more we should be adding to some of these things that are headed your way?

David Lansky – Pacific Business Group on Health – President & CEO
No, I think this is a good discussion and all the further work to be done is well-taken and I think, at this point, if we have an agreement about these principles and as you said a minute ago, Paul, the direction we want these measures to evolve, then there is another work plan to follow about how do we flush out and respond to the issues that people have mentioned.

Paul Tang – Palo Alto Medical Foundation
Yeah.

David Lansky – Pacific Business Group on Health – President & CEO
I do think there's a little bit, and Neil is putting his finger on it, not a confusion, but multiple objectives and we tend to mush them together between the value of some of these data types for clinical feedback and use and the value of these same data types for external reporting. And maybe there's a preamble statement that says those are both important, they require somewhat different capabilities, and we want to address them both in the further work.

Paul Tang – Palo Alto Medical Foundation
I think that was an appropriate suggestion you made about moving it up to the preamble so that we can understand that we have multiple purposes in line.

Neil Calman – The Institute for Family Health – President and Cofounder
I think what David said, and I would jump in again for a second, to say that we haven't really had the discussion about what measures are most relevant to a public, you know, that would be concerned about the quality of the providers that they're seeing or about the care they might receive in a particular institution. And I think at some point, we should get some input on that, because we really have been focused on sort of the other use of quality measurement, you know, for sort of, for reporting around programs and funding, and initiatives, and requirements, and things like that. And so, if we're going to really think about this, we really should get some input from people who are sort of expert on, you know, what kind of measures have been publicly reported before? How effective are they, you know, at affecting people's choice and other things like that so that we could really look at this explicitly.

Paul Tang – Palo Alto Medical Foundation
It's an excellent point and fortunately there is another FACA Committee working on exactly this topic. So, NCVH is holding a hearing in February on measures that matter to consumers.

Neil Calman – The Institute for Family Health – President and Cofounder
Oh, fantastic.

Paul Tang – Palo Alto Medical Foundation
Yeah, so what we can do is we'll just get a report out from that and feed that in here.

Neil Calman – The Institute for Family Health – President and Cofounder
Great.

David Bates - Brigham & Women's Hospital & Partners
Yeah, there is a lot known about that, David Bates.

Paul Tang – Palo Alto Medical Foundation
Yes. Okay. We sort of already slipped into talking about 5 and 6, which is to have a certification criteria that would deal with the capabilities to stratify by patient characteristics and to take advantage of information that's obtained outside of an organization system for longitude and care coordination. Then the 7 and 8 have to do with the whole reporting, and so I'm just reconfirming our thoughts that it was probably unintended that people would have to rely on quality measure reporting coming directly out of EHRs versus doing some auditable method of working with the aggregate data outside of the EHR but still being accountable for the fact that it's an accurate report and uses data from the EHR.

George Hripcsak – Columbia University NYC
This is George. Josh, what's the timeframe that we could carry out number 7, which is providers using non-certified systems, using EHR data from certified systems but the system itself that generates the measure being non-certified?

Josh Seidman – Office of the National Coordinator
You know, it's obviously something that's not going to happen in Stage 1. So, I mean it's something we can look to for Stages 2 and 3.

Paul Tang – Palo Alto Medical Foundation
Wow, even Stage 2? It's just, I guess, a change in the Reg, right, you're saying?

Josh Seidman – Office of the National Coordinator
Yeah, for Stage 2.

Paul Tang – Palo Alto Medical Foundation
For Stage 2, okay.

Josh Seidman – Office of the National Coordinator

Something for Stage 2, yeah.

Paul Tang – Palo Alto Medical Foundation
So, now what we seem to be talking about, some of these things are really long-term, like 2 and 3, and some of these are things that could be addressed and probably arguably should be addressed for the very next Stage, like 7 and 8. So, we may want to divide some of our recommendations and give some go ahead and formalize some and give them over to ONC and CMS as part of our response to the NPRM whenever it comes out.

Neil Calman – The Institute for Family Health – President and Cofounder
Paul, am I reading 8 correctly, to say that in a sense aren't we creating like a separate, almost like a separate certification for these non-certified systems that generate reports?

Paul Tang – Palo Alto Medical Foundation
Yes.

Neil Calman – The Institute for Family Health – President and Cofounder
You're creating a mechanism to make sure that they're accurately reporting on the data that's being passed to them. So, we're really sort of calling out for almost like another certification, right?

Paul Tang – Palo Alto Medical Foundation
I think to some extent it's true. Here's the way I was thinking about it and maybe the words aren't there. So, one is as long as you are using, number 7, as long as you're using data out of your certified EHR you can use other kinds of software to generate your reports so long as you're subject to audit and they can come in and say hey, look, are you calculating this accurately? Eight is embellishing that to say one, certified EHRs today, don't actually have to, one be tested in all measures, all quality measures in the program, and two, be tested for accuracy. So, we're saying have that be true and also something to audit, if there's a standard dataset that's published then people who are going to use their own non-certified systems to do the reporting would be asked to use the test dataset to get the answers. It does seem funny and one of the ways I can do this is take out that clause, end providers using non-certified system to generate CQM reports. What happens then that generated sort of a bi for those folks. So it's a little bit hard to get both.

Amy Zimmerman – Rhode Island Department of Health & Human Services
So, this is Amy, am I understanding that for 8 it's really up to the provider to make sure that whatever other tool they're using for the reporting generation does it accurately and uses standardized test data.

Paul Tang – Palo Alto Medical Foundation
Correct.

Amy Zimmerman – Rhode Island Department of Health & Human Services
But it's not a formal certification process.

Paul Tang – Palo Alto Medical Foundation
Correct.

Amy Zimmerman – Rhode Island Department of Health & Human Services
They would have to work with their vendor to make sure that that's incorporated into what they're doing before they use the tool.

Paul Tang – Palo Alto Medical Foundation
Correct.

Amy Zimmerman – Rhode Island Department of Health & Human Services
Thank you.

Paul Tang – Palo Alto Medical Foundation
That was the intent.

George Hripcsak – Columbia University NYC
Paul, this is George. So the intent is that EHRs should be able to do all the CQMs, that way when you buy the product, you know you can you do it and you don't have to have your own system, you can participate in the nation's agenda and then you're also adding that it should be accurate. So, it should be all of them and should be accurate.

Paul Tang – Palo Alto Medical Foundation
Correct.

George Hripcsak – Columbia University NYC
But by number 7 what we're saying is, but if you're someone who is doing CQMs as part of some other big initiative within your medical center, say, only the data our EHR generated you can you go outside the EHR and generate it that way, but then we're saying but that's not going to be, I mean the stipulation that has to be accurate is part of the audit. It's just kind of a part of what you are attesting to, but you don't actually have to go through the certification process.

Paul Tang – Palo Alto Medical Foundation
Exactly.

George Hripcsak – Columbia University NYC
That's what 7 says.

Paul Tang – Palo Alto Medical Foundation
Exactly.

George Hripcsak – Columbia University NYC
So, I don't think we should say that they need to be accurate, because that's already stipulated elsewhere in the attestation that when you send this stuff up that this is accurate to your knowledge and ability or whatever.

Paul Tang – Palo Alto Medical Foundation
Okay, that would argue for...

George Hripcsak – Columbia University NYC
If you put it here, then it may turn into a certification again.

Paul Tang – Palo Alto Medical Foundation
Right.

Neil Calman – The Institute for Family Health – President and Cofounder
Well, this is Neil. I mean let's just use a hypothetical, that, you know, there is an association of cardiac something or others, and they collect all of the data, they offer to collect all of the data from all of their members and create all of these reports and can do that out of a bunch of EHRs. We don't want to require every single person that's passing information into that third party to have to certify or to have to test for accuracy, which is what this would say. Why aren't we just saying that that system needs to be tested for its ability to collect data and report it accurately and that way we're not adding an additional requirement and burden on the providers, but rather, you know, actually making it easier for the providers to meet the requirement?

George Hripcsak – Columbia University NYC
Neil, this is George. I think, I agree except I wouldn't even say it has to be an accurate system. I mean the keyboard that you're typing in has to have the proper keyboard that when you type an "A" an "A" goes into the computer, but I don't want to sit there saying we have to test for that. So, I think at a certain point

everything you stipulate has to become part of some of regulation. So, I would think twice about even saying the latter part.

Arthur Davidson – Denver Public Health Department
This is Art. Wasn't one of the testimonies about the problem that all the CQMs were not fully tested prior to deployment of EHRs?

Paul Tang – Palo Alto Medical Foundation
Correct, that was one of the issues.

Arthur Davidson – Denver Public Health Department
And wasn't that the reason why we had the, forget about the line and providers using non-certified, wasn't that the reason that we had that number 8 there to begin with?

Paul Tang – Palo Alto Medical Foundation
Correct.

M
Wait, Correct? What's correct? Can you say that again?

Arthur Davidson – Denver Public Health Department
Yeah.

Paul Tang – Palo Alto Medical Foundation
Go ahead.

Arthur Davidson – Denver Public Health Department
So that we had, on line number 8, the last time we spoke, and I was the one who actually suggested that clause and providers using non-certified systems, so let's take that out, and it was that the EHR needed to prove that it was accurate in its reporting because that was what we heard in the testimony, it didn't always turn out to be when they were deployed.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
This is Charlene.

Paul Tang – Palo Alto Medical Foundation
Who was just speaking?

Neil Calman – The Institute for Family Health – President and Cofounder
Whose responsibility is that?

Arthur Davidson – Denver Public Health Department
I'm sorry Neil, I didn't hear that?

Neil Calman – The Institute for Family Health – President and Cofounder
I'm sorry, whose responsibility is that, that's the vendors? Whose responsibility is it to be able to prove that it's been done accurately?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
So, this is Charlene. I think what we want to do, and again, we're thinking toward Stage 3, is to think about this further up in the process where, again, when a measure is selected, it looks at what data needs to be captured, can it be captured reliably from an EHR, it's field tested, and then there's a process in place similar to what is today that once that is instrumented, you go through that process and that measure gets added to the capability, because there's going to be a lot of measures over time that, you know, the EHR is going to have to capture, and there's going to want to be a lot of flexibility here. So, I wouldn't want to constrain, I'd rather leave this one open and more general rather than constrain it by

having to go through a certification process each time. It's more the capability I think you're looking at as opposed to the specific measure.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise
Hi, this is Leslie again and I would agree with that and also the EHRs might be too confining a statement in this as well, because if we're successful with health information exchanges your source systems could be a variety and so in number 7, we've allowed for HIT in general, and we said that everything is subject to audit. Doesn't that imply enough control and enough broad system to cover the intent of 8 as well?

Amy Zimmerman – Rhode Island Department of Health & Human Services
This is Amy and I think there's a balance that we haven't quite struck yet, because what I hear Neil saying, and what I thought was being said before, is that the provider has to somehow verify or validate that whatever tool they're using and the vendor has stated it has the capability that it really does without any owner certification process and we've heard that that hasn't necessarily happened. On the other hand, we don't want to be so constraining and with a whole another set of infrastructure of certification. So, there's got to be, I don't know that I have the balance yet, but it seems like there needs to be a middle ground where some flexibility is provided but enough assurance so that the person who is relying on the software or the tool when they believe that something can do it, it actually can do it, and I think that's going back to what Art said we heard wasn't necessarily happening.

George Hripcsak – Columbia University NYC
Actually this is George. If we go to minimum necessary as our regulation mantra, there were two main complaints. One is number 7, that they want to be able to use, because they are already doing QM for 10 years, why do they have to go backwards, and number 8 was actually about the fact that they bought an EHR, they were forced to use the EHR to report quality measures and the system only did 3 of them and they weren't 3 that their specialty knew how to do or had any relevance to, and it was really the all is how number 8 got in there, not the testing accurately, that was a secondary issue, I think.

Paul Tang – Palo Alto Medical Foundation
That's correct.

George Hripcsak – Columbia University NYC
The primary issue is that they weren't doing all of them they were doing 3 out of the 38. So, that got rid of the whole point of having 38 was so you had a menu to choose from.

Paul Tang – Palo Alto Medical Foundation
So, let me…

George Hripcsak – Columbia University NYC
Maybe we should cut this down. Everything has to be accurate and everything has to be audited. Maybe number 8 should cut down to say should do all the measures and just leave it at that.

Paul Tang – Palo Alto Medical Foundation
Let me give you another practical view of this. One is the folks who don't have their own people and infrastructure to do separate quality reporting would like to have a system, like you said, that could reliably do this stuff and that's why certification is important to that group, which maybe a lot of folks in America. The folks who already had the human resources and the expertise to do this could be relied on to essentially make sure that they're doing the right thing under an audit. So, we didn't need the additional certification, that's another way of looking at this.

So, let me try to break down, so 7 looks pretty good. Eight looks like we're separating, George's last comment was the all CQMs versus the accurate. So how do people feel about the all, it sounded like people were pretty much in favor of that?

M
Agreed.

Paul Tang – Palo Alto Medical Foundation
Okay now how about the accuracy?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
It strikes me that accuracy has to be derived earlier in the process. This is Charlene. You know whatever the process is, if you're going to NQF accreditation and that kind of thing and just like measures are reported today, you know, there are processes outside of our program that verify that we've got the right dataset and those types of things to do the test to be able to submit those measures. So, it would seem like we would want to capitalize on those other processes and depend on those, I guess, some of them having to be defined, if you will.

George Hripcsak – Columbia University NYC
And this is George. In support of Charlene, remember these are not regulations or writings; these are recommendations to the other workers to make recommendations to ONC to CMS. So, I think we should focus on what we think is most important and not try to write the regulation here.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Yeah. Okay. So, I'm struggling with the minimum necessary regulation, which I support.

Paul Tang – Palo Alto Medical Foundation
So any sort of consensus around whether we should address accuracy?

Arthur Davidson – Denver Public Health Department
So, this is Art. So going back to Neil's question. It sounds like we're saying it should go back to the vendor to both provide all the CQMs and to use a standard dataset to test it.

Neil Calman – The Institute for Family Health – President and Cofounder
Yeah, my point is that you can't rely on the providers to have to test the accuracy of the CQMs with test data. I think we'd be putting a burden on them that will overtake everything else we're trying to do in terms of feedback that we get.

Arthur Davidson – Denver Public Health Department
Right.

Neil Calman – The Institute for Family Health – President and Cofounder
And the second point, which we've made multiple times is that the accuracy of the data has more to do with the workflow that captures the information than it has to do with how it's processed electronically and counted, so we're going to be doing the counting and the accuracy on the electronic part to 5 decimal places where the real problem is in the how they capture the information in the first place. So, you know, I think its overkill.

Paul Tang – Palo Alto Medical Foundation
Okay, so that's the same thing as saying take out accuracy?

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

Neil Calman – The Institute for Family Health – President and Cofounder
Yes, I would agree with that.

Paul Tang – Palo Alto Medical Foundation
Okay. So, that seems to be the, okay, so I will take that out.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
So, Paul, what did you mean by the all again?

Paul Tang – Palo Alto Medical Foundation
All means right now only in 9 out of 44 are tested in Stage 1. They're saying like George's point, gosh, we've essentially disabled menu when you only have the testing performed on 9 out of 44. So, this recommendation is saying the vendors as part of certification need to be tested on their ability to produce quality reports for all CQMs that are specified in Meaningful Use.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Okay. So the challenge here is like, and I again we've got the scenario out today and we can't do it, but let's just say there is an ED system that reports the relevant measures to ED, and then there is another system that captures the measures that are relevant to other venues. Today that ED system has to send those measures they've calculated to another system to report because it's all got to be done together. So, it's just, there are times when it's pertinent that whatever the system is its relevant measures to that system as opposed to all of them.

Paul Tang – Palo Alto Medical Foundation
Okay so that's a good caveat.

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

Paul Tang – Palo Alto Medical Foundation
Everybody was only getting required to do 9, so that defeats that problem.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Right. So, yours is a different problem but it could also cause this other problem.

Paul Tang – Palo Alto Medical Foundation
Right. Okay so I'll specify all relevant. Okay any further edits so we can get onto specialists? Well, it's been a really good discussion. Thank you and I'll try to make some of the edits to reflect this discussion and circulate it to the group again. Okay, George, who is going to present the updates for the specialist's small group?

George Hripcsak – Columbia University NYC
I'm going to present and then I'm going to hand over to Allen for any additional information.

Paul Tang – Palo Alto Medical Foundation
Great. Thank you.

George Hripcsak – Columbia University NYC
So, we met on November 28th, the small group. Our charge was that we need to, the first part of the discussion was how to approach this and we decided that we needed, and I think by the way, a document, a summary that Allen generated should have been circulated by now. That was circulated during our phone call. First, the charge is to focus on specialists oddly rather than address each group separately. The problem is given our skill set and given the number of people and the number of hours, we probably can't generate Meaningful Use that is specific to each specialty. We felt that we needed to focus broadly on how specialists can be brought in to this whole project.

And we felt there are certain issues that are more legalistic like how someone qualifies or not and that's really more appropriate for CMS to address, rather than us trying to figure out well does this really qualify or should they really qualify or not? We should stay with the mainstream of pulling together primary care providers and specialists. And so our goal is both how can Meaningful Use help specialists contribute to the goal of improving health care and how to do it in a way that it's feasible for specialists to participate and broadly beneficial.

We felt looking over the objectives that much of Meaningful Use is appropriate for specialists, including sending and receiving data, local decision support, local quality improvement, care coordination, including teams and plans and engaging patients. So, we felt on the whole as if, in fact the job we did in trying to make it general for health care was pretty good. And now here are specific items we came up with that we felt we needed to address for specialists.

One thought was registries, remember we've been talking about registries since the beginning, and we want to consider registries as an alternative way for specialists to meet quality measure requirements. It would be optional so then you could avoid forcing specialists to pay for registries that need to be paid for, but it would encourage the development through specialty societies using registries, the development of specialty-specific measures. It will require the adoption of data standards, it should be bidirectional, that is when a specialist sends data to the registry then there should be information and quality improvement information being sent back to the specialist and it can be general quality improvement information and potentially even care management information. In other words if a specialist sends information to the registry, it's possible the registry would have a thing that would send back information saying here's a patient it appears that special management needs to be done on this particular patient. So, feasibly there can even be care management information being fed back. So that's number one, registries.

Number two, care coordination. We need to expand the summary of care record to send a summary of the consultation back to the referring provider. In other words, you don't just send the referral from the primary care to the specialist, but from the specialist give the summary of that consultation back to the primary care provider and thus making it a bidirectional data transfer. And that summary should come back in a timely manner. So, that was number two, care coordination.

Number three, patient engagement. Furthermore, the referral and the consultation results is bidirectional information, should be added to make sure that it's in view and download and it's also in the care summary. Procedures and tests that are performed by the specialist should normally be presented to the patient by the specialist, except in those cases where there are specialists who don't actually contact the patient, in which case the report would go back, I guess, to the referring provider who would then be the one, that's where it would go into the view and download, and the care summary. So, that's number three, patient engagement.

Number four, images, you know, we felt that images are extremely important, especially to our specialists, but that it wasn't quite feasible to move ahead in Stage 1. So, now, we're looking in 2. So, now we're looking at Stage 3. Number one, I think we all agree that working on standards to promote the sharing of images was important. There are certain things we can do like considering one-click access from your EHR into your PAC system so you can review the studies, although that may only be relevant for large integrated systems where the specialists and the care providers are using the same EHR. But we felt the recommendation was that we ask the HIT Standards Committee, as part of their planned February 16th hearing, to suggest a next step for imaging beyond standards that's still feasible. In other words, we probably don't think it's feasible to stipulate that EHRs should take on the burden of a PAC system to show images, that's probably too far to achieve by 2015. On the other hand, just suggesting standards, that the sharing of images, there should be a standard for sharing images among systems may be too small for 2015. So is there some step in between those two extremes and asking the Standards Committee as part of their February 16th to come up with that recommendation of a next step.

And then finally, the fifth issue, not a recommendation, but issue, is that we felt that the Meaningful Use Workgroup probably cannot assign exceptions for each objective that it generates for each specialty because the committee is limited in the number of people and their expertise and given the number of specialties and the number of objectives, the matrix you get is 900, well I don't know what number, but 1,000 exceptions you'd have to consider and decide whether to go through or not. We didn't think that was feasible and so our plan at that time, now the AMA had produced an excellent document that kind of looked at the objectives for a range of specialties actually delegated to each specialty to report back on how they would address each of these objectives. That document was sent to us and then so subsequently we recommended to ONC that that it go through the AMA materials and respond to each of the comments, that is how well they can address the measure. And then Allen did an initial pass through

the AMA materials and that's what I wanted Allen's comment on today. Although, first Allen you can comment on anything I've missed and actually, the other group members should comment on to anything I've missed.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
George, this is Mary Jo. I would like to just clarify something for the record related to the HITSC planned hearing or panel on imaging. It will not take place on the 16th of February. We are now reconsidering it in a larger framework of needs for 2012 and in fact, would like to have a discussion between the HITSC Co-Chairs and Paul about whether, in fact, there might be a combined approach to this and maybe other subjects as well. But, just again, for the record, there will be no hearing on February 16th regarding imaging. But we will get back to you as those plans progress.

George Hripcsak – Columbia University NYC
Okay. Thank you.

Allen Traylor – Meaningful Use Policy Analyst – Office of the National Coordinator
Well, I think you did a great job running through and a lot of the things you said; I'll try not to repeat. But by and large, the public-health objectives seem to touch most specialists and most of them saw problems with reporting to the public-health agencies in which we've identified and ways in which we've identified. So, those objectives seem to touch the most number of providers. Also, by and large, pathologists, ophthalmology, radiology and geriatricians seem to have the hardest struggles with the majority of the objectives. And so those are the four with the most number of either areas where it's not applicable or areas where it is hard to meet the measure. As an example, geriatricians believe that the majority of the measures are hard to meet and so they have indicated it as red. Although, they do say that it is applicable to their practice, they say that the measures are too hard to meet.

Also doing a scan of each of the objectives based on the specialists, it is clear that a good educational resource is recommended for all of the specialists. As an example, there are exclusions that apply to ePrescribing, but that was not made clear to some of the specialists so they indicated that this measure is not applicable and that they cannot meet that measure despite the exclusion that does apply. That also is the same case for numerous measures like vital signs. And then, again, I think there is also some basic education that can be given, for example geriatricians have a problem with clinical decision support not being applicable or possible to their practice.

So, those are some of the highlights and I think, I don't want to really repeat what you've already said, but it's clear that there does need to be some sort of education around what the exclusions are for each of the measures because I think that would help a lot of areas in which the specialist said they could not meet the measure. And then some flexibility in the public-health measures.

George Hripcsak – Columbia University NYC
Okay, very good, thank you very much, Allen. Other members of the group want to add anything, of the subgroup? Okay, then I guess we should go through the way Paul did. First comments on our charge that we should focus on how to pull specialists in more broadly. Any comments on that issue? Okay. Any comments on registries, using registries in an alternative way for specialists to meet quality measured requirements.

David Lansky – Pacific Business Group on Health – President & CEO
Allen, this is David, oh, sorry George. I have a comment about the registry issue. Some of the registries are not actually populated primarily by the physician directories but by some other hospital or clinical information system. Did you all talk about that? How to give credit so to speak to let's say an interventional cardiologist who is getting data through the cath lab but doesn't directly see a whole lot of getting the benefit of the EHR data and is using it…Did you talk about that?

George Hripcsak – Columbia University NYC
David, first of all, your message is a little bit garbled. I don't know, is it garbled?

David Lansky – Pacific Business Group on Health – President & CEO
I can try again. Is that any better?

George Hripcsak – Columbia University NYC
Way better.

David Lansky – Pacific Business Group on Health – President & CEO
All right. The question was some of the specialists who are especially in hospital-based practice or other institutional practice, may get their EHR data not directly through their own activity or even their own products through a hospital system let's say and I gave the cath lab as an example for interventional cardiology. Did you talk about whether or how to give those providers credit toward Meaningful Use if they're getting the use of the data meaningfully, but they are not actually the operators, owners, and investors in the product?

George Hripcsak – Columbia University NYC
Well, that is a good point. We did touch on the difference between how specialists use systems and how primary care providers use systems in the traditional EHR sense, but this is an extra wrinkle.

Amy Zimmerman – Rhode Island Department of Health & Human Services
So, this is Amy. Doesn't this sort of relate to what we discussed with 7 and 8 previously on where the reports come from in terms of some sort of assurance that the measures are being generated accurately and whether the data has to come from a certified EHR or another certified? I mean, to me there is a very, putting registries into the mix raises the same sort of questions in my mind of 7 and 8 in the previous discussion, unless I'm misunderstanding somehow.

George Hripcsak – Columbia University NYC
So, number one is the mechanism to do the quality, so there's the data, which come either from the EHRs, as David pointed out it could be coming from other systems that are not traditionally EHRs, then there's the process of taking the data and turning it into the quality measures that we've pre-specified, then there's an alternative, which is a little bit beyond number 7 and 8 from the other documents, which is that it's possible that the society may be generating quality measures specific to that specialty and is it imaginable that there could be a process that they could propose those measures in place of the ones that are there, that is that it's not just a registry but to say the subspecialty organization actually generates measures and just proves that they're doing quality measurement that's relevant. Now, we didn't figure out how to vet that. But the idea was how do we kind of add to the generation of these measures that are relevant to the practice.

Paul Tang – Palo Alto Medical Foundation
And, George, this is Paul. Would there be a requirement that the registry has to publicly report, at least for the CMS measures so that is for methods that CMS would have access to those reports, because they obviously do for the ones that are coming out of EHRs.

George Hripcsak – Columbia University NYC
So, CMS has to have access to the method and the results.

Paul Tang – Palo Alto Medical Foundation
Yeah.

George Hripcsak – Columbia University NYC
Public means something different. Whether it gets publicly reported is a separate issue.

Paul Tang – Palo Alto Medical Foundation
Correct, correct. So, they would be under the same rules that everybody else is reporting directly to CMS in the future, that is it's accessible to CMS.

George Hripcsak – Columbia University NYC
But David Lansky, do you think this is feasible or is this just too far?

David Lansky – Pacific Business Group on Health – President & CEO
Well, I don't know about the ability, it's important because you've got some specialist that are going in this direction and there's a whole movement around these registry developments which is going to have these mixed data sources. So, I don't have an answer and now I think that we have brought a demand for it in the specialty community. During the Meaningful Use that we're talking, they want to get credit for it…more blended environment than what was the traditional EHR product model.

George Hripcsak – Columbia University NYC
And then, David, this is George again, do you think the method would have to be that the specialty society would come to CMS/ONC whoever and say here are the measures I'm using and have some process to approve them or do you think it would even be possible that, and again I don't know how we vet it, but they could actually generate measures and as long as the specialist is participating in that, that's good enough and they don't have to match the list of 38 or 100, or whatever?

David Lansky – Pacific Business Group on Health – President & CEO
I think that's possible. We could deem certain submitters or CMS could deem certain submitters. CMS is…generating these kinds of measures this way, and as we say earlier on the call these are all going to be eventually eSpecified. I think that's a viable path over the next 2-3 years but it will take some analysis to see how lively, applicable that would be.

Paul Tang – Palo Alto Medical Foundation
Here, let me add in a couple more questions and maybe also add a piece of input. So, one, George would the data that's required to calculate the CQM that is derived from the EHR would that be required to be submitted through the EHR? Again, it's to make it equitable with the work that is being done by the other folks who are not reporting to registries. And the other one is NQF has made a decision not to endorse, in the future, not to endorse measures that are just, you participate in a registry.

George Hripcsak – Columbia University NYC
So, it has to be clinically relevant, you mean that the measure itself is that you're participating in the registry?

Paul Tang – Palo Alto Medical Foundation
Correct.

George Hripcsak – Columbia University NYC
Yes and I would imagine that we would not want that. How we stop that I don't know, but we would probably not want that to your second question. To your first question, I think it's analogous to number 7 where the data has to be derived from an EHR or in some cases a relevant system if it doesn't happen to be an EHR like a cath system, it has to come from the source data system, but if it goes through.

Paul Tang – Palo Alto Medical Foundation
A human.

George Hripcsak – Columbia University NYC
A human being.

Paul Tang – Palo Alto Medical Foundation
Yeah, a human, because the data that are done in these local, you know, reporting repositories are obviously coming electronically from EHRs. We just want to make it commensurate or analogous to what everybody else is going through.

George Hripcsak – Columbia University NYC

Well, I mean, my hope would be that it would go through an electronic, it doesn't have to be the EHR, but it should be an electronic mechanism.

Paul Tang – Palo Alto Medical Foundation
Correct.

George Hripcsak – Columbia University NYC
So, that would be my hope.

David Bates - Brigham & Women's Hospital & Partners
So, this is seeming to me like it could be a little bit of a slippery slope. I want it to be 1 of the 38 or that they get some sort of exemption. In other words, there's a long history of society setting up not very meaningful measures and then using them themselves and we don't want to go down that path.

David Lansky – Pacific Business Group on Health – President & CEO
I agree with you David.

Paul Tang – Palo Alto Medical Foundation
So, that's why if we have the same requirements, that is that it's electronic, it comes out of the EHR electronically and it gets submitted to CMS, then at least, you know, it avoids the, and they don't share it problem.

George Hripcsak – Columbia University NYC
I don't know how to ensure that they're meaningful and that's really the edge that we're, you know, that's where the line, the dividing line we're trying to decide is how much do we give the flexibility versus how much control. I don't know if it evolves, that you start off with registry with more freedom and pick measures over a 3 year period that are, and then ensure that they're meaningful.

David Bates - Brigham & Women's Hospital & Partners
I mean, I would use a fairly narrow funnel to begin with, because there just is a long history of abuse in this area. You know, I would say it's 1 of the 38 or you apply for an exception to.

Paul Tang – Palo Alto Medical Foundation
Right, but I don't think we're giving them a bi on the measure itself we're just allowing them to take advantage of something they're doing "in addition."

W
So, Paul?

David Lansky – Pacific Business Group on Health – President & CEO
This is David. I'd go up stream a little bit I think and to me the judgments of the meaningfulness of the measure is really up to CMS for the other reporting entity, it's not really our job. Our job is to make sure there is an efficient capability to move the whole environment to a digital platform that's flexible and I think the thing, we may have to do some creative thinking but I'm hopefully there's a way to put some criteria for the capability, not measures and let CMS say what the measure is or how they are going to deem or validate, or approve the measures, that's their problem.

David Bates - Brigham & Women's Hospital & Partners
Yeah, I agree with that. I thought George was suggesting something different.

George Hripcsak – Columbia University NYC
Well, hold on, so what's the new, can David or David describe the new suggestion?

David Bates - Brigham & Women's Hospital & Partners
David Lansky, do you want to do that again?

David Lansky – Pacific Business Group on Health – President & CEO
No…

W
My question….

George Hripcsak – Columbia University NYC
Wait, wait, wait I just want to get, I want hear what, because David Lansky earlier said that deeming might be possible. David Bates is saying, well it really is applying for an exemption. So deeming means you have authority to generate measures and then maybe we'll check up on you because we're sending them to CMS. David Bates is saying, no you really need to apply for exemption, it means you send the proposed measure to CMS and it gets approval or not, that's not deeming. So where do we end up?

David Lansky – Pacific Business Group on Health – President & CEO
No, I'm backtracking. This is David L. I'm going back. I agree with David Bates that there is a risk of abuse in deeming the societies to be the judge of what's a good measure, but since our goal is to make it easy and efficient for the providers, in this case specialists, to satisfy a requirement that lets say CMS establishes, CMS will be the definer of what's the appropriate measure in this scenario. What we have to do is figure out what are the criteria that we care about regarding the technology adoption in use that will support the ability of the specialist to report to CMS. And I think where we get into the trouble is not so much what the measure is as what the data infrastructure is and how do we supply it or approve it as being a contribution to the overall program.

George Hripcsak – Columbia University NYC
Okay.

Neil Calman – The Institute for Family Health – President and Cofounder
Well, this is Neil. I would have more faith in those organizations than you do apparently, David Lansky. I mean, I think the associations and the organizations are, you know, for the most part we've heard testimony from a bunch of them over time, you know, they're thinking ahead of what the country's looking at for them to be doing and I guess I'm not as skeptical that there's not a large overlap between what the societies would feel are important to capture and what we would think are important to capture. I don't know. I guess I'd be in favor of trying to make this something that's really relevant to the people in the specialty and to start there and then see what happens.

George Hripcsak – Columbia University NYC
So, I would characterize this is that we agree that we have to cover the infrastructure and that there may be some ways to allow societies to generate these things. Exactly how they get approved, whether it's deemed or apply for exemption is really a CMS issue.

Neil Calman – The Institute for Family Health – President and Cofounder
I agree.

George Hripcsak – Columbia University NYC
So, is that adequate, David Bates?

David Bates - Brigham & Women's Hospital & Partners
Yeah, I suppose.

George Hripcsak – Columbia University NYC
All right, well we can even put in the fear we have if you go too far.

David Bates - Brigham & Women's Hospital & Partners
The dermatology measure was that the skin was examined.

David Lansky – Pacific Business Group on Health – President & CEO

Yeah, the ophthalmologist said you had to look in both eyes. So, I don't think we want to, to Neil's point, I think what's evolved in a good way in the last 5 years is a constructive tension between the specialty… society approval and then going through NQF and then going to CMS and that's reasonably healthy and it'll probably get refined. And I don't think we have to, you know, judge or override that process. We have to somehow provide the support script to be implemented in the real world.

Paul Tang – Palo Alto Medical Foundation
Okay. So, I think the summaries, there is no concept of deeming or waiving. I mean there's just another way to get information in this case to CMS, but it's not changing the measure and it's not making up some alternative non-electronic way.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
And this is Charlene.

Paul Tang – Palo Alto Medical Foundation
Yes?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
This is kind of back to George's earlier point. It seems like the recommendation we made, I think it was 7 should support the discussion we just had under the quality measures.

Paul Tang – Palo Alto Medical Foundation
Correct. I think that's right, Charlene, in other words this is just another way of getting the measure calculated and submitted, but it does not create a waiver for reporting on these specific CQMs that are part of the program.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Which I think is good.

Paul Tang – Palo Alto Medical Foundation
Yeah.

George Hripcsak – Columbia University NYC
Okay, other comments on registries? Care coordination and having the summary of care records send a summary of consultation back to the requiring provider, any comments about that, bidirectional link? Okay, patient engagement, adding these same referral and consultation answers to information that is shared with patients? And four, any comments about images?

Allen Traylor – Meaningful Use Policy Analyst – Office of the National Coordinator
George, this is Allen. Part of the analysis that we did here and we talk about care coordination is the ability to, or the option for providers who don't see patients but still need to meet a measure to be able to pass that information, certain information back to the original referring provider, and the referring provider then can organize and coordinate to determine what information goes to the patient. One specific example is with patient's specific educational resources in that the specialist could possibly use care coordination efforts to then send that educational material back to the referring and then the referring can organize the data and give it to the patient, and that could possibly be a way to meet the measure.

Paul Tang – Palo Alto Medical Foundation
I'm not sure I understand why the specialist wouldn't have an obligation to give that to the patient?

Allen Traylor – Meaningful Use Policy Analyst – Office of the National Coordinator
So, this is just an example of where a specialist may not see a patient.

George Hripcsak – Columbia University NYC
So, in the case where the…

Allen Traylor – Meaningful Use Policy Analyst – Office of the National Coordinator
This is in direct response to what the specialist had said. So they said we don't see patients, so this is hard for us to meet.

George Hripcsak – Columbia University NYC
Right, so we state in patient engagement is that for specialists that don't see patients they'd meet the measure by sending the information back to the referring provider.

Paul Tang – Palo Alto Medical Foundation
So, are you talking about pathologist or radiologists? So, for example a radiologist certainly can, let's say prep materials or after contrast, you know, precautions, those are patient specific-educational materials and one would like that to go directly from radiologists, yes?

David Bates - Brigham & Women's Hospital & Partners
I think so. I mean the primary care providers don't want to be the intermediaries in this. There's not a really good reason.

George Hripcsak – Columbia University NYC
Well, some of them want to be the intermediary between the patient and the pathologist, though.

Paul Tang – Palo Alto Medical Foundation
So, yeah, pathologists truly don't see the patient but a radiologist does have contact it's not in an encounter situation, but they certainly have information about the procedures that is patient specific and should probably come from them.

George Hripcsak – Columbia University NYC
So, it sounds like the spirit of our recommendation, if you truly don't see the patient, then it doesn't make sense for to you send information blindly to the patient, although you could argue that is what labs do right now, you go for your blood test then you get an e-mail that says your lab results, but you've never really met anyone other than the tech, so in fact it does get done, but in general I think that our recommendation was if you're not meeting the patient, it would be information that would be sent back to the referring doctor. But, otherwise, it could be done directly from the specialist.

Neil Calman – The Institute for Family Health – President and Cofounder
Well, I think, this is Neil, from a patient safety point of view, I think we should be promoting that the patient's get the information directly. I mean how many cases do we hear about of people getting reports and stuff and not following up? I think there's a huge patient safety sort of concern here and by giving people access to the information directly and immediately, you create a safety mechanism.

George Hripcsak – Columbia University NYC
Well, how is a pathologist going to get the ID and password for their portal to every patient's specimens that are coming in from around the city? Because this is for view and download and for the clinical care summary. They would have to set up a mechanism where they're going to ask the patient before they review the specimen; do you see what I'm saying? So, if you have no contact with the patient there is no opportunity to sign them up for your portal.

Neil Calman – The Institute for Family Health – President and Cofounder
Well, I'm not sure that that's true. I mean, I can think of a mechanism. I don't know how you could send a specimen and you know, when you barcode the specimen or however you identify it to send it to the pathologist there could be a unique identification number handed to the patient at the same time that says here's a way you can access your report directly. It doesn't have to be done by the pathologist; it could be done by the doctor collecting the specimen.

George Hripcsak – Columbia University NYC
But, that's the referring doctor.

M
Yeah.

Neil Calman – The Institute for Family Health – President and Cofounder
We need to think it through, but I think the more opportunities you have for people, the principle ought to be the more opportunities you have for people to get information directly from the source, the greater the opportunity we have to decrease errors and safety concerns.

Amy Zimmerman – Rhode Island Department of Health & Human Services
I agree with that, but I also think that patients may want to hear it from different people. So for some patients to just get an e-mail with a path report without any contacts or anyone to talk to, may not be their preferred method. So, I think there has to be a way here where it's not just a result out of context of anything else with no communication with a provider.

Neil Calman – The Institute for Family Health – President and Cofounder
No, no, I wasn't suggesting that be the only mechanism.

David Bates - Brigham & Women's Hospital & Partners
You know the safety principle, I would submit is that you have to have nearly 100% reliable approaches for making sure that all the important results get to patients and, you know, just sending things from somebody who doesn't know the patient at all, may or may not be helpful. I'm in favor of more access for patients on the one hand, on the other hand, for truly important abnormalities the key thing is that the systems have to have 100% solutions to make sure that the result made it to the patient.

Amy Zimmerman – Rhode Island Department of Health & Human Services
This is Amy again, to me this an issue of coordination between the specialist or the pathologist and either the referring specialist or the primary care provider. But while I agree, I think there should be as many routes for patients to get the information, I think to me this is leading to the emphasis should be on making sure that there's a clear coordination…the person who has the results and knowing them with whoever referred them who's delivering to the message to the patient in a way in which will be assured and helpful to the patient.

Neil Calman – The Institute for Family Health – President and Cofounder
So I would support David Bates in saying that I think it's great to have 100% systems, but we've never invented one and so redundancy in systems is another way you protect against medical errors and to have people have access through both mechanisms I think the safest of all. Not that we shouldn't strive to have both of them to be 100% effective and therefore, you know, I think we won't hear so many cases of these kinds of reports that get lost and people who don't get the follow-ups that they should get.

Leslie Kelly Hall – Senior Vice President for Policy for Healthwise
This is Leslie Kelly Hall. Could we offer then that the specialists provide their information in a way that somehow is ready to be absorbed by a patient portal? So whether that's blue button ready with some metadata associated with it to attach educational materials, but making sure that they are ready to participate in data exchange. Because some of the real barriers you mentioned like patient ID for a specimen that's going to a pathologist, that the ID is really around the specialist and the referring physician and the patient ID is a sub identifier. How do you then get through all of those barriers? But if we just state and reward those who have it ready to participate in a patient centered HIT system, we could possibly meet the goal. Does that make sense?

George Hripcsak – Columbia University NYC
This is George. I think the principle we're kind of agreeing on, and it's just a matter of how we implement it and what we connect to what and what responsibilities. I think will require some more thought. Let me just for a second drop out of the agenda. Paul, are you on?

Paul Tang – Palo Alto Medical Foundation
Yes, I am.

George Hripcsak – Columbia University NYC
Paul, you're going to need to drop off soon, maybe we should talk about our plans and then I can come back and continue the discussion on specialists.

Paul Tang – Palo Alto Medical Foundation
Great. Okay, so I had already introduced the concept of the timeline or one that we need to hear more from HHS first. The thought I had, as far as organizing ourselves, is a bit like our previous stages, that is in categories. And we'll send out the goals that we agreed, sort of the priority areas and some of the guiding principles we set up for ourselves in that face-to-face meeting. So, we'll look through the category with those principles and priorities in mind and try to see how, what some of our draft thoughts in terms of Stage 3 objectives would be. And I think it's probably more effective for us in small groups in each of these categories to come up with some drafts that we talked, like we're doing now, then to try to brainstorm right on the call with everybody. Does that make sense? I guess I'll take that as a yes.

George Hripcsak – Columbia University NYC
Yes. Yes.

Paul Tang – Palo Alto Medical Foundation
Okay. So could we get some volunteers to help lead and participate on the smaller group that comes up with drafts, you know, objectives for each category? So starting with category 1 which is the improved safety, quality, efficiency and reduced healthcare disparities category, it's the largest so hopefully we'll have enough folks volunteer for that. We can do this by e-mail.

George Hripcsak – Columbia University NYC
Yeah, that might be better; I think it's going to be hard to do that.

Paul Tang – Palo Alto Medical Foundation
Let me do that. I'll just put it out and then please just volunteer for one or more categories you want to participate in and we'll organize ourselves and then get that going. And so then we'll probably, Mary Jo do we already have a next call?

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
I don't believe we have one scheduled but I can work with you afterward and it sounds to me like you might like to go ahead and schedule more than one at a time.

Paul Tang – Palo Alto Medical Foundation
It sounds like we'll need that, right. We're going to start being in production mode. I mean these discussions that have been happening I think they are very rich and very responsive to the information we're getting both from the field as well as some of these other driving forces. Okay so I will send out an e-mail request, please respond on the categories you'd like to participate in. Thanks to George.

George Hripcsak – Columbia University NYC
Paul, do we have any hearings? So, we also have to discuss what hearings maybe needed. I guess that will be the outcome of the small groups.

Paul Tang – Palo Alto Medical Foundation
Correct. The one we already talked about having to do with number 2 and 3 in conjunction probably with the Standards Committee and other folks that are participating in this whole quality measure area will organize, it may be one of these full day hearings followed by a full day sort of debriefing and starting to work on the strategy for addressing it back to our recommendations 2 and 3.

M
Very good.

Paul Tang – Palo Alto Medical Foundation
Well, thank you. I'll transition and then get on and listen in. Thanks George.

George Hripcsak – Columbia University NYC
Okay, thanks Paul. Okay so we were on patient engagement. Data ready to be absorbed by a portal I think was our last comment. So do we need to at this point or maybe off-line rephrase that point and then come back to the group eventually? And maybe stick with the goal rather than solving it in this recommendation? Because this is really a recommendation to ourselves. We need this, it's something that we're sending to someone else and we have to do more work on it. Some of the things are for our own notes as we work on our own objectives. Okay. I'm sorry go ahead? Any comments on images? Use of standards, need for hearings, putting PACs within the EHR.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
I think your recommendation is a good one. I think we should just look at what our options are, but certainly endorsing the need for that and the fact that there are some standards that still exist. I like your recommendation. And sooner rather than later, so I don't know that means to Mary Jo.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
I'm sorry; pardon me Charlene could you repeat that?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
In terms of analyzing the current state of the standards for imaging, and again a lot of it depends on what the viewer is that you're using in terms of resolution. But again, there's just been a lot of work to standardize the pairing of images and I think getting that on the drawing board sooner rather than later is a good thing with the standards committee.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Yes. To clarify, well let me clarify one thing. Would you like to hand this to the Standards Committee or would you like to work in collaboration with them so that…are joint?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Yes and yes.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
That's what I thought.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Yes the second.

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

George Hripcsak – Columbia University NYC
Very good, well they requested that, so that sounds good.

Arthur Davidson – Denver Public Health Department
Hey, George, this is Art. I disconnected myself when I was trying to go off mute and just before I lost you there, you were still on the patient engagement. I just wanted to ask a question.

George Hripcsak – Columbia University NYC
Sure.

Arthur Davidson – Denver Public Health Department
On the earlier discussion with Paul, item number I think its 3, where it talks about patient reported outcomes. I don't see anything about that with the specialists here. Does that mean that we're not expecting them to include patient reported outcomes as part of patient engagement?

George Hripcsak – Columbia University NYC
I don't think that was the intent. I think patient reported outcomes on the CQM Workgroup was general across our population and we weren't trying to exclude it for specialists in the Specialists Workgroup, although I think it might come under, it might be harder for specialists who don't ever meet the patient to pull in the patient reported data, although as Neil points out not impossible necessarily.

Arthur Davidson – Denver Public Health Department
Right, but there many specialists who do and we just want to be sure that they're included in this.

George Hripcsak – Columbia University NYC
Did you see anything that excludes, Art does it say?

Arthur Davidson – Denver Public Health Department
No. No.

George Hripcsak – Columbia University NYC
Okay, good. I think the intent was to include them.

Arthur Davidson – Denver Public Health Department
Okay good.

George Hripcsak – Columbia University NYC
Okay and then any comments on Allen's quick summary of the response to the AMA materials? Or any comments on how we address exceptions for specialists?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
This is Charlene again. On that topic, actually George I forget what we decided on this one, but I know that the Implementation Workgroup made some recommendations around this area. But it's recognition in the certification process that today, because of the possession requirement, it's difficult for some of the specialists to actually attest because they don't own all the elements necessary for a certified system. So it's the need for specialists, for that decision making to happen so that they can not necessarily have to own all of the components of an EHR to be able to attest if meeting those objectives aren't relevant to them. So did we decide not say that or? But I think the certification process needs to be flexible enough to be appropriate for the relevant objectives that the specialists can meet.

George Hripcsak – Columbia University NYC
All right. So that's really a separate thought than any of the ones that we went through, right?

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

George Hripcsak – Columbia University NYC
It's not exactly the same thing. It's analogous to number 7 where we say well if you do quality measurement, you should be able to get the data from the EHR electronically and report it up without having to go through the EHR. This is a different thing but analogous and actually it's something that, I guess David Lansky has mentioned.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Yeah, it's relevant. We want to make it relevant. It's easier to make it relevant. Again it's not to preclude that there's certain things that shouldn't be done, but also, there are just things that don't make sense too.

George Hripcsak – Columbia University NYC
So what's the recommendation then? Can you put it in words just so I can write it down here?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Actually there was a recommendation I think that was made and let me just send you those words, okay, but it's around the fact that the certification process needs to support the ability to be able to attest to having a certified system for those Meaningful Use objectives that are relevant to the specialties. And I know there's this whole exclusion thing in there, but are relevant to the specialties. It's just how we deem that I think is the question.

George Hripcsak – Columbia University NYC
So, wait a minute, so the point is that, so are we talking about the cath system for example for cardiologists?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Well, no actually I was more thinking like if you look at a radiologist or who are under law to be able to respond to this. There are just like 12 objectives that are relevant to them to be able to meet in most systems today this is that whole space, that slippery slope space, where those systems today for instance don't have ePrescribing in them or whatever is the appropriate, you know, capability.

M
George, this is, you know, for a clinician that does not have prescribing privileges around whether they should have to have an ePrescribing.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Right, module, right.

George Hripcsak – Columbia University NYC
So, and Charlene, so now I understand, is it specifically, because you brought up certification, is it specifically with the certification side or about the actual reporting to CMS side? Because it's two, one thing is you need to have electronic prescriptions in the systems you buy because you're not going to be prescribing anyway, according to your specialty.

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

George Hripcsak – Columbia University NYC
It's a different thing is that and then to CMS, I'm not going to be sending you any electronic prescribing information, which is the exemption question. The exemption question.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
Right. Yeah, I think in many cases, the exception is handled by CMS it's the certification process which is a challenge right now.

George Hripcsak – Columbia University NYC
Got it. Okay. So the certification should allow for systems, specialty specific systems that are targeted to the objective that they'll have to report on.

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

George Hripcsak – Columbia University NYC
Thank you. Other comments on specialties in general or going back any? Okay. So I'll need to rephrase using this input and then we'll send that around. Any other items? We finished our agenda now. We've pushed ahead and did the plans for the future. Any other comments?

Arthur Davidson – Denver Public Health Department
I have a question with regard to this last point that Charlene is bringing up. So do we have a definition for what a certified EHR is?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
In terms of, yes, I mean, the certified EHR for someone to attest, it has to today meet all the objectives of Meaningful Use for that appropriate venue even if there are exclusions for that. So in many cases, again, you might not have to have that function on site, but you have to possess the capability to have that functionality. So it's just a little nuance in there that makes it really hard.

Arthur Davidson – Denver Public Health Department
So we are trying to change that definition?

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
For Stage 2, yes.

Arthur Davidson – Denver Public Health Department
For Stage 2, which would mean that an RIS could be a certified EHR?

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

Arthur Davidson – Denver Public Health Department
Okay.

Charlene Underwood – Siemens Medical – Director, Government & Industry Affairs
I don't know if that was ever the intention of the rule, but…

Arthur Davidson – Denver Public Health Department
But that's where we're at today, where we think that's important to do.

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

Arthur Davidson – Denver Public Health Department
Okay.

George Hripcsak – Columbia University NYC
Other comments? Okay very good. So we're going to set up a new call over e-mail. We'll talk about membership in the small groups to work on the agenda that we had presented at the previous Policy Committee meeting and I think it's time to open it for public comments, Mary Jo.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Operator would you please open the lines?

Caitlin Collins – Altarum Institute
Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do have a comment from Carol Bickford.

Carol Bickford – New York Nurses Association
This is Carol Beckford from the American Nurses Association. I wanted to support the conversation about patient engagement and the report and the capacity of the specialists or the encouragement that the specialists provide direct communication to the individuals and that the bidirectional reports output is

made available to the patient as part of the safety and patient consumer participation discussion. I support that inclusion of those reports being available even though the primary care provider traditionally has supposedly been the person you get the information from. Thinking of it from the standpoint of those who may not be physicians and may be consulted. It's very important, for example that are advanced practice nurses, who are strong educators and other providers have reinforcement in direct communications to the patient, as well as providing a report back to the consultant requester.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Thank you. Are there any other comments operator?

Caitlin Collins – Altarum Institute
We have no more comments at this time.

Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology
Thank you. George? I think that's all. If you would like to adjourn the meeting?

George Hripcsak – Columbia University NYC
Okay, well thank you very much everyone. This was a great meeting going over those items and I think that the small groups working together and building the recommendations work well and we'll continue that and thank you all today.

Neil Calman – The Institute for Family Health – President and Cofounder
Okay, thanks, have a happy holiday.

M
Thank you. Happy holidays.

Arthur Davidson – Denver Public Health Department
Thank you, George.

M
You too.

M
Happy holidays.

Public Comment Received During the Meeting

1. CMS could provide provisional approval to collect and report the specialist data from their EHR based on the thesis that the measure and decision support could be "meaningful to their special disease process and may impact on broader health conditions/chronic diseases

2. In reviewing the draft ONC meaningful use NPRN, I suggested specialty issues were important and could be addressed in the preamble by requesting public comment on how specialties have been impacted my existing or expected future meaningful use measure development, and provide input on how to address. This could include registry and role of CMS.