

Meaningful Use Workgroup
Draft Transcript
February 7, 2012

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; this is Mary Jo Deering in the Office of the National Coordinator for Health IT. 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? David Bates? Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families

I'm here.

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

Neil Calman?

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

Here.

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

Tim Cromwell? 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? Joe Francis? Leslie Kelly-Hall?

Leslie Kelly-Hall – Senior Vice President for Policy for Healthwise

Here.

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

Yael Harris?

Yael Harris – Human Resources and Services Administration

Here.

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

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 Tagalicod? 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?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Here.

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

Okay are there any other Workgroup members who I haven't called? Okay, over to you Paul and George.

Paul Tang – Palo Alto Medical Foundation

Thanks, Mary Jo. So today's call we're going to hear an update from ONC about the feedback from their REC Centers, particularly about some of the challenges they have in implementing Meaningful Use, so that's very important information for this group in particular. Then we'll go on, and can I ask who hasn't been on an update in terms of our process for developing Stage 3 recommendations? Has everybody been through one venue or another? Okay so that will be fairly short. And then George will present the results of the small group recommendations for specialists and I know Charlene sent in some edits and we'll have a discussion on that. And do a little bit of organizing ourselves for the NPRM, the eminent NPRM release and see how we're going to get the work done in terms of getting our response ready to present back to HITPC and meet the presumably 60 day turnaround time. Okay and then conclude with public comment. Anything else for today? All right why don't we start with Dawn? Is Dawn on the line?

Dawn Heisey-Grove – Office of the National Coordinator

I'm here, yes.

Paul Tang – Palo Alto Medical Foundation

Great. So, I believe she sent out slides ahead of time and do we have a Webx or?

M

Yeah, I think they're up.

Paul Tang – Palo Alto Medical Foundation

Okay, thank you.

Dawn Heisey-Grove – Office of the National Coordinator

Hi, everybody, I'm going to be talking about some data that we have been capturing in our clinical relationship manager CRM database here at the RECs. The RECs have been entering various data which is basically things that are keeping them from attesting to Meaningful Use or AIU since about November. So, if we can go to the next slide. A little bit of background. Each data are captured on a practice level basis and there were initially some categories that were created that were very broad and very vague in the intent to basically make sure that the RECs who were entering the data would enter anything that they could possibly think of as a barrier. And so, after two months of collecting information we had about 4100 records and we went through and classified them with categories that enabled us to do, you know, further analysis and parse out the information that is captured in there. There is some really, really interesting information there. Go to the next slide.

What we ended up seeing is, again, this is data as of January 10th, and all of the information I'm going to show you is still very much a work in progress. So, as we go through it if you have suggestions on things you might want to see or how we can improve upon it we'll definitely take those. But as of January 10th we had 4100 records, barrier issues created of those 26% were basically practices that were considered on track. So, what that means is the REC was entering it saying, you know, this practice is ready to go, they're just waiting for January to, you know, start their 90 days or they're just waiting out their 90 days to get to Meaningful Use and that is actually really valuable information just because those are practices that we might be able to tap into to find solutions to the barriers that the other ones are reporting. So, it's really kind of nice that the RECs decided to enter that big portion. So, that's a little over 1000 records.

And then the remaining different barrier issue categories that we have, we found practice issues, vendor issues, the attestation process in general and then Meaningful Use measures specifically. So, if you go to the next slide you can see the breakdown once you take out the on-track issues and so these are the things that were considered barriers. The practice cannot move ahead for one reason or another. And you can see that the largest pieces of the pie are the practice issues and the vendor issue, and then attestation and Meaningful Use are kind of on the side there.

So if we go to the next slide we can, this is just a general sense, we've got about 2000 for the first two months of data entry, we do not expect that going forward. In January of 2012 we had about 300, a little over 300 issues created. So, we're thinking that maybe more in keeping in what we'll be seeing going forward. So next slide.

So what we also did was within the barrier issue categories we created more refined subcategories so that you could drill down depending on what your interest is or where you're trying to target your interventions and you can see that the subcategories are on the right-hand side of the slide. Administrative is, you know, they're working on their planning to do their implementation or their Meaningful Use set up, or they can't afford the vendor fees or the vendor upgrade fees, or the module fees, or they just can't afford the EHR product in general.

Provider engagement is that the providers aren't responding to the RECs or they're just not vested in getting into the EHR and using it or into Meaningful Use practices and workflows. Staffing is more where there is a single staff member at the practice that seems to be responsible for everything and they're not there for whatever reason. Training is they're working towards getting the providers up to speed in the workflows or other things that they need to know, sometimes just simple data entry, and then vendor selection, it's the huge portion of the pie that is holding practices back. Let's go to the next slide.

The vendor issues, the biggest one here is the upgrades, that's the 32% that is salmon colored on the left-hand side of the pie and so basically these are practices that are waiting for their upgrade before they

can do anything else to move toward Meaningful Use. And then certification is different from upgrades in that these providers have an EHR product in use but it's not a certified product, so they're waiting for the product to be certified and that's another large portion. Then delays in implementation and installation I think is pretty self-explanatory. Inaccurate reports and/or data, these are reports from the REC where the data that they're seeing doesn't reflect what the practice is doing or they don't feel that the reports that the vendors product is generating are correct.

Lack of support, which is that purple 5%, is the vendor is just not responding in some way. They are slow to respond, they're not training properly or the RECs documenting this is just not being very helpful. Technical is kind of a broad category in that it captures problems with installation in hardware and software and those kinds of things. Support materials are where the REC is documenting that there are some issues with the...I'm sorry, training and support materials are where the vendors documentation or the support materials what they train whatever are not sufficient to get the providers up to speed and then I missed one is the 16%, another big chunk, are the reports are slow or unavailable. So, a large portion of the practices were reporting or the RECs were reporting for the practices that they either don't have the reports to track whether they're getting towards Meaningful Use so they can't, you know, gauge whether they're at 50% or 60%, they just don't know or they're not being able to run them, so it's just working slowly so it's just not worth it to even try and run it. Next slide.

Attestation process, the biggest portion of this is programs that are waiting on AIU to do their attestation for AIU because the Medicaid Program in their state is not up yet and that's 76%. The next largest piece of the pie is something that I think everybody is aware of is challenging for some groups, it's just calculating the patient volume there. And then the Medicaid and Medicare sections, those are practices that are dealing with technical issues with, you know, registering or something like that, you know, just technical small little details to a specific program that they're trying to register and attest to. Next slide.

So, then if you look at all barrier categories, we look at the top 10 categories. Now, what I should point out is on the right-hand side that number of issues column is the number of reported issues in total in the CRM. It doesn't reflect the number of providers that are affected by each of these issues. We haven't delved into that just yet, but we do plan to. So, this is just of the 4100 issues, for example the biggest problem is practice issue, vendor selection. So, practices are having problems picking their vendor or it just is taking a lot, and then you can read the rest of the slide it's pretty self-explanatory. But you can see that the major of this reflects just the same as the pie did, the major problems are with the practice and the vendor categories. Next slide.

So, one of the other things that we did when we were re-classifying the data is to come up with what I call a parent category. So, what we're going to have the RECs do is classify which stage the practice is at, are they trying to reach standard use or are they getting to Meaningful Use. And so, right now the barrier data that we have in here, the majority of it is providers who are trying to get to AIU and then the next, you know, the other category is Meaningful Use. So, when you break down the top 10 by these two different categories you'll see the next slide.

So, this is the top 10 categories for that AIU Medicaid category and here, again its vendor selection, but then the second major barrier is pretty far behind. So, the first one, vendor selection we have 465 reports of that being a problem. But the second one is only 146 reports of issues and that's Medicaid. The state Medicaid Program isn't up yet and they're just waiting. So, that speaks pretty well to the fact that once these state programs are up we might see another influx. And then technical issues with the vendors and certification are, you know, close behind the attestation process issue. So, if we go to the next slide.

These are the top 10 barrier categories for Meaningful Use and you can see that far and away the biggest thing that providers are waiting for is an upgrade from the vendor. And then the next one is measure specific issues. So, these are the Meaningful Use categories. And what the RECs could do is they could create a barrier issue and then there were checkboxes for each of the core menu sets and then they had categories for core CQM, alternate CQMs and additional CQMs. So, they were able to select those individual things. One barrier issue could report out multiple measures as a problem within one issue.

So, if you go to the next slide, here's a breakdown of the top 10 measure specific barriers. So, if you remember from the previous slide there were 256, I believe, issues that were reported, but again these numbers aren't going to add up to that 256 because one issue could have multiple barrier types of these core menu issues reported within one. So, the biggest two, far and away, were the core number 13, which is the clinical summaries and core 15, which is the security review. And when you look further into the data that we have, 22% of the clinical summary reports are providers that aren't printing clinical summaries, they're just not printing them in their normal workflow and 15% are providers that are still trying to work out their workflow either with the vendor or some other way where, you know, they don't know which button to click or they're trying to figure out who in their office staff is actually going to print the clinical summaries, 63% of the 97 reports that we got for core number 13, we didn't have enough information to go any further with it. So, they just checked the box and left it at that.

For core 15, of the reports that we got that actually had information on it, 36% percent of those 92 are actually just waiting on a security risk assessment to happen and then 12% are working through the assessment identified issues. So, I think that's the last slide. I'm going to open it up to questions.

Paul Tang – Palo Alto Medical Foundation

Thanks very much, Dawn. It's very interesting and we've been sort of hungry for this kind of feedback data and what's going on in the field. We have to recognize that the RECs are serving a specific population so they too, just like our earlier doctors may not be representative of the whole group. So, we'll take that into account.

Dawn Heisey-Grove – Office of the National Coordinator

The other thing I should add is that not all of the RECs are entering the data right now into the CRM, there's about 33 of the 62 RECs that have entered data and 3 of the RECs are definitely in the lead. Three of those, they are responsible for I think over 1000 of the entries here.

Paul Tang – Palo Alto Medical Foundation

Okay. Okay. Yeah. So there's some caveats about the data but they certainly are getting some feedback and I guess one of the things that stands out of course is our vendor issues. I wonder if I could ask a couple of things, one is the vendor selection, which is the biggest chunk of the vendor issues, is some of this due to lack of availability or inadequate availability of vendors to meet the needs whether it's upgrade or selecting a new product?

The second question is, you know, there's hundreds of vendors that are certified, some vendors may not be as ready as others either to fully meet needs in each criteria or have the staying power to get practices through either Stage 1 or I'm also thinking about staying power to keep up with Stage 2 and Stage 3. Do you have a sense for any of these things?

Dawn Heisey-Grove – Office of the National Coordinator

Right. So, vendor selection is actually within what we categorize as a practice issue because it's not a vendor problem per se it's just making a decision. And I manually reviewed all 4100 of the records and have a general sense that I can say, my impression is that it's not lack of vendors that is happening here. I think it may be over abundance of choices. You know, what I saw when I was reviewing the data is that just looking, you know, they have lots of things scheduled and they're just going through each and every one of those 100, you know, hundreds that you mentioned that were certified. So, that was my general impression from looking at that data.

And then your other question about hundreds of vendors that are certified that are just not working through the progress, the other thing that I saw pretty frequently when I was looking at the data was that a large portion of them were doing a rip and replace. So, that could speak, again, anecdotal, that could speak to the fact that the provider wasn't happy with their original choice and decided to just change out. And we have to delve further into that to really get a better grasp on that. But, those are good questions.

Paul Tang – Palo Alto Medical Foundation

Other questions?

George Hripcsak – Columbia University NYC

Dawn, this is George. Still on that, is vendor selection, like is it an obstacle or is it just saying that's the phase they're in. How is the data gathered? Are they saying the reason I can't do Meaningful Use is because I can't pick a vendor or is that we're saying where are you in the process and they're saying; well we're in the process of doing vendor selection?

Dawn Heisey-Grove – Office of the National Coordinator

So that is a really interesting question. What we saw with the RECs is that they're actually using this barrier issue tracking tool in different ways. So, you know, the three large RECs that I mentioned are pretty much entering a barrier issue for every single one of the practices and they're just documenting the stage in which they're at. So, for that group, the ones that are entering and using the data in that way, I would say that there, you know, may just be a documentation of the status that they're at. Other RECs were only entering ones where they felt that there was a barrier and in that situation I think that those RECs would be saying that this is something that the provider is just stuck on and they can't get forward.

Paul Tang – Palo Alto Medical Foundation

Would you be able to separate those two so that we can have it a little bit more clearly?

Dawn Heisey-Grove – Office of the National Coordinator

I can certainly try.

Paul Tang – Palo Alto Medical Foundation

Well, I mean instead of you doing it manually after the fact maybe you have a what stage are they in part of your questionnaire survey and then another about barriers and sort of make it clear.

Dawn Heisey-Grove – Office of the National Coordinator

Oh, I see. Yeah, I mean we can explore that. I think it would be a simple analysis as well because we could figure out, you know, the RECs that have all of their practices with an issue and parse it out that way as well. But, yes. It's an interesting question that I hadn't explored. I like it.

George Hripcsak – Columbia University NYC

Let me reiterate, this is George, that this is wonderful though. Thank you so much.

Dawn Heisey-Grove – Office of the National Coordinator

Thank you.

W

Dawn, this is...I have a question is there any way to do an analysis or have you already done this, looking at whether these barriers vary by practice types? So, if I take a private practice or by practice site or urban/rural, or is it pretty universal it doesn't matter; those variants don't change the order of the barriers?

Dawn Heisey-Grove – Office of the National Coordinator

We have not started to explore that. I am just in the process of merging these new categories back with the other ones but that is on the top of our list to start exploring. I have some preliminary slides that show that information, but it's definitely in the plans to get that out, because I think it's going to vary. I think that these are definitely changed depending on what kind of practice is being reported on.

W

Thanks so much.

Paul Tang – Palo Alto Medical Foundation

Other questions?

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

This is Charlene Underwood. Again from the vendor's perspective, do you see it like, you know, certainly we've heard the feedback there are delays in, and again, I think the dimension of if they're in that phase they are waiting for an upgrade, but any sense in terms of the degree of the delays? I mean any sense in terms of like, you know, they're waiting months or are they waiting weeks, you know, any breakdown like that or is it just part of the process? Because sometimes you've got to get scheduled in get your upgrade. So, it's not the normal process, other delays?

Dawn Heisey-Grove – Office of the National Coordinator

Right, I mean, most of these said that, you know, they were scheduled, they said they were scheduled or they are just waiting, you know, their turn in the queue. What I think we can probably do to kind of parse that out is we have an expected date of Meaningful Use and the barrier issue itself. So, we could look at that and see, you know, how far out it is, because presumably the expected Meaningful Use date might not be too far off from when their installation actually is or their upgrade, sorry.

Paul Tang – Palo Alto Medical Foundation

This is Paul. I have a specific question on your top 10 measure specific barriers and one has to do, the second one, the security review actually is a good thing, basically they're waiting to do the risk analysis and that's the whole reason we put that in there because even though HIPAA was passed a long time ago, many providers have not even done their security risk. So, that's why we put it in there and it's good that they're at least waiting to get that done.

The second piece was the first one on clinical summaries and you talked about 20% not printing. Now, easily our hope was that people were not printing but they actually have, the patients have this available to them, these after visit summaries and clinical summaries available on-line at any time they want it. So, the idea we were trying to push people toward having a PHR or patient portal so that they can basically have access to this soon after the visit and any time they want. When you say 20% aren't printing are those practices that not only are not printing but they also do not have an electronic way of accessing the information?

Dawn Heisey-Grove – Office of the National Coordinator

So, the amount of detail varied, you know, with what the REC decided to put into the comment section, but there were actually a handful at least that said the provider didn't want to pay the extra money for the patient portal so they have to print them but they're not willing to print them for example. So, you know, I just looked at this subset this morning and there were at least a good, you know, portion of them that were like that. So money might be a barrier to having the patient portal.

Paul Tang – Palo Alto Medical Foundation

Okay.

Christine Bechtel – National Partnership for Women & Families

Dawn, this is Christine Bechtel. Thanks also for this, this is terrifically helpful. As you think about sort of the policy issues and issues with our various functional criteria or quality measures are there any particular ones, you know, kind of along the lines that Paul was just asking where we think as a group we probably need to make some recommendations or, you know, think about doing some tweaking for either Stage 2 or Stage 3? Or is this mostly stuff that CMS and ONC need to sort of give guidance on. I mean where are we seeing the issues that are kind of policy oriented?

Josh Seidman – Office of the National Coordinator

Yeah, this is Josh. So, I mean, I think, I probably, you know, should have provided a little context at the beginning. When you all have some, you know, fantastic hearings with great testimony I think one of the things that comes up is that there are a lot of issues that have come up, but obviously when you have people testifying you don't have a large "n" and so part of the idea here was to begin to try to put some empirical analysis together to try and help support the more anecdotal evidence that you've been collecting individually on your own and then through the public hearings. So, I think, you know, this is certainly the start and I think Dawn was, you know, trying to be careful with a bunch of caveats about the data. We are where we are. We've got a long way to go in terms of really sinking our teeth into it.

But because you all are, you know, sort of really trying to get as much information as possible as you think about your recommendations for Stages 2 and 3, you know, we wanted to get you whatever we had as soon as we have it. I think that some of these things clearly could, depending on how the data evolves, could have implications for both your recommendations and ultimately for our policy making. We have always said that one of the important parts of moving Meaningful Use forward is understanding actual real-world experience and this is some of the first, you know, real good data that we've collected that begins to point us to some of the issues in a quantitative way. But, I think I would caution against, you know, in a sense, you know, drawing conclusions at this point.

Paul Tang – Palo Alto Medical Foundation

Well the things that have been mentioned so far, I think one of the areas that George raised is if there's a way, so that Dawn doesn't have to read 4000 comments and separate maybe for each practice where they can indicate what stage they're in and maybe you can delineate, you know, 10 stages. Then we can separate the entry for what stage versus where the barriers are because that's clearly going to be really important. A lot of the vendor selection might literally be just what stage they're in versus a different problem.

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

This is Neil. Can I ask a few questions? Do we have the actual names of the vendors?

Dawn Heisey-Grove – Office of the National Coordinator

Yes we do.

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

And does it appear that the problem is arising from a few vendors or that different problems are arising across the board with the majority of the vendors?

Dawn Heisey-Grove – Office of the National Coordinator

So, right now I don't think I can actually say that with any certainty. What we need to do is look at, you know, the number of barriers reported by vendor and then, you know, caveat that with well, you know, Allscripts, and I'm not saying that this is one of them, I'm just saying Allscripts might be the highest vendor with the number of barriers reported, but it may be that they're the largest vendor in our group. So, we have to look at the data in a special way to make sure that we're.

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

Right, I guess the thing that I was thinking is if the same problem is occurring repeatedly with the same vendor, there ought to be able to have a way of feeding that back into the certification process so that, you know, clearly if the product is certified but dozens and dozens of people are basically saying they're having exactly the same problem meeting one of their requirements with the same vendor product then clearly that certification process isn't working or, you know, the person did something bogus in getting that product certified in the first place. I don't know if that's within our purview but we really should think about how that data should feed back in because that is sort of our major responsibilities is to make sure that what we're requiring of people is actually possible of them. My second point is, is the reporting to this database mandatory and if so, why is there such a poor level of reporting. You said the vast majority of the stuff that you have is just from three RECs.

Dawn Heisey-Grove – Office of the National Coordinator

The reporting isn't mandatory because some of the practices are maintaining these, I'm sorry some of the RECs are maintaining these data in a separate system. And I'm working with those RECs or starting to work those RECs to get that data and try to incorporate it into what we have here in some way, shape or form. We're also hoping that by seeing the data and seeing how it can be used other RECs will start, you know, jumping on and entering it.

And, in terms of the three big REC, you know, groups that are active in data entry, I think there's a difference in how they're using it and we're going to explore how those top three are using it which

accounts for I think about 1000. So, you know, it's about 25%, not the vast majority. But, see if we can get other RECs to do what they're doing, which is enter the barrier which is somewhat of a misnomer in this situation into the system so that we can see those practices that are accomplishing Meaningful Use, so we can again use those as best practices, which may answer some of your question about the EHR vendor, you know, issues as well, because, you know, 50% of the practices that are using one vendor are having no problems and the other 50% are having problems, that may be an indicator that it's something about the practice type, which I think was an earlier question, practice size or whatever versus and actual vendor issue.

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

So, just a follow-up comment. Since we're providing the RECs with funding, it would seem to me that if this tool turns out to be as valuable as it appears to be that we could potentially be doing something to think about what authority we would have to require reporting or at least to have that part of the reporting mechanism, because ultimately this is the feedback tool that we need. I mean, they're supposed to be, you know, stimulating adoption and without this kind of organized feedback it's really hard to know what's happening. So, I don't know whether that's a possibility but I put it out there for consideration.

Josh Seidman – Office of the National Coordinator

Yeah, so this is Josh. I think on that issue, I mean, it's something, there are certain requirements that we have and any time we try to build a new requirement obviously there can be some challenges, but they are required to report certain data to the CRM and there may be opportunities to expand it and certainly, you know, we would welcome input from you all and from the public about that. Neil to your other issue, you know, I think if there are issues that we identify around vendors that relate to something about the product somehow, you know, not doing what it was certified to do, I think you're right that would be reported back to our certification process and we'd certainly take that into account as we evolve that program. There may also be data, you know, things like lag time for upgrades and things like that which are not certification issues, but there could be value in transparency around that data for, you know, things like vendor selection and other issues that are coming up so that we can provide, you know, greater insight into, you know, differences among vendors and some of the things that need to happen in order for practices to succeed.

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

So, you're saying that the data could be used to drive the market part of this?

Josh Seidman – Office of the National Coordinator

Right.

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

Yeah, that would be very useful as well I think.

Paul Tang – Palo Alto Medical Foundation

Josh, I think this is helpful information. Would it be possible for us to get a copy of the actual survey tool you're using and perhaps we might have some suggestions about other kinds of data to gather, because I think this line of feedback is really important not only for the certification as Neil mentioned, but just the feasibility as you were eluding to Josh, but also part of the IOM recommendation on EHR safety was that it created some of the feedback about the safety issues occurring with vendors and you can think of it as more generic, it doesn't have to be a specific vendor, but this kind of feedback particularly from the field would be very useful.

George Hripcsak – Columbia University NYC

Yeah, that's a good point Paul; this is George, about the IOM Committee.

Paul Tang – Palo Alto Medical Foundation

Yeah. So is that possible for us to get a copy of the survey and it may have multiple kinds of uses, one could be in the Adoption and Certification Workgroup we have another could be this Workgroup looking at

well how are our requirements and objectives playing out, and perhaps another line could be in the vendor selection kind of EHR safety area.

Dawn Heisey-Grove – Office of the National Coordinator

Yes, so there's two answers to that question. The first is I think that I sent with my slides a word document that describes, you know, the barrier issues, the selection criteria, as well as sort of the barriers category description. So, that is a place to start. It has definitions for each of the categories. And then the other thing is I can write down all of the questions from the CRM that they're using to document the barrier issues it's not a survey tool necessarily, but I can just copy and paste the questions for you and send them out.

Paul Tang – Palo Alto Medical Foundation

Thanks so much Dawn.

Dawn Heisey-Grove – Office of the National Coordinator

Sure.

Leslie Kelly-Hall – Senior Vice President for Policy for Healthwise

This is Leslie. I just had a big picture question. It seems that your survey has very much highlighted the difficulty within practices to transition and convert and that the RECs are doing a great job with helping practices. Do we have a question in the survey that just simply asks would you be converting without Meaningful Use? Because we have seen a slow adoption in the past and these barriers are real, now with proper incentives these barriers are being overcome and Meaningful Use is successful. Do we have that kind of question?

Josh Seidman – Office of the National Coordinator

Yeah, I think it's a great question to ask. It's not really part of identifying barriers, which is the purpose of this tool. I think that there are probably other types of surveys out there that are looking at that like SK&A. And I think, didn't we have access to that?

Dawn Heisey-Grove – Office of the National Coordinator

We're going to be getting.

Josh Seidman – Office of the National Coordinator

We're going to be getting access to that data. So, I think we will be able to do some analysis of that. Another thing that Dawn is doing is she is working with other people here at ONC on integration of various data sources. So, taking things like that SK&A data, HIMSS class data and other types of data as well as CMS data and integrating that with the CRM data to think about how we understand all these things together. But, I think that's probably a little bit separate from the barriers.

Leslie Kelly-Hall – Senior Vice President for Policy for Healthwise

Thanks, Josh.

Paul Tang – Palo Alto Medical Foundation

Any other questions? Good. Well, thank you very much, Dawn. Is something that you think we should get a regular update on so that we can keep somewhat in touch with the information from the field?

Dawn Heisey-Grove – Office of the National Coordinator

I'd be happy to. The data, you know, regularly maybe on a monthly basis, so if you can take that and let me know when you want to see it again.

Paul Tang – Palo Alto Medical Foundation

Sure, thank you so much.

Dawn Heisey-Grove – Office of the National Coordinator

Sure, thank you.

Paul Tang – Palo Alto Medical Foundation

Okay, let me move onto developing Stage 3 recommendations. And as you know we've broken ourselves up into the five categories. Since most of you have heard the process for developing it, I'll just summarize that very quickly. One, in our post October 5 hearing we met together and came up with essentially principles and focal areas and we wanted to use those lenses to guide our development of Stage 3 thinking that it doesn't have to be just an increment of Stage 2, but as the final stage, at least before 2015/2016, we want to make sure we're heading really towards the outcomes, measurement and improvement goal that we set for ourselves at the very beginning. So the principles we set up ourselves is we wanted to align with the emerging payment policy and the National Quality Strategy to be in tune with the contemporary initiative, we wanted to, you know, emphasize our focus on parsimony by harmonizing the qualifications among the various CMS programs. We certainly heard a lot from the field saying, you know, we have this, we have ACOs, we have PCMH, we have evaluation, purchasing, etcetera, and we want to make sure that they're just not all additive, because if you overburdened the providers we're just not going to get as much effective output.

Third is to concentrate on where the initiative is going which is in population health management. So, we need to get population health data for analysis. Fourth is to support innovative approaches, so we're trying to...but our objectives want to support and encourage innovative approaches to using HIT to improve health and healthcare. And fifth talking about flexible adaptive platforms rather than some prescriptive regimented formula, and finally, not to penalize success, so don't take people who are innovating and getting better results and bring them back to some kind of core, that's not what we want to do.

So, we had a number of focal areas we set for ourselves. They approximately map to our five categories, one is in addition to just saying, well let's get features and functions out there and let's get reporting which tends to be retrospective, let's work in Stage 3 to have a much more real-time impact of this information at the point of care, so, instead of quality reporting retrospectively thinking a lot more towards the clinical performance dashboard that can be present every morning. For example, instead of reporting what are the adverse event's you've had in the past, how do you detect and prevent and mitigate things that are going on now, and how do you continuously support learning throughout the whole health system?

In the patient empowerment category we've been working on access and download and how do we go more toward support of the decision making by both the patient and their caregivers and how do they do more with that information. How do we measure things that are important to patients not just process measures that may or may not be important to providers. Looking for more sources of data not necessarily just in the EHR but things that come in through let's say EHRs or patient portals. We talked about functional outcomes and other measures that matter to consumers and patients. More of a focus on clinical decision support, which is sort of the Holy Grail of all of this. It's nice to have this data accessible, it's nice to view it, but how do we turn it around and shape our decisions that we make every day.

And then finally, the tools to both understand and to manage population health. To that we added in our last conversation, wanting to make sure, yeah we're getting data into these systems, how do we make sure we're getting complete data and accurate data. So, that is a major barrier or goal is to make sure that we have accurate data so that when we operate on them, let's say in clinical decision support or in reporting that we know what we're getting. And we always are faced with the how do we make sure we get data no matter where it is, the whole health information exchange.

So, those are the kinds of considerations that we want to put before us as we develop Stage 3 recommendations. I think it can be a big signal to where not only this tool, the electronic tool, but where health systems need to go in order to deal with the problems and the health issues of the future. What we thought we'd do is start out, we had some place holders from our Stage 1 and Stage 2 development processes and so we have this column for things to consider in Stage 3 and so we can certainly start there. But, I think we should be looking at the feedback we got from our October 5th hearing, the feedback we just got this morning, other feedback particularly on the direction that the payment system

and the National Quality Strategy is going. How do we support that? For example, The Million Hearts, that's an example of something that could be extraordinarily important in terms of a clinical issue, but the tool we build needs to support that more as an exemplar because it's got to be the tool that supports all other health conditions. But, that's a really good example to work with.

And so we've distributed to you these principles and focal areas. The last statement we made in terms of the matrix with the columns for Stage 3, the feedback we got on Stage 2, and I think there was one more as input to your groups, all the small groups working on the next generation of these objectives and criteria. This particular group, the Meaningful Use Workgroup per se is not working on the quality measures. There is a Quality Measure Workgroup that David Lansky chairs and so they're going to be watching over that, but clearly any of the ideas that we have we certainly can be sending over that way. Any other questions before I talk about responding to NPRM?

Christine Bechtel – National Partnership for Women & Families

Paul, it's Christine, I just wanted to, as I was listening to you talk about quality measures and I was sitting here thinking, you know, there are some kind of quality measures, and we had talked about this approach early on, where if we simply required the measure reporting or, you know, performance then we actually could get away from the functional measures.

Paul Tang – Palo Alto Medical Foundation

Right.

Christine Bechtel – National Partnership for Women & Families

Is it worth, you know, having one of the inputs for the work, in addition to all of the documents that were sent out, you know, some kind of an overview of the quality measures that ONC or CMS are contracting for, you know, some input as to where we think the Quality Measure Workgroup is going so that we can think about, you know, it's going to be hard to do the work in silos, and take that approach is I think what I'm getting at.

Paul Tang – Palo Alto Medical Foundation

It's a good comment, Christine. I'll let David Lansky say some things as well. We have the report we can redistribute it about the quality measure concept.

Christine Bechtel – National Partnership for Women & Families

Right.

Paul Tang – Palo Alto Medical Foundation

That were more aspirational. I think they are really good concepts. And then David's group just got an update on some of the work being done by the contractor currently. I have to admit there is a bit of a gap between the aspirational and what's going on now and that's something I think we want to, and David can comment, I think we want to keep pushing towards the aspirational goals and objectives that we set forth in that quality measure document. David, do you want to talk about that anymore?

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

While I like Christine's suggestion I'm wondering whether through these subgroups that are about to start is a place to have a kind of a reporting function or a conversation with each of those groups at some point about whether their domain has opportunities to strengthen the quality measures and displace some of the functional requirements. And if we think of each of the major sort of functional areas as being on a glide path or a developmental path where the ultimate state potentially is some kind of a quality measure which reflects attainment of the function and therefore we don't have to keep track of the function. It's a good exercise to test whether we're making progress towards that kind of a model. And we could hand that off to these five subgroups at some point in their work process with respect to that. The other thing I'm wondering is whether the NPRM response process that we're about to talk about is another place that may surface in looking at that NPRM as well.

Paul Tang – Palo Alto Medical Foundation

Exactly. Let me combine those two ideas. If we hand out, Mary Jo would you hand out the report from the Quality Measure Workgroup, then each of the subgroups can look at the quality measures that are relevant to them and perhaps do a sort of contingency recommendation. In other words, taking Christine's point, if this quality measure concept gets enacted then we can sort of drop this functional requirement, that would be a nice statement and would bolster the value of having these new quality measures coming to be. Does that make sense?

Christine Bechtel – National Partnership for Women & Families

Yeah, I think it does. Yeah, you know, I was just thinking back, because I Co-Chaired with David the Patient and Family Engagement Tiger Team under the Quality Measures Workgroup and so we had these like spectacular aspirational quality measures, but I just don't know which are under contract in development for Stage 2 versus 3 and can we count on them. And, so I think that idea of saying, okay if by then we have this quality measure then you could drop these functional requirements. I think that works.

Paul Tang – Palo Alto Medical Foundation

I think that would be a great advance. It would be useful for providers not to have to chase these process measures and functionality objectives and really to keep their eye on the main ball which is how do measure and improve the outcome. So, I think that would be a really great demonstration. And from David's point of view I think it would support the goal of developing these new measures along these lines.

George Hripcsak – Columbia University NYC

Paul, this is George. So, I agree with this completely. I think it's harder than it sounds though.

Christine Bechtel – National Partnership for Women & Families

Yes.

George Hripcsak – Columbia University NYC

And I think that you're really going to be faced with do we feel comfortable letting go of this functional objective which is kind of covered by these three quality measures but not completely and we're willing to give up some control here and cut down to some bare minimum, realizing that it's not completely covered by the quality measure.

Paul Tang – Palo Alto Medical Foundation

So, let's go through that thought process and that exercise to see whether, you're right that there is always a devil in the details.

Christine Bechtel – National Partnership for Women & Families

Yeah and I agree with George. I remember this from last time as well, but, you know, I think it is trade-off. So, but I think it's worth considering and I think it would be very helpful to have some substantive and written input that we can use in our thinking whether that's the measure concepts that were recommended or some further information from the Quality Measures Workgroup or whatever that would be helpful before our groups get going.

Paul Tang – Palo Alto Medical Foundation

Right.

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

Paul, this is Mary Jo. I just wanted to clarify what I would be sending. I think I first heard you ask to circulate the report of the Meaningful Use Workgroup's eCQM Subgroup, is that correct or was there a different one?

Paul Tang – Palo Alto Medical Foundation

Well, actually that's not what I was asking to send around, but it's David Lansky's Quality Measure Workgroup [it's suring up](#) talking about the core, it had that circle.

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

Okay.

Paul Tang – Palo Alto Medical Foundation

The core and the six domains.

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

Okay.

Paul Tang – Palo Alto Medical Foundation

Thank you. Now going into the NPRM I think we're going to have our work cut out for us over the next two months. So, HHS has been repeatedly saying that the NPRM will come out in February and so sometime within the next three weeks we'll see that. We will need some time to digest it, I'm sure it's not going to be short. I don't know how long it will be, but we'll have to digest that and look at the Delta from our recommendations. And our goal really is to provide comment as we did in Stage 1 on the Delta and some new updated thoughts we might have on those. So, we're hoping that our next call I believe is March the 8th, correct Mary Jo?

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

I'm sorry I was on mute, it's March 6th and we have tentatively set aside 4 hours. We have March 6th 10:00-2:00. Then you have an all day meeting on the 13th 9:00-5:00 and we have a location here in DC. And then there's another meeting on the 23rd that's 10:00-12:00. So, the first one is 10:00-2:00 on the 6th and the last one is 2 hours on the 23rd.

Paul Tang – Palo Alto Medical Foundation

Okay. So our thought is we're really anticipating that it will come out in February, that we'll need some time for all of us to read through it and that at the next call, March the 6th, CMS and ONC will present to us the summary of the NPRM and we'll sort of organize ourselves to understand what's the amount of work necessary to review and respond to the NPRM. So, we'd like to really understand the NPRM well, understand sort of the areas where we'll need to spend a lot of our time in responding and come in well prepared for our face-to-face on the 13th to be able to just march through those areas and come up with our draft recommendations.

We'd like to finalize that by that second call in March so that by the April, and I think it's in the first week of April, the April HITPC meeting, we need to put out our draft to the full committee for their endorsement.

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

That's Wednesday, April 4th by the way.

Paul Tang – Palo Alto Medical Foundation

Okay, let's say April 4th.

Josh Seidman – Office of the National Coordinator

Paul, this is Josh. Just a question about the presentation from CMS and/or ONC on NPRM. The Meaningful Use Workgroup's next call is on March 6th, the Health IT Policy Committee meets the next day, March 7th, I don't know, I would think you would probably want the Policy Committee to get a briefing as well. So, I just didn't know if you would want to have it presented on, you know, on repeat days or?

Paul Tang – Palo Alto Medical Foundation

Well, in some sense, we almost have to because scheduling-wise that's where we found the time for the Meaningful Use Workgroup and we are going to spend our time organizing ourselves. So, let's see, I think we overlap by maybe four or five members and yes it will be repetitive for those members, but it seems like we need to have that presentation to set up our discussion on that day. What do you think?

Amy Zimmerman – Rhode Island Department of Health & Human Services

This is Amy. I wonder, from an efficiency point of view, I'm not one of those that's on both committees, but if it's more efficient for CMS and/or for our committee, if we listened, and I don't even know what time that meeting is, if we sort of listened in or participated, not, you know, actively, but listened into the presentation and then found some time after that meeting to stay on to organize ourselves.

Paul Tang – Palo Alto Medical Foundation

Well that was the problem, we couldn't, Mary Jo can comment, we couldn't get time, that amount of time after the 7th.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay.

Paul Tang – Palo Alto Medical Foundation

Is that right Mary Jo?

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

That's correct.

Paul Tang – Palo Alto Medical Foundation

So, that's our timing problem. So are people okay with the duplicate and I guess is CMS and ONC okay duplicate knowing that in a sense it's in our court to try to formulate for the committee the draft recommendation response. What do you think, Josh? He might be on mute.

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

This is Mary Jo and I will take the liberty of jumping in and observing it since, you know, you are the people who have the biggest responsibility, why you really do need your face time to ask the questions that you need to ask and then the next day there will be those who maybe have different interests in the NPRM who can have their chance to ask the questions.

Paul Tang – Palo Alto Medical Foundation

Yeah, I'm guessing that our discussion is going to be much more detailed. So, I'm guessing that the presentation will be longer and probably interrupted by clarifying questions. So we could have a much shorter summary version. And explain to the full committee that the Meaningful Use Workgroup is intently and diligently working on this for the committee. So, Josh, I don't know whether you're back, would that be okay?

Michelle

Hi, this is Michelle; Josh may have dropped off the call. So, I'll just follow-up with him to make sure that he gets that.

Josh Seidman – Office of the National Coordinator

Sorry, something happened to the phone, I don't know what, but I just came back on. Sorry, was there a question?

Paul Tang – Palo Alto Medical Foundation

Yeah, okay. So, we were saying just because of scheduling we weren't able to get the Meaningful Use Workgroup call after the HITPC meeting and since we're going to spend a lot of detailed time it probably is worth having that presentation and it's probably going to be more lengthy and have more clarifying

questions on our call on the 6th and then maybe a shortened version on the 7th and we can also explain to the full committee that clearly the Meaningful Use Workgroup is spending a lot of time in exploring all the details but we just wanted to have a shorter briefing to the full committee. Does that make sense? Would that be okay?

Josh Seidman – Office of the National Coordinator

Sure. And I will discuss this with my CMS colleagues who will do it.

Paul Tang – Palo Alto Medical Foundation

Okay. Great. Thank you. So, by the end of our March face-to-face, hopefully we'll have most of our response drafted and we'll finish on our call on the 26th and be ready to present to the full committee on April 4th and hopefully will take in some feedback and revisions and make those revisions right away because presumably we have to turn in our response back to CMS and ONC within 60 days of February. Other comments about that process? Okay, George do you want to talk about the Specialist Small Workgroup recommendations?

George Hripcsak – Columbia University NYC

Thank you, Paul. Is it possible to put the documents on the web? Either the original or Charlene's?

M

Paul, while we're waiting I have a question about the timing of the Workgroup output, the subgroups.

Paul Tang – Palo Alto Medical Foundation

Go ahead.

M

When is that supposed to be at least ready for first presentation to the HIT Policy Committee?

Paul Tang – Palo Alto Medical Foundation

And this is on Stage 3 or the response to the NPRM?

M

No, on Stage 3?

Paul Tang – Palo Alto Medical Foundation

Working backwards we would like to pretty much be done by the end of this year. So, we wanted to, in the third quarter, have the RFP process where we put out our draft that we've gone through. So, the small groups put together recommendations, the Meaningful Use Workgroup in its entirety, like this call, reviews those and finally approves those and there is some iteration going on there, then brings it to the Policy Committee, get its feedback before going out with an RFP for public feedback, etcetera.

M

Right.

Paul Tang – Palo Alto Medical Foundation

So, you can see how the lead time is, we're talking probably getting our Meaningful Use Workgroup recommendations out of the Policy Committee in the summer.

M

Okay.

M

Can you be more specific Paul? So, when do the small groups need to be done roughly?

Paul Tang – Palo Alto Medical Foundation

So, we would want to start the discussion with the Meaningful Use Workgroup that would be in quarter two, so I'm guessing sort of in the May timeframe. So, in other words we're going to get through our response to the NPRM and then in May/June I would guess we would have our first iteration back with the full Workgroup and then iterate around that before we get it back out to the full committee in the mid to late summer. Does that make sense? So, I'll try to narrow it down a little bit more, but it sort of we get a month to two months after dealing with the NPRM response to put together our small group drafts to the full Workgroup. Does that help?

M

That sounds reasonable.

Paul Tang – Palo Alto Medical Foundation

Yeah.

George Hripcsak – Columbia University NYC

So we should e-mail, Paul we should make up that timeline and e-mail it around to the Workgroup members?

Paul Tang – Palo Alto Medical Foundation

Yes.

George Hripcsak – Columbia University NYC

And to the subgroup members in case there are subgroups that have members beyond the Workgroup?

Paul Tang – Palo Alto Medical Foundation

Exactly right. Does that seem reasonable David?

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

Yeah.

Paul Tang – Palo Alto Medical Foundation

Okay. Great. Thanks.

M

Thank you, Paul.

George Hripcsak – Columbia University NYC

Okay, so George here, Mary Jo if it's possible to put one of the documents up that may be helpful for people on the web, but if not I'll just start going through it. The process is the Specialist Subgroup realized that images were an important part of engaging specialists; it's a large part of many of the specialist work. We knew that we were already working on standards and the question is what's the next step we can do? And, so we started thinking about that. We, through an indirect route, we thought one way to do it would be to do a joint work between the Policy and the Standards Committee, although what we concluded eventually was first the Policy Committee should come up with a clinical goal and then we can iterate on feasibility, but first we should have a drive from the Policy Committee which then comes back to the Workgroup and to the whatever Subgroup.

So we worked on it a little bit in the Specialist Subgroup and then I had a conversation with Doug Fridsma and then most recently we've had some comments from Charlene on the call, from her and her colleagues, and she has also pointed out some other resources, a blog here that has actually very useful information. So, let me just kind of go through what I have as of, just before Charlene's input, because I'm going to add that, but after Doug Fridsma's input. So the long-term goal, you know, ultimately is to improve quality, efficiency of healthcare by promoting the sharing of clinical images among healthcare providers and with consumers that is kind of our kind of high level long-term goal. We realized that, you know, this is going to require a couple of things, standards, viewing technology that is incorporated into EHRs and the sharing of images. And Charlene points out that a lot of that is what the Standards

Committee needs to work on and I agree with that. So standards are not what we're saying; we want to get back to the clinical goal.

So, we came up with two sample clinical objectives. One of them, and I'll just read it, access to at least one image using a viewing function that displays the image within the context of the patient's health record. The viewing technology should have sufficient resolution and function to support in office viewing. So, first of all the objective is saying it should be possible for clinicians to get access to the images in some form or another and it should be done in the context of the EHR not some application that feels very separate, in other words, you should be able to see the clinical data and the image in some way connect to each other.

What we're trying to do is stay separate from how that would get implemented. Is this an example of an EHR with a link to a web viewer, a link to a PAC system, a link to some national registry, or federated model, we don't want to comment on that, we just want the user to feel that they can view the image. And we ended up settling on, at least temporarily, on the phrase in office of viewing. Because one issue is well how much resolution do you need for that? Do you need diagnostic quality? Do you need to be able to manipulate the image, to zoom in, change the contrast, view an entire time series, an entire 3-D view? Or do you want to, for in office viewing, have something that short of that is like the first view of the image, for example something that you would use in patient education. You take one view of this to say show the patient here's where the lesion is, but the patient is not going to sit there going through, in your office, going through various forms of contrast or something.

One of the comments that has been made is that well maybe a way to do this is to separate simple images from more complex series. So, like a chest x-ray or something like an ankle film from a break is something that is more manageable in size and complexity as opposed to say cinematography of a catheterization or other forms of timed series or even some complex 3-D images. So, again, what we're trying to do is step back to enable the patient to go to the clinical goal, but the clinical goal includes stating the resolution and we're not resolved yet in how to state a sufficient resolution.

The second objective, perform at least one test of the capability to exchange images among providers of care and patient authorized entities electronically. So, if that sounds familiar it's because it's just taking the Stage 1 HIE objective and putting in exchange images instead of data, basically saying if we're going to push the thing forward maybe we do a test of capability as the next step in sharing images, which again, trying to be divorced from how this gets implemented is this point-to-point sharing of images. Does each institution host an image server? Is there a state-wide image server? We don't know what the right one will be.

Well then let me just go through this, and then a number of considerations. For example, one of the big ones is any objectives we come up with need to be assessed for feasibility, that's our joint work with the Standards Committee. The second consideration, limiting it to static images, that's what Doug called them, static images such as x-rays and single shots of MRI scans as opposed to more complex things. The third item, need to assess the cost benefit of different levels of resolution and function for different uses such as second opinion or patient education, suggestion being that in fact you do need that little bit lower resolution but you should still be able, at least in the long run, be able to jump to the high resolution version so you can do a full second opinion which requires potentially the full diagnostic ability.

The fourth item, how should consumer access, viewing and access control be implemented, is it like other HIE? Fifth, several architectures are possible but we want to remain neutral on the architecture. Next, how can we ensure sufficient time and resources to go from the certification process through implementation before we start expecting successful use to get either Meaningful Use incentives or avoidance of penalties, so it's giving the field enough time to gear up and the provider enough time to gear up. Make sure that these requirements are for sending not just receiving images. So, specialties that produce images, part of Meaningful Use will be sharing those images by whatever mechanism the Standards Committee comes up with.

The viewer should feel integrated into the record not just the linkage to a separate PAC system where you sign into that thing. The interpretation of the images should accompany the image and that the objective, although they may not be identical should cover both eligible professionals and eligible hospitals. So, that was kind of a straw man of what to consider but it's actually fairly complex to figure out what would be a next step. Maybe, Charlene could you comment next, since I couldn't really cover all your comments. So, maybe if you comment next.

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

Yes, I actually shared it with some of our folks representative of specialists who use imaging technology, radiologist and others, as well as, you know, the folks that do...into radiology and certainly one of the key ones is relative. A couple of key points there, relative to, you know, the standards, clearly there's a lot of domain knowledge because they've been doing this kind of for years and again most of us know that the current state is when you seek someone for an image you often get a CD and we speak sneakernet...which is a good way, and should continue to be a way that we support sharing information. The trick comes though, and the concern is what we really don't want to move, we don't want to set it up in how we ask for this such that an EHR becomes a PAC system. The PAC systems have their place, it should be linked to that from our EHR, but, again we don't want that necessarily to, you know, move into the domain space, if you will, of an EHR costs and all those kind of things you need for access.

When you look at access there's really two dimensions that we need to think through. Number one, when you're seeing a patient you want to share, here's the break or here's the study and I want to look at it, here's the interpretation, what is the degree of resolution that you need in that perspective, but for instance if you're a patient and you're getting a second opinion, then you actually might need diagnostic quality to share that. So, again there are two different use cases there as we're kind of thinking this through.

The third dimension is, again, from the specialist perspective they're accountable, they actually can receive incentive money and do we need to have, you know, objectives that apply to them as part of this process, i.e., that exchange objective, you know, certainly would apply that they can actually exchange the information.

The other point that starts to get a little nebulous is if we start to build out, and this links to what our national infrastructure looks like, in the context of an integrated system it's pretty easy to see how you can link to an image within the context of the community and the role of an HIE, it's a little more difficult to think how to link to a port image and where that information is stored. So, again that's just kind of another use case that was brought up as a consideration. So, clearly there is value in sharing images that should reduce costs, it should make information accessible within the context of an integrated delivery system, it's pretty straightforward in getting there. As we start to get outside the domain of the delivery system that's where some of the issues arise in terms of, you know, how we support the exchange of that information. And I think one of the folks suggested a potential use case to kind of walk through that, you know, scenario. And, I think that, you know, when we're always talking about that closed loop scenario, it's kind of in our care coordination agenda, again it's going to be pretty important that we think through the use of images in that kind of closed loop referral scenario. So, to what extent do you really need that viewing capability at the front end and the consumers need access, and primary care providers need access, and then to what extent do you need it when you're a specialist and doing second opinions.

George Hripcsak – Columbia University NYC

Thank you, Charlene. So, comments from the Committee, from the Workgroup?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Yeah, this is Amy. I have a question and that is when you were talking about viewing, you were sort of saying agnostic to how just the ability to view, when you are talking about sending, I thought I heard you suggest, at one point, Charlene, the sending requirement really may be appropriate only for those specialist that generate the images. My question is, is sending really sending or is it giving access to? It sort of goes back to the viewing issue. I think semantics here are going to end up being important from sort of.

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

Semantics are could you send a link for instance, right? This is the link, or the address basically, and I mean, some of these test vendors now, you know, they're creating clouds where they store the images, right?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Right.

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

So, that's starting to emerge. But you kind of have to pay for it, you get it free for three months and then you have to pay for it or something. So, that's starting to emerge. So, I think that will come out, but it strikes me that maybe, you know, the kind of viewer you have will dictate if it's diagnostic or not and then, you know, for what we need to exchange is the location of where that image is stored.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Right, so I agree with that, I think that's exactly sort of the kind of thing I was saying. I think we want to just be careful with what sending an image means.

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

Yes.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Sending an image meaning sending an actual image or sending access to the image, and I just think eventually the semantics here are going to be important in terms of interpretation.

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

Yes and that was the feedback the community gave because if you're too general then it may just become a PAC machine, you know, that sort of thing.

Paul Tang – Palo Alto Medical Foundation

The other issue though is once you do this cloud system all of a sudden ID and authentication are extraordinarily important and we have that covered locally but once you go into the cloud it's a completely different ballpark.

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

Yeah, these things are emerging and you hear about them, so it's like...

George Hripcsak – Columbia University NYC

So, I would say, I agree and we have to be very careful and pick good words for this. I think what we shouldn't do is, so we won't be picking on it, so Paul that will be the trade-off, and that's why we want the Standards Committee engaged, but at this point all we want to happen is that the specialists by some means shares the image and maybe it's not for us to specify. So, just that the access is shared be it by the link or by actually sending the image out. I think it's a later discussion of whether a CD counts for it. I would hope not, but maybe that's a later discussion anyway.

Arthur Davidson – Denver Public Health Department

Paul?

Paul Tang – Palo Alto Medical Foundation

Yes, Art?

Arthur Davidson – Denver Public Health Department

Yeah, this is Art. I think that Charlene's got some nice additions in the version that I'm reading that I think was circulated earlier, but Charlene in your suggestion about that the provider must be able to access the

full diagnostic image, that seems to be a little bit at odds with what George was saying about in office viewing. So, I think that maybe a little bit...

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

The feedback was more around when you're doing a second opinion and so in both cases, we have to cover that call and in that case, if you're a physician that does do second opinions on images you probably have a viewer.

Arthur Davidson – Denver Public Health Department

Right and that could be a special viewer for them, but I think we're talking about for most people for whom even just reading a diagnostic report is often much more adequate than the need to actually see the full image or, you know, the diagnostic quality. So, there's where I may side more with George. But on the next bullet you have there about calculating a dose of exposure, I think that's a wonderful idea and I think that's something we should expect to happen with an EMR.

George Hripcsak – Columbia University NYC

Okay, so two things, thanks Art, so number one; I think it's just long and short-term. I think we certainly want providers to be able to get the diagnostic quality images if they want it, but the question is, is that Stage 3 or is that further off and we do the simpler one, you know, just a simple view of the image first. So, I think we don't limit it to non-diagnostic and we don't force diagnostic, but rather that decision, trade-off becomes part of the conversation about feasibility. I think radiation exposure is important and I have to think about whether that's really out of scope for what we're doing, if we start taking on too much we won't get anywhere, but I think it's a good idea to look at it, and I think that's an important concept, which is patient's total radiation exposure.

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

This is Neil. Is radiation exposure captured as part of the Metadata for a digitally captured radiography image?

Paul Tang – Palo Alto Medical Foundation

Unfortunately, I know this from being on NQF PSAC Committee, measurement of radiation dose is actually fairly controversial, but there was just a new measure that was endorsed for, well, yes I believe endorsed or approved for endorsement, and it would be hard to explain that to the ordering physician what's the context, so I think I tend to agree with George, that this is out of the context. It's an important thing, certainly even if it were not a Meaningful Use requirement it doesn't mean people shouldn't be going there, but whether we're ready to make it a Meaningful Use requirement is sort of a separate issue.

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

I just have one other comment, thanks for that. It sounds to me like, you know, there's pros and cons to the quality of the image question. So, for a providers sitting in their office, the higher the quality image they're either requesting or being sent the slower it's going to load and if the system actually supports storing that image, the more space it's going to take to store the image in the recipient's computer. So, I think we have to, you know, sort of think about kind of the trade-off and it sounds to me, just from listening to the discussion, that we're really looking for something that might actually require some sort of almost like an option menu, you know, are you looking at this to view and to show the patient or are you looking at this, you know, just a higher quality image, and I'm not saying we use those words, but, basically, one is just a trade-off speed and storage versus, you know, the quality and the time for downloading it, you know, based upon bandwidth and remember that we're still dealing with places in the country where bandwidth and access to high-speed Internet is still a question.

George Hripcsak – Columbia University NYC

So, Neil that's very good. I think it would be, like pretty much a two-step process, it would be do you want the simple version or the complex version? They don't have to have the same viewer. It could be that the simple version through a viewer that is somehow coordinated well with the EHR, but if you want to see the super high resolution, you actually go out and in effect end up in a PAC system and whether that's mediated over the web so that in fact you don't send the whole image to your local office, it's saved on

some server somewhere and you're just looking at each view as you zoom in and out and change the contrast. So, I think that's for further discussion.

The one to one concept though that you just reminded me of is that if you have a big complex series of images, if the specialist identifies these as the three most relevant things, then that could be part of the simple view. In other words, if you're looking at a cath report and a cath sent in on a CD and then you pick out these three stills and that's kind of what's most relevant to the primary care provider who is just kind of following up and showing the patient, but it requires the ability to mark the image, and I assume that's in the DICOM standard already, and only sending them those down and that's part of the simple version is the three views that were identified by the reader, the reading physician, and then if you want to see the whole thing you do that say through a separate PAC system, which might be web-based.

Leslie Kelly-Hall – Senior Vice President for Policy for Healthwise

This is Leslie and the DICOM viewer feature does offer the ability to see multiple cases and to be able to get highlights from the specialist without having to have the complete record downloaded and/or without having to have access to the actual radiologist quality image. So, those kinds of things are available in the DICOM standard to determine what kind of image is needed.

George Hripcsak – Columbia University NYC

That is helpful.

Paul Tang – Palo Alto Medical Foundation

So, I think there's also a difference, Leslie, I'm just asking between having a standard available and how it's implemented in the various viewers. So, the challenge I think has been is there a common viewer that can view output from all of the different manufacturers? So, that's just a question to you.

Leslie Kelly-Hall – Senior Vice President for Policy for Healthwise

This is Leslie, again. In the actual standards a DICOM viewer is often used by multiple vendors.

Paul Tang – Palo Alto Medical Foundation

Okay. George, do you have a timeline of sort of, and this interactive work with HIT Standards, maybe we have specific questions of them that we need that feedback by a certain time in order to meet our timelines or whether there is going to be a joint Workgroup or hearing?

George Hripcsak – Columbia University NYC

So, I think the process that we ended up with is that we come up with something that we feel is sufficiently specific but yet sufficiently vague and that the Policy Committee can see it and say that they agree with this direction and then at that point that starts the process where we hand it to the Standards Committee and figure out how to do, I mean I would think a joint hearing would be the next step, but I'm not the decider of that. So, I think for the timeline, I think it would normally be the next available Policy Committee meeting where I take the input that Charlene gave on this thing, the discussion today, put it into a document that we circulate to the Workgroup, see if people are okay with that and then present it to the Policy Committee for them, or maybe you could do it without a Policy Committee meeting, I mean maybe you could do it over e-mail, I mean, I don't know how that works, is it possible to present something like this to the Policy Committee over e-mail, so then we can send it to the Standards Committee?

Paul Tang – Palo Alto Medical Foundation

I don't think this is something that is easily handled over e-mail. So, we're targeting Stage 3, correct?

George Hripcsak – Columbia University NYC

Yes.

Paul Tang – Palo Alto Medical Foundation

Okay, so that's one timeline and it sort of fits in with what David Bates just asked about and we're going to publish a timeline for our overall Stage 3 development. I can see how it's possible the NPRM for Stage

2 might have something related to this, if so then that would kick us into high gear in having to come up with something to respond to their NPRM. So, let's say they had something similar to this in the NPRM for Stage 2 I would think we would want to make sure we had our thoughts together along with the Standards Committee to be able to respond to their proposal. So, that's the only thing that would disturb the timeline and make it a fast track.

George Hripcsak – Columbia University NYC

So, let's say there isn't a lot in the NPRM about imaging we would we want to present this on March 7th?

Paul Tang – Palo Alto Medical Foundation

We certainly we can so that we can, as you say get additional feedback on its way to the Standards Committee and ask Standards to respond by "x" time so they could input into our Stage 3 draft recommendations.

George Hripcsak – Columbia University NYC

Very good.

Paul Tang – Palo Alto Medical Foundation

Any further comments on this feedback from the Specialist Workgroup? Okay. Let's go to public comment. So, we're going to get ready for the NPRM and depending on how it comes out, you know, we may need a different working strategy in terms of responding, but we have laid out earlier the report back from CMS and ONC on our 6th call, the face-to-face meeting on the 13th and our follow-up tidying up on the 26th call in order to present to HITPC on the 4th of April.

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

Okay, just a minor check on that, it's the 23rd which is your last call.

Paul Tang – Palo Alto Medical Foundation

Sorry.

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

That's okay, didn't want people to put it potentially on their calendar.

Paul Tang – Palo Alto Medical Foundation

Right, right.

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

Operator would you open the lines for public comment?

Caitlin Collins – Altarum Institute

Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. And we do have a public comment.

Paul Tang – Palo Alto Medical Foundation

Go ahead please.

Julie Cantor-Weinberg – College of American Pathologists

This is Julie Cantor-Weinberg with the College of American Pathologists. I wanted to commend the Specialist Workgroup for their focus on images but also strike a note of caution. It sounds like you're mostly thinking about radiology which is probably appropriate, but digital pathology is an emerging issue and is increasingly being adopted, we're waiting for an FDA guidance on the topic. The College of American Pathologists in a few months will be issuing a validation standard. So, it's just really important

that as you set clinical objectives and standards you don't do it in such a way that it locks a standard in place so that it will adversely affect an emerging trend. For example in digital pathology 3-D images are very common. So, just a note of caution on emerging technology, thank you.

Paul Tang – Palo Alto Medical Foundation

Good point and thanks for reminding us.

Caitlin Collins – Altarum Institute

We have no other comments at this time.

Paul Tang – Palo Alto Medical Foundation

Okay, well thank you everyone for spending time with us this morning and we look forward to a hearty response to the NPRM in this next month, thanks.

George Hripcsak – Columbia University NYC

Thank you.

W

Thank you.