

Meaningful Use Workgroup
Final Transcript
March 6, 2012

Presentation

Mary Jo Deering – ONC – Senior Policy Advisor

Thank you very much. Good morning, everyone. 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'm going to begin by taking the role. Paul Tang? I think you're there, Paul, on mute. George Hripcsak?

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

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Michael Barr?

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

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

David Bates? Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Tim Cromwell? Art Davidson?

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

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO

Here.

Mary Jo Deering – ONC – Senior Policy Advisor

Joe Francis?

Joseph Francis – Department of Veterans Affairs – Associate Director, Health Services Research

Joe is here and I'm also covering for Tim Cromwell.

Mary Jo Deering – ONC – Senior Policy Advisor

Okay. Great. Leslie Kelly-Hall.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Yael Harris?

Yael Harris – ONC – Director of Evaluation
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
David Lansky?

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

Mary Jo Deering – ONC – Senior Policy Advisor
Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Greg Tate? Latanya Sweeney? Rob Tagalicod? We have Rob Anthony, right?

Robert Anthony – CMS – Health Insurance Specialist
That's correct.

Mary Jo Deering – ONC – Senior Policy Advisor
And Charlene Underwood?

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

Mary Jo Deering – ONC – Senior Policy Advisor
Amy Zimmerman?

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services
Here.

Mary Jo Deering – ONC – Senior Policy Advisor
Okay. Back to you, Paul and George.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I got cut off. How many people do we have then – Amy and George and 15?

Mary Jo Deering – ONC – Senior Policy Advisor
Okay. We have Michael, Christine, Neil, Art, Marty, Joe, Leslie, Yael, David Lansky, Deven, and Charlene and Rob Anthony.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wonderful. Okay. Thank you, everyone for joining. I don't expect we'll take the full four hours because we'll finish all of our work, but I think there will be some natural break points because I think it's a bit long on the phone. This is to get ourselves both organized and get through some of the NPRM before our face-to-face meeting next week on the thirteenth.

What we thought we would do is Rob Anthony has kindly agreed to give us a walk-through of the NPRM today and there will be a repeat with tomorrow for the full committee, but because we need to get our work in progress he was kind enough to agree to do that for us today. Then we'll have clarifying questions after he finishes and then we'll sort of start going through systematically with category one and look at the NPRM space to objectively measure.

We don't have a spreadsheet that compares right together the Stage 1 and our recommendations for Stage 2, but one of us will sort of point those out and then we'll just walk through. It's possible we can get through Category 1 and then do the rest of the categories in our face-to-face. Does that sound good?

Neil Calman – Institute for Family Health – President & Cofounder

Paul, could you just clarify the difference between what we're going to try to accomplish today and tomorrow?

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

Okay. Today is the overview. Tomorrow is not a work through our response. Rob, is it going to be the same presentation?

Robert Anthony – CMS – Health Insurance Specialist

Yes. We'll actually do this overview and then we'll also do our typical program update and what we know about attestation.

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

It's basically an overview of the NPRM, as well as an update from Stage 1, but there won't be a formal discussion about the response. We'll prepare that in this work group and then bring it to full committee next month for their reaction to that. There will be clarifying questions, I'm sure, but it won't be working through and preparing responses for the committee at this point. Does that make sense?

Neil Calman – Institute for Family Health – President & Cofounder

Thank you.

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

Okay. Rob, let's turn it over to you.

Robert Anthony – CMS – Health Insurance Specialist

Thanks, Paul. I'm going to do a really quick Cliff Notes overview of what's in the Stage 2 NPRM. I apologize to everybody who is logged in and is able to see the slide deck and everything else. I, unfortunately, am not. I'm having internet connectivity problems and yes, I appreciate the irony of that, but I will be saying, "Next slide," and somebody on the other end will be advancing for me.

If we can actually go the next slide that says Proposed Rule, I just want to highlight for everybody who's listening in that everything we're discussing here in this presentation is part of the Notice of Proposed Rulemaking. For those who have been paying attention to the details and those who haven't, at this point time the Stage 2 Meaningful Use NPRM, along with the 2014 Certification and Standards NPRM that's published by ONC, are both on display. They are not officially published yet. They will officially publish on the seventh, tomorrow, and that means that that is when the 60-day public comment period will begin. For anybody who wants to see both of those rules on display, the links are included here on this slide. Of course, comments can be made March 7 through May 6 at www.regulations.gov.

Just a brief overview, we keep calling this the Stage 2 NPRM and that certainly is the bulk of what is available here, but there are a number of things that are covered in this NPRM. Some of them are minor changes to Stage 1 of Meaningful Use and we'll go through some of that a little later on. Obviously, there is the new Stage 2 requirements of Meaningful Use; a discussion of new clinical quality measures and new reporting mechanisms for clinical quality measures; a discussion of appeals, which we actually won't cover in detail in this presentation, but it is detailed in the Stage 2 NPRM; some discussion of payment adjustments and the hardship exceptions that are associated with them. There are some minor Medicare

Advantage program changes, as well. Again, we don't go into a great deal of detail on that here, but also some minor Medicaid program changes. What I'm going to focus on primarily here is, obviously, the Stage 2 requirements for Meaningful Use, some of the CQ areas, and some of the changes that we made retroactively for Stage 1.

I'm obligated to include the arrow in every single presentation that we do. We did it all through HIMSS and I just wanted to highlight it for those folks who may be listening in this is the conceptual approach that we presented for the stages of Meaningful Use. Everybody obviously on the committee is familiar with it. The idea that there are three stages with the first stage being data capture and sharing, really putting the technology in place, and getting people using it in Stage 1. Our focus here in Stage 2, obviously, advanced clinical processes.

A number of people have sort of asked about general timeline and I wanted to highlight that, as well. NPRM, the proposed rule, we had intended for this to be published in February. We're a little bit late with that, but I think we're still good for our overall timeline, which is to publish the Stage 2 final rule in summer of 2012. I just wanted to highlight again I'm sure that most people who on the Meaningful Use Workgroup are familiar with this, but I just wanted to make sure that everybody who might be listening in understood that when it comes to the Stage 2 requirements the absolute first possible date for anybody to begin using these Stage 2 requirements would be October 1, 2013 for hospitals that are on the fiscal year and the beginning of the calendar year for eligible professionals, which would be January 1, 2014.

The secretary highlighted this in her announcement of our intentions to delay and we did indeed propose in this Stage 2 NPRM a delay for those providers who had first attested in either fiscal year or calendar year 2011 a delay just for them for the 2013 year. The reason this gets a little confusing for folks is because people are not sure, does this mean that everybody is going to have to start using Stage 2 requirements when they start? What's going to happen?

This chart sort of neatly illustrates where we're going with everything. Everybody who comes in starts with Stage 1 requirements for two years and then moves on to Stage 2 for two years and then moves on to Stage 3. The delay is in the shaded area here. Those folks who had begun Meaningful Use in 2011 would have been required to begin using Stage 2 requirements as of 2013. We delayed for them for a year so that the earliest they would have to begin using is in 2014. Obviously, this came at the recommendation of not only the HIT Policy Committee but industry groups, vendors, providers, a number of stakeholders who have let us know and we agreed that there really needed to be time available for vendors to be able to develop the software and have time for providers to put all of that into place.

Just a brief overview of where we went from Stage 1 to Stage 2 here. As I move forward I realize that a lot of this is sort of covered ground for folks in the Meaningful Use Workgroup. I do know that there are a number of people listening in, so I just want to make sure that everybody understands where we are so you'll excuse me if there is a little bit of duplication here. As we moved from Stage 1 to Stage 2, we did preserve the core and menu structure that we had in Stage 1.

We did place an emphasis on trying to keep the number of objectives total similar and somewhat reasonable for folks. That meant collapsing or combining a number of Stage 1 objectives so that they made a little bit more sense. We did this based on some of the feedback that we had from providers and also some of what we were seeing with attestation for the high levels that people were achieving in certain areas. In a couple of instances, we'll cover what those are when we get a little bit more into the individual objectives, we did eliminate some objectives from Stage 1 and then obviously an addition of the new objectives, most of which went into menu for eligible professionals and for eligible hospitals.

We did keep the number of total objectives relatively similar. We moved from 15 core objectives and a selection of 5 of 10 menu objectives for EPs for a total of 20 to 17 core objectives with 3 of 5 menu objectives for a total of 20. For eligible hospitals, we moved from 14 core and 5 of 10 to 16 core and 2 of 4 menu for a total of 18.

If we're all on the same slide this should say Meaningful Use Concepts. Did want to highlight some of the sort of overarching changes. One of the biggest changes was we sort of eliminated the idea of the deferral language that was a concept that we discussed in the Stage 1 final rule where we said essentially that menu items would be moving to core and therefore, anything that you chose not to do at this point in time you were essentially deferring. This was sort of the rationale behind having the complete EHR and having everything there. You would need this technology because when you moved into Stage 2 all of these things would become core and you would need to have all of this. It's not that you were avoiding those choices. It's that you were deferring them to a later stage.

We encountered a lot of confusion over what that meant so we have switched in Stage 2 to the idea that you are selecting X number of objectives – three out of five for EPs, two out of four for hospitals. Because of that we went back and clarified that exclusions no longer count to meeting one of the menu objectives. One of the things that you are able to do in Stage 1 is of the five of ten objectives that you select you potentially could select objectives that had exclusions and for which it qualified for the exclusions and essentially choose objectives and not have to report on them, even though there were other objectives that you might have reported on.

That's not a possibility now with Stage 2. If you select a menu objective and you claim the exclusion for it, you still can do so and meet Meaningful Use but you have to attest that you are not able to meet and report on any of the other objectives that are available. Essentially, whatever you're reporting on you have to be able to report on.

We are also moving from the concept you may remember from a number of the Stage 1 measures that providers could base the denominator on all patients or on just those patients whose records were maintained within certified EHR technology. That, again, also caused some confusion with folks, but the idea really was that there would have to be a base number. About 80% of all patients would have to have their records maintained within the certified EHR technology and you essentially could have based your denominator on just that 80%.

Obviously, as we're moving into Stage 2, more of an implementation, we would expect that people are moving away completely from paper records and it is becoming completely electronic records and now the denominators can no longer be based on just those records within certified EHR technology. They have to be based on all patient encounter stop patient locations equipped with certified EHR technology.

Now we still are maintaining the 50% notion for EPs. There was a question about number of locations that were equipped with certified EHR technology and we set the base threshold in Stage 1 that an EP had to have at least 50% of their patient encounters in locations equipped with certified EHR technology. Obviously that was outpatient encounters. It doesn't include inpatient or emergency room. That still holds true for Stage 2.

Then, finally, there is no real change to the notion of how you meet an objective. You meet an objective by meeting the measure. There have also been a number of people who have asked questions about that. Well, what do we really mean by achieving an objective? As far as we are concerned for the purposes of Meaningful Use, meeting that measure, whatever it may be, more than 50% of patients X is complying with the objective.

So as we go through these core and menu objectives, what I've done in the slide here is we've bolded changes from Stage 1. Obviously, where there are completely new objectives we've bolded the entire thing. A lot of these you'll see are the bolded percentage recommendations, but some of them are, for example, as we have here in number one, the addition of laboratory and radiology orders to CPOE. We tried to make that obvious as we've gone through this.

As many of the Meaningful Use Workgroup members know, the recommendation of the HIT Policy committee was to have most of the menu objectives from Stage 1 moved to core and we have taken that recommendation as we've moved forward. You can see here that we have CPOE moving to 60% as

recommended with the addition of laboratory and radiology orders for CPOE; ePrescribing to more than 50%.

The recording objectives moved from more than 50% to more than 80%. We did have a number of questions as we presented this information at HIMSS about what happened with areas like recording a problem list, an active medication list, and an active medication allergy list. As I mentioned before, we have taken some of these objectives and combined them in order to make them a little bit more manageable. Those objectives are combined with the transitions of care summary objective with the thinking being that those would be necessary items to fulfill that objective and therefore would still be maintained by EPS. Also, as we looked at attestation data, there is a very high compliance rate for all of those recording objectives. We felt pretty confident that moving forward we would see a number of providers performing them regularly.

We also combined some of the clinical decision support functions. There had been a lot of questions in Stage 1 about drug-drug and drug allergy alerts. That being a separate objective from implementing a clinical decision support rule, could drug-drug and drug allergy, for example, be used to satisfy the clinical decision support rule measure? It cannot. It is a separate measure but because there was some confusion about that moving forward we tried to pull those things together and make it clear that what we have here is a single objective implementing five clinical decision support interventions that are based on relevant clinical quality measure in addition to enabling drug-drug and drug allergy indications within the system.

We do go into a little bit of detail within the Stage 2 NPRM about the five clinical decision support interventions. Preference is to have those based on relative clinical quality measures, but we do realize that there may not be relevant clinical quality measures for every provider that participates in which case if there are no relative clinical quality measures upon which to base those clinical decisions to support interventions the provider can simply implement the five clinical decision support interventions that are relevant to their scope of practice.

Incorporating lab results moved from menu to core for more than 55%. It is important to note that as we look at Stage 1 incorporating lab results does seem to be a rather popular choice for menu and seems to be moving forward, so we did go with a slightly higher proposal for the threshold for this than the HIT Policy Committee advocated.

Generating patient lists by specific condition, using an EHR to identify and provide more than 10% of patients with reminders for preventative and follow-up care. We did move from the notion of providing an eCopy of health information to online access to health information for more than 50% of patients. We did make one of the measures of this objective that more than 10% of patients actually are accessing that information.

We've been highlighting and we highlighted for the folks at HIMSS, we highlight in our materials going out to the public that this does introduce a new concept. Obviously, in Stage 1 there were no actions by a patient that could disqualify a provider from meeting Meaningful Use. The actions were primarily focused on what the provider did.

Here in Stage 2 we're introducing a new idea in which the provider is actually encouraging patient participation. We do agree that the provider is in a unique situation to encourage patient participation so that measure of 10% has been put in place. We did move from providing office visit summaries within 24 hours rather than within 4 business days. Again, this is fitting with the idea of having rapid electronic access to information. Using the HRs to identify and provide education resources moved from menu to core so we maintained the 10% threshold.

If we're all still keeping pace, this should be objectives 13 through 17. Number 13 is a new objective that we placed in the core rather than the menu because we consider it to be an important part of patient-provider communication and that is to have more than 10% of patients send secure messages to their eligible professional. Medication reconciliation we did place at a slightly higher percentage than the HIT

Policy Committee recommended, 65%. Again, we're seeing in Stage 1 data that there is a pretty high participation rate for this.

Finally, for summary of care documents, this is the objective that I had discussed a little bit earlier about where we had done some combining of different objectives from Stage 1. Really as we look at Stage 2 this is sort of one of the hearts of exchange here that we're putting the focus on in Stage 2. Providing a summary of care document, we've gone into a great deal more detail within the Stage 2 NPRM of the fields that we should propose. For those who recall from Stage 1, we really only required four fields to be part of the summary of care document for transitions of care and that were diagnostic test results, problem list, active medication list, and active medication allergy list.

We're now proposing to require a number of different fields that we feel are relevant to continuity of care. We provide an extensive list of that within the NPRM. In addition, we are making it a requirement to include those same four elements of diagnostic test results if available—problem list, active medication list, and active medication allergy list. Even though those are no longer separate objectives, providers are still going to have to maintain those in order to meet this particular objective for providing a summary of care document at transitions of care.

In addition, we are placing a measure on this that 10% of those summary of care documents have to be sent electronically. Now there are some additional constraints that we've put on that. One of things that we put around this is the notion that 10% have to be sent to another provider without an organizational affiliation, so it cannot be sent within the same practice. It cannot be sent within the same group. It cannot be sent within the same hospital affiliation. It has to be sent to somebody with a different EHR and that is a different EHR vendor. It is not a different of an EHR, so two providers who are running Epic 9.5, for example, would not be able to send transitions of care to each other and be counted as part of that 10% of sending electronically. It would have to be somebody who sent from Epic to MCESA just to use some branded examples.

Number 16, the Successful Ongoing Transmission of Immunization Data, you'll see that we continue with this for hospitals. We're moving beyond the idea of transmission of data to public health agencies and we're moving now to the successful ongoing transmission of data. We did not include at this point in time in the core the successful ongoing transmission of syndromic surveillance data simply because we don't feel that there are enough syndromic surveillance registries. It's not mature enough at this point in time to make that a requirement, so we have left that in the menu.

Seventeen, of course, we continue to place the emphasis on conducting and reviewing a security analysis and incorporating that in the risk management process. There are not specific requirements to include encryption of data at rest. That has been asked by a number of folks and I just want to highlight it here. Although, it is part of ONC's certification and standards the ability to encrypt data at rest is included.

The following are the five menu objectives for eligible professionals and EP has to select three out of five of these. Most of these are the new objectives so more than 40% of imaging results that are accessible through certified EHR technology. We do clarify within the Stage 2 NPRM that it does not have to be the storage of the actual image within certified EHR technology, although that is possible. It can be direct access to that image through certified EHR technology, whether that's a link to a storage site or a link to another technology that contains that; recording family health history for more than 20% of patients. Again, as I mentioned, successful ongoing transmission of syndromic surveillance data we left in menu because there aren't a great deal of those public health registries available. Then we included in four and five the successful ongoing transmission of cancer case information or the successful ongoing transmission of data to a specialized registry for particular specialties.

Many of the hospital objectives are very similar to what we're seeing with eligible professionals, so I'm not going to repeat each and every one of those. As you can see here, these first six are identical to what we're seeing with eligible professionals, including the clinical decision support interventions and drug-drug, drug allergy. Obviously, hospitals should all have clinical quality measures that are applying to

them and on which they are reporting so they should be able to base all five of those clinical decision support interventions on relevant clinical quality measures.

We again here moved from the idea of eCopy of health information to providing an access with 10% of patients actually accessing it so again putting the emphasis on the provider driving the patient to actually use tools that will help improve their health care. We did the same here with medication reconciliation proposing a higher threshold than the HIT Policy Committee did. The notion of electronic medication tracking was one that was proposed as a new objective and had been proposed as a menu objective being new. We felt that this was an important part of patient safety so we moved it as part of the hospital core objectives so using eMar, implementing it, and using it for more than 10% of medication orders. There was some initial discussion about whether that would be implemented in a particular area of the hospital and how to do that, but we've chosen to provide as much flexibility as possible here and just set a baseline of 10% of medication orders however hospitals manage to implement that and track.

Hopefully, again, we are on the same slide with Stage 2 Hospital Core Objectives 12 through 16. We did move all of the transmission of public health data for immunization data reportable lab results and syndromic surveillance for hospitals to the core because all of these are much more mature for hospitals and hospitals have many more agencies to which to submit. Again, we have the summary of care documents here for transitions of care and again, 10% of those sent electronically. There are going to have to be 10% sent to providers without an organizational affiliation.

Here are the four hospital menu objectives. Hospitals have to meet two out of four of these. We did leave recording and indication of advanced directive for more than 50% of patients in the menu objective. It was in the menu objectives last time around and we think there continues to be some difference from state to state about how exactly advanced directives work and how exactly they can be recorded within an EHR, what is legal and what is not, so at this point in time we've chosen to leave that as a menu objective. The other menu objectives are new to Stage 2. Again, the imaging results that are accessible through certified EHR technology, family health history for more than 20% of patients, and ePrescribing for more than 10% of discharge prescriptions.

I want to talk about some of the changes that we've proposed to Stage 1. Obviously, we're going to see these changes for these objectives as they move to Stage 2, but it's also important to note that we've made some changes retroactively to Stage 1 for folks. They are going to be required in 2014 where these different changes in denominators and exclusions and counting will actually be included as part of the certification criteria for 2014 technology. They are optional in 2013 so a provider could count the original method, which is what is in the Stage 1 final rule currently, or they could use this method that we're proposing. They are not required until the new technology is in place.

For CPOE there was a great deal of confusion about the denominator for CPOE, what patients what into what? Was it time limited? Did it mean patients who had a medication that was ordered just by the EP? It doesn't. Does it mean patients who had a medication that was ordered within the EHR reporting period? There wasn't a time limit on that, but there was a lot of confusion about it and people made assumptions and there were a lot of people trying to figure out, "Well, how does this work the way it works?"

Then we discovered as we moved forward with this that there were certainly some eligible professionals who were in a position that they did not quite meet the exclusion, which was that they prescribed fewer than 100 medications during the reporting period, but they didn't prescribe often enough to be able to meet the CPOE threshold. It put them in a curious situation, so we had to make some flexibility available for those folks and we issued some sub-regulatory guidance in the form of an FAQ. Moving forward, we are proposing within this reg that the denominator be moved from calculation based on unique patients to calculation based on number of orders during the EHR reporting period. We're moving from a percentage of unique patients with at least one medication in their medication list to number of orders that are done during the EHR reporting period.

Similarly, there was some confusion for vital signs. The requirement is that blood pressure, height, and weight be recorded for patients age two and above. This seemed sort of a reasonable accommodation to make when we provided the exclusion for any providers who do not take blood pressure, height, and weight as a normal part of their scope of work.

As we subsequently discovered and heard from a number of providers, there are indeed a number of providers who may take blood pressure and may not take height and weight. We're moving from an exclusion that is based on all three of these to one where it is based on excluding blood pressure or excluding height and weight. We are also moving to age three as being the age limit for blood pressure and no age limit for height and weight.

There is also in the current Stage 1 a requirement to test health information exchange with another provider, the electronic transmission of key clinical information. Anybody who is familiar with this objective is probably familiar with the confusion that it caused for folks. There was confusion about what information exactly had to be exchanged. There was confusion about how the information was to be exchanged, so we issued a number of FAQs following up on this in which we clarified that exchange had to indeed be electronic. It could not be through the physical transmission electronic media, such as a USB stick or a CD-ROM or so on and so forth. There was a great deal of confusion about what essentially amounted to a test at that point in time. Moving forward, we've really sort of placed the emphasis on a more robust health information exchange through transitions of care in the summary of care document. Effective in 2013, we are proposing to remove the requirement for the test of health information exchange for Stage 1.

We're also moving because we're moving from the proposal from the current requirement of providing patients with an eCopy of health information upon request and providing electronic access to that health information. The former is a core objective. The latter objective is a menu objective under Stage 1. We were discovering that we're seeing pretty high numbers for providers who were not meeting the first objective because they were essentially not getting any requests for electronic copy of health information. We were seeing a number of folks who were not selecting the electronic access to health information menu objective.

We're moving now toward more of an idea of providing information online and the ability for patients to download and transmit that health information. Beginning in 2014, not only for Stage 2 but for Stage 1, we are proposing the replacement objectives of providing patients the ability to view their information online, to download that information, and to transmit that health information.

Finally, for public health objectives effective in 2013, we are adding to all three of these for immunization, reportable labs, and syndromic surveillance the addition of except where prohibited to all three. There are some situations where providers are prohibited by law or practice from providing information to a public health agency and we did want to make that provision clear.

Next slide, that is a very rough sketch and overview of the objectives for Stage 2 and changes to Stage 1. I'm going to go very briefly through the clinical quality measures here and what is proposed and what people can expect to see. I won't go over individual clinical quality measures because there are a number of them that are proposed just as we did last time. I'm sure that we'll get down to a different number in the final rule and you'll be able to see that we've proposed a number that have tried to fit a wider variety of workflow when you take a look at them. I do want to draw attention to some of the timing and some of the reporting proposals that we have in the Stage 2 NPRM.

One of the things that you'll notice as I went through those objectives that there is no longer an objective for reporting clinical quality measures. It is not that reporting clinical quality measures is no longer required. It's just that there was confusion in terminology when we discussed measures of Meaningful Use objectives versus measures of clinical quality measures. There is still a requirement to report these things. It is simply that we haven't included it as an objective, but it is still a requirement for Meaningful Use.

There is no change in the reporting periods from Stage 1 to Stage 2, so there is still 90 consecutive days within the calendar year for EPs in the first year. There is still the same submission period, so on and so forth. There may be some changes in timing for some of the reporting options and that is when we have, for example, a pilot program there may be, as you may be familiar, EPs who participate using the PQRS method may have to delay toward the end of the year to submit their information because of when that information is submitted on an annual basis for PQRS. They still have the option to submit those CQMs through attestation on our website.

As we move forward, we really tried to think in terms of alignments. It was alignments among the quality measurement and reporting from other programs. On the hospital side you have IQR, for example. You have some of the Joint Commission quality measures. On the EP side, you have reporting for PQRS. There are the Medicaid ... measures. There are ACO programs, a number of different areas, so we really as we move forward with this both reporting and in the measure sets try to think in terms of aligning the same measures across programs, as well as minimizing the number of submission requirements that providers had to meet. In other words, for some of these, we tried to get to the point where submission for one program would meet deeming in another program because they shared measure sets. That was really our defining thought as we move forward with these.

Obviously, as we move forward with this alignment we were thinking in terms of reducing provider burden so there didn't have to be all of these multiple submissions to different programs but still with the idea of supporting the overall program goals that we have with all of our quality measurement programs, which is to improve the quality of care, improve health outcomes, and ultimately lower cost with those improvements.

You'll see as we go through a lot of the clinical quality measures the way that the clinical quality measures were proposed were according to domain. I'll list what those domains were a little further down, but the idea behind all of the demands were, first, making care safer by reducing harm, ensuring that patients and their family were engaged in their care. This is true not only of CQMs but of the Meaningful Use objectives encouraging patient participation in their own care; promoting effective communication and coordination of care, both among providers and between providers and patients.

Obviously promoting effective prevention and treatment practices for those areas that are the leading cause of mortality. You'll see that we have a number of proposed clinical quality measures on cardiovascular disease, diabetes, the high mortality chronic disease areas. Working with communities to promote best practices for health living and then ultimately as we say the idea of reducing costs through improving health care, making quality care more affordable for individuals, employers, and everybody by developing those new delivery models.

That led into these overall domains that all of the CQMs fall into. Now I won't go through what each of the clinical quality measures are underneath those domains, but these are the overriding domains, the groupings into which they fall. It's patient and family engagement, patient safety, care coordination, population health, public health, the efficient use of healthcare resources, and clinical processes.

All of that is sort of a buildup so that this slide will make a little bit more sense to everybody as we move forward. As you look at this at clinical quality measures, this is where we are proposing for clinical quality measures to change from Stage 1 in the 2010 final rule for Stage 1 and Stage 2 as we move forward with this final rule. We are moving away from the original notion of what we had in the final rule of three core or the three alternate core plus three menu for a total of six CQMs for EPs. Hospitals had 15 total clinical quality measures that they reported on.

Now the proposal is for a total of 12 clinical quality measures for eligible professionals; a total of 24 clinical quality measures for eligible hospitals. There are multiple proposals within this NPRM and each of them has a level of detail in it that I really couldn't get too deeply into in the time we have here, but I wanted to briefly sketch the outline. There are proposals for how clinical quality measures are chosen for EPs.

One proposal, the first proposal, is 12 clinical quality measures with at least one clinical quality measure coming from each of those six domains that we have previously talked about on the last slide. Another is a notion of eleven core clinical quality measures and they'll list within the NPRM what those core are, plus a selection of one menu clinical quality measure that is relevant to the provider's particular scope of practice.

The other proposal within this is for PQRS group reporting, so essentially if a provider as part of a group is reporting through the Physician Quality Reporting System initiative that essentially that reporting would deem the provider for reporting on clinical quality measures for Meaningful Use. In effect, we've aligned the measures within PQRS with what we are proposing for Meaningful Use and therefore, reporting for PQRS would be the same as reporting for Meaningful Use again, the idea of alignment and reducing burden for physicians.

Something similar for eligible hospitals a proposal to essentially create an electronic IQR reporting system for hospitals that would work the same way where they would report once to report on IQR, the Inpatient Quality Reporting program, and that would deem them for Meaningful Use. A proposal for eligible hospitals is for 24 CQMs with at least one of those CQMs coming from each of the six domains from the previous slide.

Again, CQMs basically remain the same through 2013 what we have currently established and what's been published in the July 2010 final rule. We are updating specifications for CQMs that are carried over and there are a number of different reporting methods available in 2013 for EPs and hospital. Obviously, continuing in 2013 is going to be attestation through our website. There are also the electronic reporting pilots that we proposed in a separate role for 2012 and that we are proposing in this role to continue to allow people to use in 2013. This is essentially as we stand up for 2014 and beyond the electronic reporting for EPs and hospitals there would still be the opportunity to electronically report through those pilots. Then, of course, Medicaid continues with a state-based electronic submission.

Next slide, this is again just an overall breakdown of what is proposed within the rule. There are options for the different clinical quality measures just for the incentive program, but we are also proposing the second option, which is essentially EHR incentive program and PQRS that if you submit and report those CQMs under PQRS using certified EHR technology you would be deemed for Meaningful Use.

For those EPs that are in an ACO we're proposing a number of group reporting options for CQMs. Obviously, the first is the PQRS option that I discussed before. There is also an option for EPs who are in an ACO, Medicare Shared Savings program, that if you are satisfying the requirements of the Medicare Shared Savings program reporting on those clinical quality measures using certified EHR technology through group reporting that would also deem you for participation within the EHR incentive program again focusing on the idea of alignment and the idea of reducing reporting burden.

These are obviously for Medicare only. Medicaid would still have to continue at the state level for EPs and then PQRS this is patient level data that is reported for PQRS, the GPRO option, but it is a possibility for EPs who are already reporting through that option to deem themselves for the EHR incentive program.

As I mentioned for hospitals the 24 CQMs, we are working on an aggregate method of reporting that would essentially be an XML-based format that we would specify that hospitals would generate through their certified EHR and send to us and we would upload into our system. Then we are also proposing, as I said, a manner similar to what we have for PQRS for hospitals that report on the IQR system. We'll have more details about that as we get a little further along on things. Essentially, it's the idea again of deeming and aligning.

One of the other major areas that are covered in the Stage 2 NPRM is on payment adjustments and on hardship exceptions. Payment adjustments are mandated by the high tech law and in Stage 1 we referred to them and outlined part of what the law had already outlined, but we didn't go into a great deal of detail about how they would be applied, the timeline, and so on and so forth. We did do that in the Stage 2 NPRM.

Obviously, the idea behind the payment adjustments is an additional incentive for both EPs and hospitals to be meaningful users. It is by being a meaningful user that you avoid the payment adjustments going forward. I did want to draw attention to the fact that the law basically says that if you aren't a meaningful user then you are subject to the payment adjustments. There seems to be some confusion about whether adopting, implementing, and upgrading, which providers can do for participation in Medicaid in their first year, that doesn't qualify as Meaningful Use.

It is not meaningful use of technology. It is just adoption, implementation, and upgrade of technology so therefore, providers who are participating in the Medicaid program who are in AIU on the relevant timeline would not be qualified as meaningful users. For many Medicaid EPs that may not make a difference because they may only be eligible for the Medicaid incentives to begin with, but for Medicaid providers who are also eligible for Medicare but who have chosen to participate in the Medicaid program they're going to have to be meaningful users along the same timeline in order to avoid any payment adjustments to the Medicare side of their billing.

I'm going to go through a lot of this pretty quickly but there was a question about how the payment adjustments were applied. This is entirely statutory. It is not within our per view and it would require Congressional action to change that. The percentage is essentially a reduction of your Part B physician fee schedule payments that the provider otherwise would be entitled to. If they would be entitled to \$200 for a given service under the fee schedule, for example, they would only receive X percent of that \$200 in this particular year; 99% of that in 2015, if they were not a meaningful user for 2015.

The same is true for Sub-Section B hospitals. It is a decrease of the percentage increase to the inpatient perspective payment system payment rate that the hospital would otherwise receive. In other words, on a yearly basis there is a percentage increase to that IPPS and being subject to the payment adjustment for not being a meaningful user would mean that hospitals would see a decrease in that increase. I know that sounds a little bit confusing, but it is a reduction in Medicare payment overall.

Next slide, something similar for critical access hospitals that are paid on the basis of reasonable cost reimbursement. Absent payment adjustments, reasonable cost reimbursement for critical access hospitals is one 101% and this lies out what the statutory requirement was for the payment adjustment that would be applicable to critical access hospitals in each succeeding year if they were not meaningful users.

Essentially what we've proposed in the Stage 2 NPRM when it comes to payment adjustments is a perspective look at Meaningful Use. Part of this is because of the requirements by statute that if you as a provider are not a meaningful user that you are subject to the payment adjustment beginning in 2015. That means at the beginning of 2015, whether that's fiscal year or calendar year hospitals versus EPs, and that means that we couldn't wait to see if you were a meaningful user in 2015. We had to look at a backward period and see when you would be a meaningful user.

We are proposing within this reg what the reporting period will look at is for determining when you are a meaningful user. We are looking back at the last full-year reporting period because by the time we hit 2015 for Medicare EPs everybody who is participating should be, we hope they're going to be, in a full-year EHR reporting period. For 2015 we would look back at 2013. For '16 we'd look at '14 and so on and so forth. For those EPs who first demonstrate meaningful use in 2013 the schedule works out essentially fine. We would just look back at the 90-day EHR reporting period for 2015. As long as you had your 90 days in that 2015 you would be deemed a meaningful user and then it reverts back to the full-year reporting period 2014 for 2016 and so on.

There will be those EPs who may not demonstrate Meaningful Use in '12 or '13. They may demonstrate Meaningful Use for the first time in 2014 in which case we do provide for those EPs for when that 90-day period has to fall within the preceding year. We need enough time to not only allow the EP to report that attestation but to make sure that we process that within the systems prior to the onset of the 2015 calendar year. Essentially, in order to avoid that 2015 payment adjustment an EP who is demonstrating

Meaningful Use for the first time in 2014 has to attest no later than October 1; basically, three months before the end of the calendar year, which essentially means they're going to have to begin their 90-day reporting period no later than July 2 of that year.

Hospitals work in a similar way under this proposal. It's just that it operates on the fiscal year so a hospital that's demonstrated use in '11 and '12 we're going to look back at the first full fiscal year reporting period, which is going to be 2013 for '15, '14 for '16, and so on. If they're demonstrating for the first time in 2013 that's fine. Their 90-day reporting period would be what we look at in 2013 and then we revert to looking at full years '14 and '16 and so on.

Hospitals work similarly in that the hospitals that may not demonstrate Meaningful Use until 2014 for the first time we've specified when they're going to have to attest by so that we have time to process everything in order to avoid those payment adjustments. Basically, a hospital that is attesting for the first time in 2014 is going to have to attest no later than July 1 of that year, three months before the end of the fiscal year, and that means they're going to have to begin their 90-day reporting period no later than April 1, 2014.

There is an ability within the statute for us to provide hardship exceptions. There has been a lot of curiosity about what the hardship will be and we've proposed several categories within this NPRM. We are proposing the following three categories on an application basis and basically, it is based on insufficient internet access for EPs that are newly practicing. It is a time limited exception, so essentially if you are fresh out of residency and you don't have a look back period for us to take a look at for Meaningful Use, we didn't want to penalize people right out of the gate. There will be a two-year period for EPs to establish and become meaningful users if they are newly practicing.

Then, of course, finally extremely circumstances. There could be unexpected office closures, natural disasters, a vendor that goes out of business, sort of in some ways a catch all category for things that could be very wrong, but it is on an application basis. We want to make sure that there is nothing ... that could prevent somebody from meeting Meaningful Use. We do require that applications will have to be submitted no later than July 1 of that year before the payment adjustment year. We do encourage people to submit their applications earlier than that. There may be some follow up questions and things that we want to discuss.

We do want to look back at insufficient internet access. We do base that on the FDA broadband access as defined within that area. That's sort of what we'll be looking back at. There is the possibility, obviously, that insufficient infrastructure, as well, could prevent people from doing it. We want to avoid a situation where EPs simply don't want to purchase that type of technology and that's why this is an application process. We want to make sure that it is a verifiable exception.

There is another possible exception that we have discussed in the NPRM but we haven't proposed. We're looking for public comment on this. We did receive a lot of feedback from vendors, from stakeholders, professional associations, and providers about specific barriers within special workflows that could prevent certain EPs from meeting Meaningful Use. It was never one particular specialty, one particular practice that it was definitively said, "Ah, these folks cannot meet Meaningful Use." It was more a combination of barriers that would constitute a pretty significant hardship.

One was a lack of direct interaction with patients. Very often the folks that we talked to were providers who did test results, provided consultations with other physicians, but they didn't do face-to-face interaction with patients. Although, we did provide for that in one of our FAQs, when combined with these other elements, it presented a distinct hurdle.

There was also in most of these areas a real need for follow up care. Obviously, the emphasis is on continuity of care within these objectives and since it was very possible that providers within these particular areas wouldn't follow up care with patients that that type of follow up care would be done with other providers to whom those providers gave information that seemed to be a particular hardship for them.

Then, finally, another compelling factor was the idea that there was really a lack of control for many of these providers over the availability of certified EHR technology because of the way their practices were structured. We do mention, for example, anesthesiology, radiology, and pathology within the NPRM as specialties that we think could face these hardships and we are seeking comment at this point in time, but we have not proposed it as an exception.

Next slide, I'll run through these next very quickly, but our proposed exceptions for hospitals are very much the same. It's for internet access. For new hospitals that have no history behind them, again, another time limited exception of one full year for a cost reporting period and then, of course, extreme circumstances.

I think this slide might have actually crept in by mistake so we'll just go to the next slide. A similar exception for critical access hospitals for internet access for new critical access hospitals time limited for one year after they accept their first patient and again, for extreme circumstances.

We are coming into the home stretch here. These are a few Medicaid-specific changes. Next slide, one of them is an expansion of the definition of a Medicaid encounter basically to include encounters with patients who are receiving assistance under 1905B, including Medicaid expansion populations, basically to permit the inclusion of patients seen within 24 months instead of 12 and to permit patient volume to be calculated from the most recent 12 months instead of on the calendar year. We had some pretty significant feedback about including all of these things to make patient volume calculations easier, less of a burden on providers, and also to make this more readily available to folks and finally to include zero pay Medicaid claims within those calculations.

Then finally there was the proposal within this to include some additional children's hospitals that were essentially inadvertently excluded through the last final rule. We base our definition of a hospital on whether a hospital has a CMF certification number, a CCN, but because these children's hospitals, though technically eligible through every other requirement, do not have CCNs because they never see Medicare patients, they were inadvertently unable to participate. Essentially we've got a proposal in place to give them fake CCNs or placeholder CCNs so that that they can participate in the program as we originally intended.

We are proposing to extend the state flexibility for the definition of Meaningful Use to Stage 2. There was the ability for a state to require certain menu objectives to be in the core public health objectives. We are proposing to continue with that. No state at this point has exercised that flexibility but it's certainly possible in the future that they might.

That in a nutshell, although I realize that it was a fairly long nutshell, is an overview of the Stage 2 NPRM. As I said, I encourage everybody to take a look at some of the details because there are more details within the text. If there are any questions I'd be happy to try and field some.

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

Well, thank you, Rob. That was very comprehensive and the right amount of detail in terms of trying to brief us. I think what we'll do is have some clarifying questions not of the granular type but things that maybe only Rob knows in terms of the summary that he gave.

I might open up with a couple that sort of illustrate that. In the menu context, you said in Stage 1 you had menu and by in large you moved those menu to core and you proposed doing a similar kind of approach with Stage 2 that is ... menu that you'd expect to go to core in Stage 3. Some of those menus you have let's say for EPs including let's say the Cancer Registry or the other specialists registries. I'm not expecting that those things that apply to only certain EPs would go to core for everybody, right? It's not exactly all menus go to core.

Robert Anthony – CMS – Health Insurance Specialist

I couldn't tell you exactly what would move from menu to core at this point for Stage 3. Certainly in areas where we know there isn't wide applicability for folks we've tried to build in that flexibility, whether it's keeping that objective at a menu or whether it's providing an exclusion for providers. We certainly wouldn't want to exclude providers who are unable to meet that simply because they don't do that type of work.

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

One more that sort of perplexed this group. We tried to keep advancing the advanced directive requirements and it's been mentioned that some states make it difficult. Could you give just one or two examples of that so we have a better appreciation for what may cause some complexity in this kind of requirement?

Robert Anthony – CMS – Health Insurance Specialist

I wish I could give you some specific examples off the top of my head and I probably can come back with some examples for you. We did have some feedback from providers and from certain states as we looked at this. Certainly on the Stage 1 NPRM and we looked back at some of those things as well that there were certain states that specifically would not view that as a legal document. There was some question as to what the value would be of simply a link and whether a link to a copy of a document would serve as a legal document. I think those were really sort of the questions. Each state seems to define it a little bit differently and exactly what can and can't be included seems to be prescribed from area to area. I think the feeling was here until we get a little bit of clarity around that we didn't want to push that into a core.

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

Actually that's very helpful what you just said. We'll take that into account when we discuss this. Other clarifying questions of a policy nature for Rob?

Christine Bechtel – National Partnership for Women & Families – VP

Paul, this was really, really helpful. I have two questions. One is around the kind of care summary electronic exchange piece. If I'm understanding it right, if 65% of transitions of care would have a care summary sent, and that could be on paper, and then for 10% of all transitions that summary needs to be electronic. Where I'm falling down is is it 10% of the 10% have to be to an unaffiliated provider who uses a different vendor, or is it all of the 10% that are electronic have to also be unaffiliated provider different vendor?

Robert Anthony – CMS – Health Insurance Specialist

It's all of the 10% unaffiliated with a different vendor. The idea really being to encourage the electronic exchange beyond closed networks, whether that closed network is an organizational system or whether it's, for example, within a particular vendor that may say, "Well, you can exchange easily with everybody who is on X particular software." That is wonderful and it's important and we encourage that type of exchange, but it's also important to encourage exchange to other vendors.

Christine Bechtel – National Partnership for Women & Families – VP

Right. Absolutely. That is 10% of all transitions, not 10% of the 65%?

Robert Anthony – CMS – Health Insurance Specialist

I believe it's 10% of the 65%. I'll have to go back and look at it specifically.

Christine Bechtel – National Partnership for Women & Families – VP

That would be great because my read was 10% of all of it. My second question is on quality measures. You propose a number of options and in the EP realm one of the options would be if you're submitting for PQRS out of your certified EHR then that would qualify. As I understand it, under PQRS EPs only have to submit three quality measures to qualify for PQRS. Is that the same here?

Robert Anthony – CMS – Health Insurance Specialist

Again, this was part of the alignment idea. There is a little bit more detail about this within the CQM section, but the idea would be that the PQRS reporting would be more comprehensive. We would align those measures across the EHR incentive program and PQRS and we would essentially use the reporting system that we already have in place with PQRS as a method of electronic reporting.

Christine Bechtel – National Partnership for Women & Families – VP

But the number today under just straight up PQRS, forget Meaningful Use, in order to qualify is only three, so I think that would be under Meaningful Use, if you go with that action, it would only be submitting three quality measures for Meaningful Use.

Robert Anthony – CMS – Health Insurance Specialist

No. I'm sorry. The idea is to align the measures across both of those systems so that the PQRS measures are similar to the incentive measures.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, but it would be a different number, a higher number under Meaningful Use than it is under just be correct today. That's what I'm getting at.

Robert Anthony – CMS – Health Insurance Specialist

It would be a different number than it is today. You're correct.

Christine Bechtel – National Partnership for Women & Families – VP

Okay. Thank you.

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

Rob, on these measures that are based on the patient actions, which we were just talking about one example, is there going to be a set of exclusions? For each of them you can envision scenarios that would be hard to meet it. Is the goal at this point to just kind of gauge from the community because there's an NPRM whether these are feasible, or is it to collect a set of exclusions that make sense?

Robert Anthony – CMS – Health Insurance Specialist

You know we draw attention to that specific potential problem within the NPRM and we're soliciting public comment specifically on that about whether that in particular makes this 10% measure a much higher hurdle than we had envisioned. I think we're really looking to community feedback to figure out what that really needs to be.

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

Then my second question is, this is a little bit specific, but let me ask it anyway. On order entry are we saying that in order to be a meaningful user you need to be able to count all your paper orders? You can't enter unless you can count your paper orders and then you'd have to do some percentage of it electronically, but the ability to count every order is now in effect a criterion.

Robert Anthony – CMS – Health Insurance Specialist

Correct. To do a denominator you're going to have to be able to account every order. That is correct.

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

Alright. You state in the NPRM that the feedback you've gotten is that's not a major hurdle, although that's what the NPRM will find out.

Robert Anthony – CMS – Health Insurance Specialist

Yes. We had initially gone with that in the Stage 1 NPRM. We had a feedback with folks exactly what you were saying that there was a question about being able to count those paper orders. As we've gotten into it the feedback that we've gotten overwhelming is that it would be much easier to count the orders than it would be to figure out unique patients and medications going back X number of years. The hope is that as we've moved into Stage 2 that we're moving beyond the idea of paper orders that we're at least tracking those through this electronic system.

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... take it back on that general approach so that you know that some of our recommendations for Stage 2 resorted to counting rather than percents just because of this counting paper orders problem. Maybe you could outline your thoughts in terms of why you went back to percent. What was against the counting method?

Robert Anthony – CMS – Health Insurance Specialist

I'm in a little bit of a tough bind here in that we have a Notice of Proposed Rule Making that is public and I really can't go much beyond the bounds of what we have in our notice of Proposed Rule Making. That's what is there and that is what is for comment. I think as you look at what we have in the core and menu objectives you'll see that there was an effort to be consistent with the type of denominators and thresholds that had already been established and were familiar for providers in the program.

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

Other questions for Rob?

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services

I have a question related to the eCopy and online access. The replacement objective is around providing patients with the ability to do online download and transmit their health information. Can we assume that if a provider participates with health information exchange that that can be the mode, or is it that each EHR for each provider has to be able to provide that? In other words, if I had five different providers or ten different providers, do I have to go to five or ten different places to get my information, view it online, access it, send it somewhere, or if there is a centralized way to do that in a community which providers participate in is that allowable?

Robert Anthony – CMS – Health Insurance Specialist

Josh Seidman, are you on the phone?

Josh Seidman – ONC

Yes.

Robert Anthony – CMS – Health Insurance Specialist

Do you want to talk a little bit about what the certification capabilities will be for this for 2014?

Josh Seidman – ONC

Are Steve Posnak or Mike Lipinski on the phone?

Mary Jo Deering – ONC – Senior Policy Advisor

No, they're not.

Josh Seidman – ONC

Okay. I think I probably will defer that to them ... technical issues around what the

Deven McGraw – Center for Democracy & Technology – Director

One of the things that I noticed is that with respect to some of the certification criteria, although I don't know about this one, Amy, it does note that a provider can rely on an HIE to provide that functionality, but you would have to get it certified.

Robert Anthony – CMS – Health Insurance Specialist

Yes. That's sort of the direction I was tending with this. I agree. Obviously, if there is a way for providers, especially within a community, to combine information through health information exchange that is possible. One of the requirements though is that this has to be provided using certified electronic health record technology, which means that the HIE itself would have to be certified. It is a certification capability that the certified EHR has to be able to provide this, so an EHR will essentially come equip with that, although it is possible to use another certified technology to be able to accomplish it.

Amy Zimmerman – RI DoH – Chief, Children’s Preventative Services

Okay. My understanding now is that if an HIE is an intermediary but it’s not doing any data transformation it does not need to be certified. If it’s doing any data transformation, be collecting data and moving to public health or whatever the use case may be it does. That’s why I was also trying to clarify here. Thank you.

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

Rob, we’ve talked about this notion of the online access that we provide. For an HER that has a patient portal that makes accessible, i.e. the providers provide online access to health information, is that sufficient to meet the objective versus how many people have actually logged into this? I understand your 10%, but if 50% provide online access to health information, does it qualify essentially for your entire patient base if the provider has made available patient portal into their EHR?

Robert Anthony – CMS – Health Insurance Specialist

Sure. This is the question of if I put it on and nobody looks at it it’s almost a Zen ... of online access; if the health information falls in the forest but nobody’s there to listen. From a provider’s perspective, if that information is online and it is accessible to a patient, so in other words, they have instructions for how they would log on, they have a log in account, whether they’ve activated that account or not, that information is there and could be accessed by the patient. That would count within the numerator.

Obviously, the second part of it, the more than 10% that’s the emphasis on now they’re actually using it. It’s not enough to just put it on now. Now we need to go one step further and say, “Ten percent of those patients are actually going online and viewing or downloading or transmitting that information.”

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

Correct. Thank you. Thanks for that clarification.

Robert Anthony – CMS – Health Insurance Specialist

Sure.

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

Other questions? Well, Rob, this is very, very helpful. It’s nice to hear an overview of the 455 pages and those details in those pages and some of the clarifications also help with some of the words in the reg don’t provide, for example, the clarity that you just talked about in terms of online access.

Robert Anthony – CMS – Health Insurance Specialist

Well, I appreciate that and certainly we are actively soliciting public comment and any of those areas where people feel there is additional clarification that is needed I would encourage folks to let us know that. I would also encourage folks, and I say this not only to the workgroup members but to anybody who is listening in, please let us know what you like in addition to what you don’t like. We often hear about what doesn’t work for people, but we don’t always hear about what does work for folks. We want to make sure that it’s not always the vocal minority that carries the day on this one.

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

Appreciate that. Okay, if there are no further questions then I think what we’ll do is start getting into some of the discussions beginning with Category 1. I think the tool we’ll use is if you all have the NPRM open we’re looking at Page 156 for Table 4. That describes the Stage 2 proposed objectives and measures. What we’ll do is verbally contrast that with Stage 1 and our recommendations. That might be a little easier said than done.

Let’s start with CPOE. The proposal is that they move from medication orders only as a 30% level to including lab and radiology orders and all of them being at the 60% level threshold. The denominator has changed from the unique patient to basically 60% of orders and that implicitly says counting paper orders are submitted through CPOE for meds, labs, and radiology.

I don't have Quick Access. Does somebody else have quick access to what we've proposed? The exact wording for labs I'm looking up now.

Robert Anthony – CMS – Health Insurance Specialist

Actually, the NPRM is wrong because the NPRM says we proposed Yes/No for lab and radiology. We proposed Yes/No for radiology but not for labs. We may want to clarify that so it doesn't go into the final rule. However, what we said is medications we just increased the threshold to 60%; labs more than 60% of unique patients seen during the reporting period with at least one lab test returned during that reporting period have at least one lab order entered that same period using CPOE. So, we'd be using the same like a parallel structure to medications but instead of medication on the medication list, we use structured lab results in the EHR.

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

Just for clarifying for folks who are listening, the reason for that sounding somewhat complex denominator was so that you could get that information directly from your EHR because you do know what test results were returned. If we were trying to be responsive to how do I count all the paper orders and that's what we came up with.

Christine Bechtel – National Partnership for Women & Families – VP

Hey, Paul. Before we dive into far, I want to make sure that we're not kind of assuming that all of the Policy Committee recommendations were right and that should be our baseline because I think there were a number of areas where CMS either went farther and ONC either went farther and for good reason or they didn't go as far for good reason, and I think we need to understand the rationale. I seem to recall, and I can't remember if I read it in the rule or where I read it, that a long of folks in stage one basically said look, we were counting paper orders anyway. So, if that's the case here, then I'm not sure that we want to just sort of have a knee-jerk reaction and say you shouldn't have to do that. If they are doing it anyway, and if this encourages them, in fact, to stop doing paper orders by 2014, which is not close, then I'm okay with that. So, I just want to make sure that we're not just assuming that some of the Policy Committee recommendations are necessarily the right answer.

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

Actually, we aren't at all. We're trying to explain the rationale for how we came up with the recommendation compared to not only the proposed rule but the rationale as explained in the NPRM to that end and then trying to see. So, no, there's no

Christine Bechtel – National Partnership for Women & Families – VP

Okay. I just want to be clear about that. That's very helpful.

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

So, Paul, one thing that's changing, as we said, counting paper orders, this is George. My initial impression is that if it's possible to count paper orders, this is what we would have done in the first place. So, the NPRM role is to see if this is feasible. If it's feasible, then fine. If it's not feasible, it should go back to what we suggested.

But they have changed something else which is now all the orders are in aggregate. It's not that gives you 60% of meds, 60% of lab and 60% of radiology, but 60% in aggregate, and I guess I'm okay with that, but that is a switch. We were making sure that they did some of each type. They're not doing that. They're just counting it as a whole. So, if you only do 10% radiology orders, then you don't need to do that one at all. You can still meet the objectives.

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

Is Russ still on the line just to check our interpretation? May not be. So, anybody else from CMS who can validate that interpretation? Okay. So, the way it's written in this cell would be consistent with what George said, which is you add up all the orders and in theory implicitly saying all the orders including paper orders.

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

When you read the rule, I had interpreted it that what you counted were the orders and it didn't even talk so much about the paper orders when I read them. It's in the preface of the rule, and it talked about, again, the decision to go to count by orders and the assumption would be the order that becomes a first—an order is never written on a piece of paper. The only place that it can exist is in the system. So therefore, the person that can make the judgment to place the order has to enter it through CPOE. So, there are some assumptions in there. So, when I was reading it, my interpretation was they were going to actually use the orders in the system as that and then maybe CPOE as the numerator, those that had been entered through CPOE.

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Charlene, what you're describing is their denominator. In order for—

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

The denominator was—

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What you're describing is what they're counting as the numerator because Rob just confirmed that paper orders have to be counted from now on.

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

So, one feedback that we give is this is not clear, but using what Rob said is that they truly were—CMS was intending to count all orders. The rationale they gave for the change didn't really say that the people who said back said that that was going to be an easy project, I don't think. Christine, did you have something different?

Christine Bechtel – National Partnership for Women & Families – VP

I don't think they said anything.

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

... actually said paper counting was easy.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Remember though, if a paper order is generated, there's always a receiving system where it is entered so it can be counted at least in labs and in meds. They're entered into the pharmacy system and the lab system, so perhaps that's why they're saying it's not difficult.

M

Right. These are not nursing orders or something like that which wouldn't get counted otherwise necessarily.

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

Right. I don't know if Josh is on the line because he obviously has been paying attention to how people have implemented on stage one, but for whatever reason, not because it was easy, but I think it became the case that people were in effect being able to count orders in that way.

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

Well, you don't know what they were counting.

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

I don't, but Josh might. That's a question we need to ask.

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

So, actually the whole using the pharmacy system or the lab system, first of all, these are not certified EHRs, you could get the total number that were transmitted, and that's actually how we constructed our lab orders is to turn around and the rationale was yes, you could get it at that denominator of all orders

who had results, and that's a pretty good process. It does mean you would have to reach into a noncertified system to get that information though.

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

Paul, it also means that small practices that don't have that capability wouldn't be able to do that.

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

That's correct.

M

Yes. We're thinking of hospitals when we talk about the systems. We're not talking about individual providers sending orders to a lab where you might have mailed something or faxed something.

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

Isn't the measure by the EPs also not just hospitals here?

M

Yes, that's the point.

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

Okay, right. You're agreeing with me. Okay. So, I don't think that's a reasonable expectation obviously.

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

So, we're a bit—having heard the rationale for making the switch, it's not clear at least from the written work, that people were saying that they were finding it easy to count the paper orders.

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

You know what, Paul, you know the way I read it, I get its interpretation the denominator is the number of medication, radiology, laboratory orders created by the EPs, and the ..., etc. and then, the way it's described is when those systems become recorded in the system. So, I agree with you. I think it's confusing, and then they ask for lots of comment about the denominator and the numerator. The numerator is the number entered for CPOE. So, it's assuming those numbers are in the system, as I read it, so if that's different than—

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

I have one more interpretation that could clarify this. So, maybe the denominator are all orders in the EHR and the numerator are all orders entered by the ordering provider versus, let's say, a nurse. You know what I'm saying? That's a different measure, but perhaps that's one way to interpret this.

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

Yes. That's how we were looking at it and interpreting it. Sixty percent was the aggregate as long as it was just lab, radiology and medication seem to be okay, but if it's all orders, that's a whole different perspective too.

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

Well, I think all med lab and radiology orders.

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

It just seems that that would need to be clarified.

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

So, first of all, let's ... that concept. Basically, that interpretation would say we're trying to figure out whether the authorizing provider is making the context with the computer so that he or she can receive the decision support. So, that's one way to look at this. Is that the concept we're interested in here?

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

That's what it explains in here that the person who's going to make the judgment to do the order will use CPOE to place the order. That's kind of the concept they're going after.

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

So, the corner case is out of a thousand orders that are generated, ten are entered into the computer and all ten are done by the authorizing provider and you get credit.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

But verbal orders also work for clinical decision support. If I call in an order to a nurse, that nurse enters it, I'm still going to get the same alert, even though it's not a verbal order.

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

Yes. The concept, Leslie, is that we want the authorized provider to get the benefit of the feedback ... order. That's why we were—

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

They went through the verbal communication with the nurse. I just don't want to penalize people after hours usage or coming in a different way. I think we should look at all the workflows, that's all.

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

That's why it's not 100%.

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

Paul, what are we saying about what kind of orders we're counting in as total ...?

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

The latest interpretation and we're testing out the concept behind it is to look at all orders that are in electronic form in the EHR.

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

That's why I asked Rob that question. He specifically said paper orders count. You have to count your paper orders.

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

Correct. What we're doing is just going on the written word. So, one of our feedback, of course, is we were finding it difficult to get clarity on it, but one interpretation—so, these are actually for us to come back with this recommendation, so, one interpretation is to say look at all electronic orders and what proportion of those were entered by the authorizing provider, and the rationale is to try to get that as close to 100% as possible so that person can benefit from the physician support that comes back, any feedback that comes back.

M

On page 50, they say paper orders are counted, right? So, we know they're counted.

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

Okay. So, they are not taking the interpretation I just gave.

M

No because it says potentially this would exclude orders that never get entered to the EHR. The provider would be responsible for including those orders, the ones that never go into the PHR into their denominator.

W

Where is that, on page 50? There it is. I see it.

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

That first paragraph. So, I'm just reading between the lines. I don't think the people who are giving feedback are really counting on catching all these paper orders. I think they were bringing up all the confusion as far as what would we count, who counts in the unique cases, and that's valid. So, our approach could either be to have a better way of doing this in an automated fashion or have a different interpretation if it needs with what we're trying to accomplish with this team. Let's get the order authorizing provider to have contact with the system.

W

Paul, one of the comments that came from the vendor community of many of the testers in stage one were early adopters. We're going to have people who are later adopters in additional stages. So, there can be cases, I would think, of more paper orders with ... at that point.

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

So, other comments, and then, I think what I'm going to try to propose is see if we can narrow in on what concept is most important to us, we think is most important in terms of deriving the values, and we'll ... on them then. It could be different from either, our recommendation or the NPRM. But other comments?

W

Just one other piece—in reviewing this kind of with some providers, their feedback was, again, they were very comfortable with the concept of this licensed professional as defined by the state. They knew who they were, and I know that still caused confusion, but they sorted that out and understand it and to change it again, it's just going to—we'll go through another round of confusion too. But they were really comfortable with the licensed professional as defined by the state because they can go look and see who

....

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

I remember that confusion at the time. Other general comments?

Marty Fattig – Nemaha County Hospital – CEO

Paul, how would you verify during an audit the number of paper orders?

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

That's one of the questions that we had when we came up with our recommendations, but we don't have an answer for that. So, let me try to put—

Neil Calman – Institute for Family Health – President & Cofounder

Paul, if you look on page 52, the definition of the denominator seems to be different than what you presented.

W

Yes. I agree. That's what I was just—

Neil Calman – Institute for Family Health – President & Cofounder

On page 52, it says the denominator is the number of medication, radiology and lab orders created by the EP or authorized provider in the eligible hospital or CAHs inpatient or emergency department during the EHR reporting period.

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

But George points out that we actually asked that specific question of them.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, we did, but what he said is not what's in the document. It seems to me like the document is more—

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

Neil, that denominator includes paper orders. Read it again.

W

It does, based on page 50.

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

It doesn't say entered into the system. It just says created, whether it's on paper or electronic, during the EHR reporting period, not into the EHR.

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services

I agree. This is Amy. If you take 50 and 52, paper orders could be included. Fifty-two is not excluding paper orders in the way it's written.

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

Okay. So, we already have one point is that it's certainly not clear.

M

We all agree to that.

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

We all agree to that. So, let me start making buckets, conceptual buckets, and see which one is the most important in our opinion in terms of this functionality and we all know that this really is at the heart of the benefit of the EHRs. So, a couple that I can think of, one is is there a way to say one is more important than the other to either get the number or orders written through CPOE or target the authorizing provider as the enterer of the orders? Of course, they can be—they can both be important, but is one of those two options more important or more indicative or a better exemplar of what we're after?

We can also look at it two ways. One is coming—the early doctors already have orders flowing in. They've figured out that it's far more efficient to capture all this stuff electronically and you want to make sure that the vast majority are going in where the authorizing provider has the benefit not only of seeing all the data available as you formulate the order, but to get the decision support feedback. So, that's one kind of scenario.

The other scenario is people more in the startup and probably that's the majority of the U.S., where you're trying to get more and more of this in order into the system by going through the system one way or another. That might be the volume. Maybe CMS has proposed two-step measures. Maybe we have the same thing. There's how much of your volume is getting in and is it getting in by the people that would like to influence the authorizing orderer.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Paul, may I ask a question? Would the radiologist be considered part of that equation? Oftentimes, they're not included in the order review and yet they provide tremendous value on whether the order is done correctly or applicable or context is needed or whether an existing radiology image could be used and not be taken to avoid radiation exposure and so forth. Do we want to include that important group in that discussion?

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

So, Leslie, can we get on the general case first before we go into specific?

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

Certainly.

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

Okay. We'll table that and come back to that.

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services

Paul, and I'm not sure you can pit one against the other here, making one more important than the other. The point is to drive COPE and get the benefit out of it. If you have only a few providers using it, but

using it with decision support versus not having anyone use it where errors can be made because of handwriting and stuff, I'm not sure one is more important than the other, and I think your point about sort of where you are on the spectrum and what you're going to drive to, whether you're starting with it or now trying to get the benefit of the decision support from the prescriber of the order to benefit from that, I just don't see one against the other. I think they're both important, which doesn't help in defining this, I understand, but I don't know if we can make a judgment that one is more important than the other.

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

We have a couple options. One is to have to two-phased measure as they've done in some other objectives. Another is to think of timing as the phasing. So, in other words, by 2014, do we think our bigger problem is to get most of the U.S. getting the volume in and then come after in stage three getting to making sure that the authorizing provider is the one that's entering it. That's another approach. So, phasing it, either putting it two steps in one stage, stage two, or separating by time stage two and stage three to accommodate that comment.

Neil Calman – Institute for Family Health – President & Cofounder

So, Paul, I think that the second piece is going to happen on its own. I can't imagine a hospital building order entry kind of intelligence into the system and then just accepting the fact that half the people that are putting orders in are never going to see it or aren't going to do that. It doesn't make any sense to me that systems will develop that way.

If people are going to build that kind of intelligence into the system, they're going to want to make sure that all of the people that are using it have access to that intelligence. I'm not sure that we need to put that in our Meaningful Use criteria. I think we should be driving as close to getting 100% of all orders entered into the system, and I think that that second piece is going to be driven by the provider community.

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

That might argue, Neil, for focusing on volume in stage two and if we have to focus on the who entered it in stage three if the natural process of—

Neil Calman – Institute for Family Health – President & Cofounder

I think that makes a lot of sense to many.

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

Other comments on that draft proposal here? Okay, let's try working on that then. In stage two, if we focus on volume, what we need to do is find as unobtrusive and as least amount of burden as possible a way to see what percent of the total orders are going in.

So, the approach that we took was to find out—in a sense, you could almost look at claims. I'm just giving you an example of how you can find out this information. You can figure out what orders were actually truly completed, whether its meds, labs or radiology by looking at claims. Then, can you work backwards and we'll discuss how do we get that information and say well, what percent of those things, those results basically the bills, were actually ordered through the EHR? Actually, we could even say by the authorizing provider.

M

How would we get claims?

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

Well, that's the second question, but that's an approach to saying we don't have to actually count anything on paper. Now, we do already—let's look at one domain at a time. Lab, we already said it has to come in a structured way. So, I think we do have labs—we do know results of labs in the certified EHR. Any challenge to that assertion?

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

That works. I don't like I like lab results.

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

Just working backwards. Okay, now if we're going to have a med list, we must know the meds, however it got in there. Yes, we would escape paper prescriptions that go to the pharmacy and we never catch them. Using Neil's principle, that's just not working for the provider. It's just not going to work for the provider to have part of the meds, certainly over time.

So, could we rely on the med list and say well, what percent of the ... that are on the med list were entered by the authorizing provider as a metric. In a sense, I think we have a very strong case for the results-oriented orders like labs and radiology because it gets useless if the providers are not there. You could see how more people could have the meds escape by going the paper route, but over time, it's not going to be a good situation.

Neil Calman – Institute for Family Health – President & Cofounder

Paul, I know in our electronic health record, the result comes back in the system matched against an order. So, is there another way that systems work so that results might come back without an order to match it up against?

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

Yes, what we can do if the result comes in and it can, and there's an order, we automatically create an order. It's not typical to the physician, but it's just the way the system works.

Neil Calman – Institute for Family Health – President & Cofounder

So, that would mean that there's this denominator that would have more things in it than the numerator. That would work.

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

Paul, I think the question is what we're trying to accomplish here in discussing this. So, we're not necessarily the experts on how hard it is to count paper orders. What we would do is have a hearing or something, and so what we have here is an NPRM, which is going to gather evidence either way and people need to up rise against it or not rise against it, but discussing it won't change it. So, I think what we want to do is say if this is acceptable, according to the public feedback then in fact, counting the number of orders sounds pretty reasonable if it works, and if it's not, then do we want to keep with our previous suggestion or suggest something different, and that's how I'd frame it because it's not like we're heads of many hospitals deciding this or actually the heads of many small practices.

W

Practices that

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

Unless I'm missing something, on page 42, it talks about the four proposed denominators for EPs and it goes in hospitals and it describes unique patients, office visits and transitions of care/referrals pretty adequately, but doesn't address at all the issue that we're talking about. So, I think we need better clarification about what number of orders really means, what the intent was because it's not described as far as I can tell, anywhere.

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

Let me throw a draft proposal that's more consistent with our approach. I think just looking at what they wrote in terms of rationale and listening to what was said, I think people are just asking—I don't think people are volunteering to count paper. So, if we go back to our approach, it looks like we're pretty well covered by resulting orders because you can count the results that were recorded and check the numerator for what came into the system. For meds, you do have an ... but like we said, it's just not in your best interest to continue with that out of this paper work around. So, if we use the same approach, which is look at the results and meds on your med list becomes the results for med orders and just take

those are the denominator and the numerator are CPOE by the authorized provider, then we might actually have our cake and eat it too from where we're headed. on that is—

M

Hey, Paul, so you're saying that we're on track for medication and labs?

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

And radiology. In one sense, we're—

M

What do you think about radiology because we did send you one?

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

Right. We could either stick with that or we could go to the 60%.

M

Now that we have images because now we have images in stage two.

W

Right because we have a link.

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

That's true. So, I'm going to restate that as a proposal and for your discussion. We would adopt what they're saying 60%. So, that's a percentage already, and we're going to put in the denominator all results. So, it's radiology results, lab results and "the results of meds" are basically the meds on your active med list. The numerator would be the order written, the order entered by the authorizing provider.

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

Paul, is it order written by the licensed professional or were you going to go via CPOE? It's really tricky.

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

That's a little tricky. It's like you said, in order to avoid confusion, we could stick with licensed professionals. What that does is, in a sense, the licensed professional is responsible for giving feedback back to the authorizing provider, and as Neil points out again, it's just going to be a matter of time when it just becomes too inefficient to keep bypassing it. But what we would do with this proposal is have a lengthy rationale for why we were thinking this direction and what we thought the remaining issues were in the counting paper order.

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

Well, here's what I have written down, which I don't think you're going to like, but let me tell you what I have written down about it. I wish I could display this. Anyway, I'll go ahead. The section should be clear whether paper orders need to be counted or disposed in the EHR, is a CPOE or otherwise. Page 50 implies paper because these three types of orders go into systems for eligible hospitals, the total number is likely countable. For EP, this may be more difficult. If the CMPRM process reveals that counting paper orders is onerous, then we return to our original proposal of 60% of each order type with the exception that radiology could also be counted via the newly required links to images.

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

That sounds good. I might explain what our original was. We could do a better job articulating the original thoughts.

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

I did say the NPRM appears to ... medications, laboratory and radiology orders so that one could skip an order type completely if it's less than 40%. I just pointed out, I'm not sure if we need to change it or not, we would prefer not to change the destination of who counts for entering orders open ... a licensed professionals. Then for clarification on the HIT PC stage two proposal, only radiology would suggest it as

yes/no laboratory was counted. I'm just doing that in case they take it in the final rule I wanted to get it right.

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

Right.

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

Which just emphasizes your point that maybe we need to clarify what we said.

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

Other people's thoughts on what George just said? Are we ready to vote on this? So, all in favor of that response?

W

Aye.

M

Aye.

M

Aye.

M

Yes.

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

Any opposed? And the same, okay.

W

That might change because I'm having a hard time following it. So, I'd just like to see it written down and then I'll come back to it.

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

Okay. This was a very, very important objective. So, we need to spend the time on it. So, returning back to page 156—

M

Paul, here's a process question. The next one on here is prescriptions. The next one in the text is drug/drug and drug/allergy. In other words, do you want to do the ones that were—and the next one in our original table was drugs. Do you want to do the deleted ones now or try to save them for the end?

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

Let's do the deleted ones. So, the next one was drug/drug and drug/allergy interactions, correct?

M

Yes.

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

Their proposal essentially was to maintain it just move it, if I understood it correctly. So, literally it gets lumped under CDS, but it's not as if it even counts as one of the five. It's five CDS plus drug/drug, drug/allergy interactions. Correct?

W

Yes.

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

Okay. So, this is really just a formatting thing. Is anybody opposed to that? Now, I will say I'm glad they didn't lump it in as one of the five because we called this out specifically because it's still a hard problem and I'm not sure we have a suitable—

W

It's a hard a problem.

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

Yes, it's just a hard problem, and we were trying to push towards better—actually, does someone have readily accessible in our proposal because we started talking about the ability to tailor that and now that I think about it, I think that got dropped.

M

Well, what we said was employ drug/drug interaction checking with the ability for the provider to refine the DDI rules. Then, stage three, we said the goal was to have nationally endorsed lists of drug/drug interactions with higher positive predictive value and ability to record reason for overwriting alert. That was stage three.

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

I think that combination is more true to both our appreciation of the difficulty and remaining talents and it still remains not a very useful tool and the stage three signal shows that we really need a better tool than what's available in the industry right now. Does that still describe our sentiment and should we still strive to maintain that then? Comments?

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

I still think that represents, there are levels that you can tailor these sensitivities to drugs but again, there are still a lot of alerts to see that happens out there. I don't know if we'll be hearing that feedback a lot in stage one, but I certainly know that we hear that among customers.

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

Maybe the annotation for us as we come back with a response could be to include why we're doing this but also because we'll be making this public as people are constructing their response, Our suggestions that they listen to more response in terms of whether the drug/drug interaction is helpful as currently implemented, something like that and the fact that we're repeating all this in public domain may stimulate more response and then CMS can use that.

M

Let me give it a try. Let me read it. My answer here is we agree, especially because it is still separate in the consolidated objective. We believe that this is a difficult problem. We believe that further work is needed in defining drug/drug interactions.

W

I would mention alert fatigue. The safety issue—that one issue was because they turned it off, right?

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

Yes. That's what I meant by a problem due to alert fatigue, a difficult problem due to alert fatigue.

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

Let me put that for false alarms that we come back and re-recommend what we did for stage two, which was the ability for a provider to refine DDI rules and provide a better rationale so they can understand what was motivating them.

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

Now, we believe that providers should enable to define DDI rules, and what was the second part? I didn't quite understand that.

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

Well, that's why we're re-proposing our recommendations. Well, that might not be the—the reason we believe that the existing commercial drug/drug interactions alert are causing alert fatigue and the... we're concerned about is it diminishes the value and the effectiveness of clinical decision support more generally. That's the reason we propose that at least providers in stage two, providers be able to refine the DDI rule and we were looking towards future stages in finding nationally endorsed lists that have a higher positive predictive value. Okay. So, let's try to make progress then. Are people happy with that?

M

So, we still agree with the consolidation?

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

It's just a movement really because they—any problems or questions, concerns about that? Okay. So, the next one is the ERX, the transmission of prescriptions and stage one was 40%. We proposed an increase to 50% for EPs and 10% for hospitals. Their proposing 65% for EPs, and I don't see it readily where the hospital one is but it's somewhere off I think.

W

That's separate. The discharge one, I think, is separate.

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

Okay. Well, let's just do what's in this chart for right now. It's currently 40 at stage one. We proposed 50, and they raised it to 65. Any comments on that?

M

First of all, they have 50 in one place and 65 in another place, NPRM. If you look at Rob's slide, he says more than 50%. I'm looking at it right now. So, they have to clarify—I think they mean 65% in that slide They changed their mind clearly recently.

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

Like suppose if they're basing it, I think a lot of what they do when they look at these raised threshold is they said of the people who already attest and recognize these are early adopters, they blew past the 40% and so that's why they felt confident in raising it. So, are people comfortable with 50 or 65?

Neil Calman – Institute for Family Health – President & Cofounder

I think 65 is fine. I'm going to make the same comment that I made thus far, which is basically if you're using it, you're going to use it for everybody that can accept it because I just don't see any reason that anybody would e-prescribe certain things and then decide, unless the patient requests it, which sometimes happens, or the medications can't be prescribed because they're controlled and we still can't do that in New York State but aside from that or the pharmacies don't, some of the Mom and Pop pharmacies still don't accept it. So, unless there's a reason for it, I can't see a reason why a provider wouldn't do it in every possible time that they could.

Christine Bechtel – National Partnership for Women & Families – VP

I would just add to that too. This is one of the areas that many of the places where CMS or ONC is proposing to raise a threshold are areas where the attestation data really supported it as well.

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

Well, what we're saying, Christine, is we only have really adopters that are doing this and so we might not be detecting all of the smaller, either smaller practices or more rural areas.

Marty Fattig – Nemaha County Hospital – CEO

One of the things that's happening in the rural communities when I visit the docs here is the patients are arriving at the pharmacy before the e-prescriptions arrive so the pharmacists are calling back to the clinic and asking for a faxed copy so that they can go ahead and fill the prescriptions.

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

Actually, I have that same issue in the community health center I work on the board member where they have their own pharmacy in their own facility and the patients are beating it to the pharmacy. So, therefore, they have a big issue with prescriptions.

M

Where are they getting stuck?

W

Well, sometimes it's at the pharmacy itself.

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

In this case, they've traced it to SureScripts or some of the external because it goes out before it comes back.

Marty Fattig – Nemaha County Hospital – CEO

That's where it is with us too. It's at SureScripts.

W

I think sometimes what we've seen also is people at the pharmacy not realizing that it's actually sitting on their fax machine somewhere because they're unaccustomed to it. So, that should happen less and less.

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

But this is not fax, Christine. This is electronic.

Christine Bechtel – National Partnership for Women & Families – VP

No, but that's how some of these pharmacies are actually—that's how the translation apparently happens.

W

And even the hospital setting to their outpatient pharmacy is going through another service to get out there and that ... that order is not coming directly from the hospital. It's going out towards PBM or SureScripts before it gets to the retail pharmacist of any pharmacy.

M

Keep in number of the thresholds high in my opinion.

W

Yes, I agree, and I also want to—

M

These are baby situations where people are not getting any of the benefits of e-prescribing.

Marty Fattig – Nemaha County Hospital – CEO

I agree that keeping the percentage where it's at—this is just a problem that I wanted you to be aware of.

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

Okay. So, maybe we can go ahead and agree with this 65 and just annotate it that these are the kinds of issues that still remain challenging for some in some areas and maybe ONC can delve into this. It's hard to find ways to stimulate improvements there.

W

Paul, I think that's a good approach because I'm hesitant to sort of design around the low bar. So, I think that's a nice way to do it is to straddle that by saying okay, the higher bar is better, but there are some issues that need to be looked into that maybe aren't solvable in the Meaningful Use realm but they are in lots of other work areas that CMS and ONC do.

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

Just to comment, remember setting a high bar is not necessarily good for patients. It's bad for patients. What you're doing is you're getting the doctor to force patients to pick a pharmacy even though they don't want to because they want to meet Meaningful Use. So, they're going to tell me, look, just pick a pharmacy. If you need to call me back and get a new prescription, do it, but for right now, I've just got to get certified. So, the high bar isn't necessarily better for patients. It pushes the whole health care system forward, but it's not improving patient's choice necessarily to pick too high a bar.

M

Going back to earlier comments, does the threshold really matter, as has been said, if they're using it, they'll use it for everybody. ... some of the challenges we're talking about.

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

So, hopefully, they're getting some feedback maybe even to their rep, and particularly to the rep, that says, I'm just going to pick on something somebody said, so say it's ..., well, that certainly operates really across country. If there are obstacles or things that throw things down there, then you can actually work with one organization to try to improve it for everybody. So, that's just an example of something where you can work on the Achilles heel and try to improve it for everybody. So, we're in agreement with some annotation about some of the remaining challenges that may be worked on in other programs. Okay, so the next one is—

M

Another procedural question, should we be answering their questions as we go? They asked a set of questions through the NPRM. Is that something we should be doing?

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

I think it's going to be a little hard in terms of having enough time.

M

Well, one of them we just answered is well they asked is 50% low enough. Of course, they should have said 65, but the other one was controlled substances, and my answer is I have no idea.

W

The vendor community on that one is not to include them because there's only pilot space so the implementation level is supposed to be low in that area.

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

Right. I think they're 15% of all prescriptions.

W

It should be ready by stage three, but it'll be tough to do in stage two.

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

So, let me summarize and say I think people are saying not to include them in the denominator. Is that correct?

M

Okay.

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

Okay. So, the next one is demographics.

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

Wait. One more point on this one. This is ..., and this is clarity. Sixty five ultimate EPs are compared to at least one drug formulary because remember we were talking about the relevant formulary and we said

well, that's really hard because sometimes if you see a lot of insurers, it's really complex. The formulary has to be up to date. But you can exclude it if you can't see it. So, are there any comments about that? The take the vendors had was just want to attest to it rather than have to check it all the time, but—

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

So, in a sense, I think the way they wrote this is if you have one drug formulary and it applies to one plan and as long as you check it and the answer could be well this patient isn't on that plan, that's the I think that's what they said, right?

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

Yes.

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

So, basically saying if the same thing is saying implement one formulary, I think, Charlene, it's probably more genuine to say well, you did that versus making sure everybody tests against an irrelevant.

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

So, the question is you've got to keep your formularies up to date, but if you receive it from SureScripts is maybe there will be by 2014 a high-enough percentage of formularies available to do 65% of the patients too. I think people are trying to do it the right way, and we should try and do it the right way, the relevant formulary.

Neil Calman – Institute for Family Health – President & Cofounder

I'm just going to ... say that I think that if we did nothing here and put no criteria in, this would happen pretty much on the same timeline. This is something that the market's driving. It's just happening. So, I don't think it's really critical to micromanage this piece.

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

So, just let it go then?

Neil Calman – Institute for Family Health – President & Cofounder

Well, I'm just saying I don't think it's critical to micromanage it. It's something that creates tremendous efficiency, has great quality criteria, great quality improvement associated with it, and there's no real cost inhibitor here on the provider part. I just think this is something that's happening naturally. It's going to continue to happen until 100% of this stuff is electronically prescribed. I just don't see any impediments. In other words, I don't think that our activities here are necessarily adding value.

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

And that would be fine and we would only ..., in fact, this is going to be very burdensome when it's going to happen anyways, be burdensome to report, and I guess as written is probably not burdensome to report. Is that fair?

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

The only burden is it's going to generate a lot of questions.

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

That may be true.

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

Well, does it have to be relevant or not? You know the question.

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

So, Neil, are you proposing to actually take out that second clause?

Neil Calman – Institute for Family Health – President & Cofounder

I don't know what that level of detail—I guess I'm proposing to say that it almost doesn't matter what we do here. In terms of the long-term outcomes that we're trying to achieve of Meaningful Use of electronic health records, and so we should make the requirements as least onerous as possible just so that we can say we're doing something around electronic prescribing, but I don't think the details matter that much.

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

As long as it's not burdensome, then the signal is that one of the reasons you want to do ... is so you can get feedback on drug formulary. It's a valid signal. Is it okay to leave it as they proposed?

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

Okay the next one demographics, I believe matches ours, which is 80%.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, the only, I think, issue that we're coming into contact on this one is not actually about the threshold, but about the standards that are used, which in the rule are the OMB standards, but the Secretary of Health and Human Services issued standards in October of 2011 that were better than the OMB standards, a little bit more granular but not nearly as granular as the IOM standards. So, I just want to flag this as something that we're looking at and hoping that we can find some better alignment there because the HHS standards are really better in terms of being able to collect data for a disparity.

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

Okay. There's a way to describe that then and bring that to our face-to-face maybe.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, exactly.

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

The next one in the chart—actually, there's a bit omission I'd like to address. So, they deleted problem list meds and med allergies. The rationale was because it's going to be part of summary of care. The concern I have is partly the signal. It's the deletion signal and the lack of having it there.

I know that for a couple of reasons, one is clearly people started paying attention to this especially in the hospital where there wasn't problem lists. Two, we are headed—we had already talked about it in stage three for trying to find automated ways that actually accept things how up-to-date these lists are, and that's a good thing because we know how much can or does already depend on these lists, and it's really not contributing like it wasn't on the paper unless it's up-to-date and complete. So, I think we were heading in a strong direction of reinforcing importance of these lists and their completeness and their accuracy. To take away a signal is a signal itself, and it also means we have to reintroduce it in stage three if we're going to actually work on the up-to-dateness of it.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I wonder if we want to—I picked up on that as well, but I also think it was a parsimony issue because as you pointed out, you can't do the summary of care record without it. People will have been doing it for two years. So, I wonder, but I also think the parsimony thing makes sense here, if there's a way to kind of bring back in the importance of at least communicating that signal in the final rule that while it's not an exclusive piece, there are things you can't do without it and it must be up-to-date and we fully expect that those will continue to be maintained in an up-to-date way because stage three is also require that.

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

Well, the issue with that, Christine, is that we'd have to reintroduce it in stage three.

Christine Bechtel – National Partnership for Women & Families – VP

So, how would we or why would we or is there a way to do that in a parsimonious way, and then, is there a way to signal that this requirement is not going away?

M

It's also a matter of where it's accessible, which is just to meet this requirement the way it's set that it's only needed for the summary could totally leave it in the background of electronic health records and not really in a place where it's a work of a living document for use, the problem list.

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

Exactly.

M

In other words, you could create an algorithm where you just generate a list at the end of every diagnosis that's been associated with any order and just spit it out on a summary of care record, but that doesn't really make it a living, useful document that really summarizes the care of a patient in a way that we've been thinking about this as a quality issue. So, I think it's a serious omission.

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

I don't understand why we got rid of problem lists and medications of all things and kept demographics and vital signs, ... status and everything else. It just seems like the wrong one to pick to get rid of first. As Neil said, let's say you never transfer patients, do you not need problem lists and meds anymore? So, it did seem odd, but I'm all for consolidation. I just would have consolidated all of them then.

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

That's a good point actually. Everything on the transfer of the summary of care could have been eliminated by that rationale.

Christine Bechtel – National Partnership for Women & Families – VP

I hear you guys and it does sound like a problem that we need to address. Is there a way that I'm trying to think about the parsimony thing, but is there a way to look at some of the other criteria of the after-visit summary that patients get and make sure that it says it has an up-to-date problem list on it so that the criteria is maintained within the context of everything else. Would that be effective?

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

I think Neil's point, and I strongly agree with it is this is one of the most useful things there and if anything, we would want to make it available at a summary of this level so people can easily get to it because of our up-to-dates and how important it is in leveraging.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

It's also an area where context can be transferred to other modules attached to this electronic medical record. The problem lists presents that active, living, breathing thing that can be addressed by other applications. So, to have it only at summary and only at end and hidden, I think could prevent some innovative add-ons to the EMR that addresses the problem list.

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

I think we're having a fairly strong and uniform response as far as wanting to bring these three items back and we can explain the rationale and the direction we're intending.

Christine Bechtel – National Partnership for Women & Families – VP

That's fine with me. I don't want my comments to be interpreted as I don't agree. I do. I was just trying to think of other ways to kind of achieve that parsimony since the after-visit summary is core, and it's required every time but whatever you guys want to do is fine.

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

Okay. The next one is vital signs.

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

Paul, on this one—this is Charlene. Would your comments put just to problem lists or to all the lists?

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

No, the three, problem, med and allergies.

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

Because I could argue, I definitely support problem lists, but to be able to do CPOE, e-prescribing and those other functions as well as med rec, which will be very high, you've got to have an up-to-date medication list, and an up-to-date allergy lists. So, those truly, I think we could have another way of being—those will be up-to-date, but the problem lists, I would agree certainly does not necessarily engage in those functions. So, it would stand out.

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

Well, I think most of the people who are speaking for all three, and one of the big reasons is you want it to be up front and not buried down.

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

But it's a necessity to even use your system to have one. So, it's by definition up-to-date if you're going to have these other requirements.

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

Actually, no. The med list, med and allergies, one of our problems, it's not often up-to-date just to get around. You don't change things. You do it on the phone, a lot of reasons. It doesn't include care.

Okay, moving onto the vital signs, I think their changes were pretty clear that is they wanted to—the feedback they got ... on some of these, it's not an all or nothing. In stage one, it's an all or nothing, you're excluded or not and they adjust the age for blood pressure. So, any problems with their proposed changes?

Okay. Smoking, let's see, I think that smoking is the same as ours as well as our recommendations. Next one is clinical decision support, we had proposed in trying to include decision support of multiple types and yet have a definition for what counts, we proposed the five attributes. They seem to accept the first attribute, which was to display the source and citation of CDS. The other attributes we mentioned were that it's considerable based on patient context. That is presented as the relevant point in the clinical workflow. That is presented to users who can act on the alert and that it's integrated with the EHR versus being a separate system.

I think none of the—let's see here, how did they write it? They implement five clinical decision support rules. So, they did one additional thing, which is to tie it to finding more clinical quality measures. I didn't see additional detail. We were trying to bring additional, we thought, clarity to the definition of what qualifies as CDS particularly How do people feel about whether that's needed or not?

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

Is this from the attributes, Paul?

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

Correct. But I think the only attributes—actually, there's another piece to the attributes. I'd have to look it up, but the attributes they included was to display the source citation of CDS. They required you to be able to link to it and read it.

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

We just expected we'd have to build hyperlinks in.

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

Correct. There was another requirement that I'm going to have to search for.

M

Page 73, Paul, there's a list.

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

Okay. That's right. It was a little bit tough. It said you had to review all of the following attributes, developer of the interventions, ... graphic citations, funding source of the interventions and release revision data of the interventions. It's a bit tough, I think. But what is a developer of the interventions? there one developer or are there multiple developers? Does everybody who did a clinical trial on a developer—that was a little unclear to me.

W

Again, it can be—some of them are developed—well, you referenced in-house too, right?

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

That's true.

M

I think they're considering it's just some commercial interest influencing the adoption implementation so they'll probably have to find a way to support a disclosure.

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

I think those requirements are actually part of standard journal requirements nowadays. So, if you had a link to that journal, you would be able to review the funding sources.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

We did it on the consumer side, for physician support and yes, we do have all of those fields cited.

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

What is the developer of the intervention? So, you're testing a pill, let's say, who's the developer of that intervention?

M

On the next page, they talk more about sponsorship of the development and the intervention than the actual developer. I think you have an ethical obligation to say this was sponsored by a particular company or—

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

... is correct, but I do think that the internationally developed requirements for journals cover this.

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

But a site may just be doing something as someone said earlier, just in-house based on collective knowledge.

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

Then, you would site an individual or a department who developed that protocol.

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

I think I agree with David that this seems to be about disclosure. If it's something that came in from outside the organization, it might be worthwhile at least letting anybody inside the organization know where that originated.

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

So, people like the work here, understand them, or how could they be improved upon?

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

You ... with the words around developer of the intervention, maybe they could just as they were a little more explicit on the next page about the sponsorship describe what they mean by that.

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

What do people think about that?

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

You said last time that you could just do the source under citation. We didn't have all the specifics, and that gave for the capability of if there was the source, if it was self-developed, right? But it didn't go into all of those specifics.

W

Is the recommendation only related to the clinical quality measure? Will some organizations be using clinical decision support for other interventions? Do we want to encourage all of the clinical decision support or only those that affect clinical quality measures?

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

So, one way to improve upon our recommendation is to say we ask for this source and citation, maybe we could say link to the source and citation and what that buys you at least for most journalists is access to some of these other funding sources of course.

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

Then, if you don't have a funding source, could you develop it yourself? It gets easier, right?

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

Right.

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

So, you could say source citation, which could include those things, right?

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

Well, we separate it into externally tier-reviewed guidelines, tier-reviewed recommendations and we have internally developed which still need to have sponsors because the idea is do you know where this is coming from and you know who paid for it basically. Is that helpful to clarify what they might mean and have where we started?

W

I think it helps to clarify that.

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

Okay. We can certainly add that. So, the other thing is do we think it's important to reintroduce any of these other attributes or are they duplicative or unneeded?

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

Paul, can you summarize for me—this is George—for me what I should be writing down here?

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

So, we were sort of enhancing or clarifying their display towards the citations to say a hyperlink to the tier-reviewed literature that supports that recommendation and if internally developed, I guess the name and the developer and the funding source, something like that. Let me go through these attributes that we had mentioned and see whether you want to include them or not. So, one was that it's configurable based on patient context and really what we concentrated on and the next three really are—let's make sure it's efficient and we don't have more alert fatigue. So, if you bring it up for everybody, all males over 50 at one problem or can you limit it to those with heart failure or to those with asthma with persistent asthma rather than intermittent asthma. That was our point to making this as specific as possible that it should have that capability. Important, not important?

W

Very important.

M

Very important.

W

I don't know this yet. I've got a cross reference because your goal was to get this in the certification criteria, right?

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

Correct.

W

There was an info button and some stuff I haven't got back. I don't know that answer.

W

It is in standards in the ONC document referencing the info button standard.

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

But that's different. That's different from the CDS.

W

But I believe that you want to make sure that any content is accurate timely. It's revised in a timely way. It's free of commercial funding that's inappropriate and that the sources are either found.

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

Yes, I don't know how you do that against the EHR functional requirement. That's sort of a processing that people have to do in terms of ... management.

W

I think it's covered in the citation request and also they were covered in the patient context.

W

I don't know where these other two through six, I don't know if they're in the—I'll have to read that, Paul. I don't know if

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

Okay. We can add some stuff Okay, so people tend to think that these workflow related things and alert fatigue were important. Let me read the third attribute we had was presented as a relevant point in the clinical workflow. So, let's say all of your alerts pop when you open up the chart, that might not be the most useful, and then, what's going to happen is the provider has to remember when they get to order entry what to do. That was sort of the thinking behind that. You want to pop up the right alerts at the right time to maximize the impact and efficiency for the user.

I'll go ahead and cite the fourth one so we can consider this in a bundle that the alert that's presented to the user should connect on the alert. So, for example, if the MA who doesn't obviously enter orders, gets all the alerts, the alerts fire one for patient. The MA gets all the alerts when they room the patient and then the doctor, the nurse don't. That's nothing

So, we meant by these three attributes that these are things that not all the HRs handle this appropriately. So, that's why we made them attributes of what CDS means. So, question for this group are they still valid and important enough to re-raise.

W

Yes. ... the timeline.

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

Is that a yes?

W

Yes.

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

Others?

Yael Harris – ONC – Director of Evaluation

I just wonder how we're going to quantify what we mean. I know what we're saying, but how do I specify that specifically?

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

Well, this is kept in the certification criteria.

Yael Harris – ONC – Director of Evaluation

But it's a broad concept.

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

Well, let's say number two, which is considerable based on patient context ... some EGs. Like is this related—is this inpatient, is this outpatient? Is it problems? Is it meds? Is it allergies? Is it the risk factor or is your risk factor—say that you should have a pap smear every three years or every six months and the same thing with mammogram, etc. Those are the things that make an alert more effective or a much higher positive predictive value, and we're just saying in the EHR certification criteria, an EHR when you're billing decision support, you should be able to handle these kinds of things.

M

Are we going to specify what that list is, Paul?

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

We were doing it by an EG, which is what was done in the past.

M

Because it's very context specific also by demographics. The question is how granular do we want to get in the recommendations.

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

So, that's why we wanted with regards to the EG approach so that ONC can decide how prescriptive to be, but we're just giving them an idea of what does that mean, patient context.

W

If we're doing that, then can we recommend that they build in the U.S. public health service preventative guidelines as part of that clinical decision support?

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

Well, I think their notion of saying five and match it to CQM is saying pick what's relevant for you without being prescriptive.

W

But when we developed specifications, the HR vendor would have to have multiple ones built in so that they could pick which ones are relevant to the population they're treating.

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

Generally, the vendors don't fill those in because they try to stay out of the context business. So, usually it's done by the organization. I heard a couple yeses for keeping these three attributes in. Other people want to weigh in?

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services

I agree.

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

I'm sorry. So, they have, for example, support of ... relevant point of care, and that's our number three here, right?

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

So, what page are you on, George?

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

Page 74, second paragraph. So, they think providers must implement clinical decisions according to ... relevant point in patient care when ... influence clinical decision making before an accident taking on behalf of the patient. ... to discretion, but—

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

I think the only difference is it's showing up as part of text instead of the requirement. So, I don't know that this text unless somebody else already read the ONC, whether this text actually got turned into a certification criteria.

W

Yes. And you haven't had that feedback pop up yet, and I'm sure people have wanted it.

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

Yes.

M

So, what they did in the text versus what we suggested and how we weren't that different, and the second comment is within the text, should be implemented in the certification criteria.

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

So, yes. So, if it's in the certification criteria, then our needs are met. So, we can test that. Maybe Josh, you might be able to help us with that.

Josh Seidman – ONC

Sure.

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

Okay, the fifth attribute we had was can be integrated with EHR. The purpose there was you have this standalone literature searcher and we didn't think that that would actually count as far as from the workflow, is this bringing the relevant support to the clinician making the order at that time and our answer was no. So, is that important?

M

Why was it presumed?

W

The way it's described on these pages is assumed.

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

Right. There are counter examples where something like some textbook or something, and you just pop up a frame in your EHR and there were examples of people wanting to say that that's CDS.

W

If the content is popped up that is clinical decision support, it has an action recorded back into the chart, doesn't that meet the objective?

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

No because it's not context specific. The user in that case would have to go look up something instead of the most CDS, you're thinking about doing something or you're proposing to do something like earning an order and you get something related to that patient's context.

W

I agree. I agree context is really important.

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

Okay. People want to weigh in on whether we include attribute five?

M

It's like it has to be to be part of the workflow and to understand the context.

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

That was our thought. Okay, we can reinforce that, and they can decide how to put it in, but these attributes, we did, like ... said, we did think hard about them and try to make them essential but yet nothing prescriptive of what the CDS actually looks like. Okay. Moving on is—

W

Paul, just one other comment, and I just want to ... on this one because of what you said earlier. If we have the supportive of the concept, supportive of linking them to things you're trying to improve upon and the whole area of performance measurement, but we've got like hundreds of CQMs out there. So, the vendor community was really concerned will they then have to build clinical decision support rules for each and/or more for each of the quality measures that they have to report and what if the providers want to use that one or another one. So, there was a sense that this requirement might require a lot of development in order to support it, and I'm just kind of more on the page that the provider would tailor their own as opposed to creating a lot of development.

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

That would be my interpretation.

W

Yes, but that was not—the vendor interpretation was opposite of that. So, I think we'll get that kind of feedback on it. I just wanted to share. There's concern there. So, we've got to think about how to make this work.

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

I think our intent was these were attributes that should be—so if you're building a rule or whatever it is that you build within the system, you should be able to tailor that to triggering by these things. That's what we meant.

W

And/or add one in or build your own—that was kind of where I was at as opposed to the vendor delivering these 600 rules that need all these measures.

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

No, I can't imagine that would be—anybody else think that it would be the vendor who would have to bill all these things? Okay.

M

I could see a vendor doing it as a marketing tool for their product.

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

I don't think there's anything against them ..., but it's not a requirement.

W

So, the problem we're trying to prevent I think is the development time schedule. So, right now, there's an expectation we've got a lot of this isn't support rule building to do, and there's a lot of other work. So, it's a good way to say that but to try and reduce that, I think, to try and follow your lead here.

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

Okay.

Christine Bechtel – National Partnership for Women & Families – VP

I have one thing before we move to the next criteria, whatever.

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

Go ahead.

Christine Bechtel – National Partnership for Women & Families – VP

I was reading the news piece about the health affairs article that I'm sure everybody has seen which indicated that clinicians with access to tests and labs etc. actually order more than those without. I was just thinking about decision support and one of the things that they talked about in the article was an example of someone who had a clinical decision support rule around MRIs and it would pop up an alert that said this—based on what you're trying to order this for, this test has a 3% result of finding anything or a 3% chance. Do we want to think about sending a stronger signal or actually requiring that one of these rules be around images or labs or images or tests or something like that in response to this?

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

That's a good question. We had that in our original page one, and actually I thought but I don't recall us following through, I thought we actually included that back in stage two proposal but maybe not.

W

I can look that up really quick, but I just think it's hard to ignore that study at this point, and while I don't have any issue with the quality measure, I just think this would be a very powerful piece.

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

One of the ways we could do that is of the five, maybe one has to do with efficiency and stuff like that..

M

That's what I was thinking, Paul, it acts as a framework.

W

Yes, I agree. I think that's right. So, the discussion on this in terms of our recommendation was we did recommend expansion of the—no, I'm sorry. I'm reading CPOE not CDS, my bad. Never mind. Anyway, it sounds like we have agreement anyway.

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

First of all, if you believe the study, then that would point against doing this because the study shows we did an intervention globally that is trying to incorporate lab results and radiology results and look at that, it causes worsening not improvement. So, if we go ahead and do decision support rule that says order fewer MRIs, maybe it'll cause more MRIs. Now, of course, I don't really believe the study. I think the study maybe showing that people and ..., people who order more images, tend to set up systems so they

can review those results and that's an equally good association. The association of cause and effect could go either way. So, they just say five. They don't say which area? Now, I'm forgetting.

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

They just say five tied to five or more CQMs.

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

And we're proposing that one of the five should be efficiency?

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

Yes.

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

It's not that bad. I don't know. But why not patient engagement? Why not do the whole framework then and do one of each? Then, it gets too prescriptive.

W

Right, but that's not what anybody's proposing, in part because we actually have some—there is a study that's sort of prompting this, but I guess I'm not following your logic, George, of how a decision support rule that is built around giving people the odds that the particular image or test that they're ordering is going to actually be useful or telling them this was already done on this date in the EHR like I don't get how that could actually increase the image orders or test orders.

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

Because the study shows that when we did something we thought would reduce the costs, it increased the cost. We show results so that you don't reorder the same image since we're showing you the results, don't order the same image again. What they're finding is they're ordering more images, not fewer. So, I'm just saying our attempt to intervene according to this study says that it can backfire.

That's what this study shows. It doesn't give us evidence of I think we should do more of this stuff. It's saying hey, wait a minute, before you do these interventions, you better look twice because sometimes they go in the opposite direction than you're expecting.

W

Right. Maybe my read of the study is different, but I'm thinking that the piece that was lacking was decision support.

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

But David, just let me get to George's question about Josh, if we say one should be this and we have—your wheel has six domains, one of which is efficiency. So, in a sense, I know they had options for which approach to take with CQMs, but in a sense, we've got pretty good odds that if they do have to match a CDS with five or more, maybe if we said five or more, each in separate domains, you have a pretty good chance of capturing efficiency. Does that reasoning make any sense?

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

You mean five out of six if you say there are five measures and measure decision support time

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

Yes.

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

As a rule that we all think?

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

Right.

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

Probably go back to Christine's argument that you have a national focus on reportability, and that's the one where we're always doing the least structural interventions with EHR. So, I think for stage two highlighting just that one would be legitimate, not only given the most recent study but the general challenge we've had of getting any measures into the efficiency bucket.

W

I also am trying to go for a slightly broader construct than even just the efficiency CQMs because the efficiency quality measures are not the best, and I think there are some other probably more functionally oriented rules that would work here as well. So, I'm worried about hinging too much on CQMs because the CQMs that we have aren't great, and we don't know which ones—CMS has proposed a whole ton of quality measures that they will then reduce and scope based on public comment, but a lot of what they proposed is really the same old, same old useful stuff that is absolutely not HIT sensitive nor enabled. So, I'm worried about that particular approach.

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

Well, our original stage one proposal were two inefficiencies. One was to have CDS around high-cost imaging and the other was around generic prescribing. To this day, I think those have both been shown in studies to be useful and worthwhile. We could go back—maybe that says either you turn to that in the appropriate, like CPOE for radiology or something, or you use this one efficiency-related CDS.

Leslie Kelly-Hall – Northwestern Nazarene University – Adjunct Professor

I also think that if it's only tied to clinical quality measures, you also might just have an imbalance about timeliness of data coming out of the backend of the CQM and also be too narrow. I liked your idea of going back to the big picture, like the imaging where there are huge opportunities for cost and efficiency that might not be related to specific CQMs.

M

Generalizable enough that as they've defaulted in the drug/drug and drug/allergy CDS as a requirement separate from the five measures, could one argue that there's an imaging CDS that's also a universal requirement or is that not going to apply to enough EPs.

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

To David's point and on this imaging, I do know that there is an effort on part of, and again, the scope of the imaging, I know it's on the radiology community to develop appropriateness criteria that could be supported through CPOE. The timeline for that is I think 2014 to get them all approved, and again, part of that is to get rid of the third-party reviewers that review imaging requests. So, I know that work is happening in the industry to—so, there might be something that we could have more concrete stuff that's relevant to stage three.

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

So, David, as far as specifics, would efficiency give people a bit more latitude and figure out where there lower hanging food or the higher impact might be for a given—it might be difference between provider versus the hospital or the same thing.

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

It might. It would probably take a little more of a review again of the quality measures matrix with this in mind to ask how many of these proposed and not yet final efficiency-related quality measures would map that to a relevant CDS rule.

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

So, maybe you're calling out it to be separate like drug/drug interaction because then it wouldn't have to be tied to an existing CQM. That's what I was thinking. The only friendly amendment would be instead of imaging alone, maybe if you did say efficiency as a separate measure, then they could pick and the couple examples that come to mind is certainly generic and high-cost imaging.

What do people think of that approach? It's really a callout like drug/drug interactions. It's in addition to the five and it's a callout. One of the reasons for that is so that it doesn't have to be linked to an existing CQM because there are very few that are good in the efficiency area.

W

I think that's a good approach.

M

Just eyeballing the efficiency domain and the table eight, they're pretty ... while not going to be widely applied.

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

Other people's thoughts on David's approach?

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

I don't necessarily oppose that, but just wonder if we should be looking more toward diversity in the CQM selection out of the six domains and not necessarily calling out anyone specifically.

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

So, I think we'll get that. Even if we hypothetically reduce the CQMs to four instead of five because we defaulted in one on imaging, it would still have four diverse self-selected CDSs.

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

So, what happens to the EP that really doesn't do much imaging?

M

That's what I was worried about. I don't know. That's an empirical question. I don't know what percentage of EPs would be affected by an imaging-related CDS.

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

Well, that's why the two that we picked out—generic almost everybody deals with. So, if we gave those as two exemplars of the kinds of CDS efficiency, almost everybody could fit one of those.

M

Right, Paul. So, you're saying don't be precise on what the efficiency CDS is just so you have to have one.

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

In fact, I think we can even do the EG because they're just so—they've even been proven, and it tells people what we mean by efficiencies because otherwise the question will come up. Are we getting agreement around that? So, it's a separate callout and under CDS in addition to the five linked to CDS, CQM, there's one for DDI, that CMS proposed and we're proposing one for efficiency EG high-class imaging and generic prescription.

M

I think that's very good, very timely from a policy relevance point of view.

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

Great. Okay, Let's see if we can plug on for a little bit more and then we're making good progress I think. The next one on page 158 is the ... lab results and I think all they did was go from our 50 to 55m I think. No problem?

M

No.

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

Patient lists, I think it's the same as ours, right? Generate at least one report?

M

... the question. What was that question on lab tests? Count the individual test, I guess that's okay.

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

It's fine. You just have to have a definition.

W

Well, I guess my question was there were some recommendations around hospital laboratory data and I'm not sure if this would incorporate that or not.

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

So, under eligible hospital, they have incorporate clinical lab test results into the EHR as structured data.

W

So, it would cover that recommendation.

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

We also tried to do something about LOINC. Is that around here? Remember we were trying to get the hospital to provide—here it is.

M

They talk about that later.

W

Paul, that was my question. That's the recommendation, we're recommending.

M

Let me look that one up. Hold on I got that. They dropped it.

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

So, that was important to us.

M

So, then we should go through their explanation. They feel that it's the hospital operating as a different kind of business competing with other businesses that do lab delivery and that is not really the purview of Meaningful Use to be deciding that as part of Meaningful Use measure.

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

But our perspective was that they—I think they run something like 40% of the labs and so we, the providers, depend on that.

W

Right.

M

And also, I can tell you that in New York, more and more hospitals are recruiting their community doctors to use their hospital labs as commercial labs.

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

None of this addresses their—really addresses their argument.

W

What do you mean, George?

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

You guys are saying there's an opportunity here we could affect 40% of the market, but that doesn't answer their question, well they don't have—we're not addressing the market in a fair way. We're addressing only the ones that happen to be using Meaningful Use

W

George, maybe I'm not following you. That doesn't make any sense. What I heard Paul say was that the community docs and the ambulatory physicians, if 40% of their lab tests come from hospital labs and those physicians are doing Meaningful Use and they need to have structured lab data, how can we not have that as part of Meaningful Use when this is a hospital who could be also applying for Meaningful Use.

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

Well, what if the hospitals investing in real estate and we have some objective we want doctors to have a nice office space, so why don't we put that in there? Let's find the section and see what they say because I actually agree to putting it in.

W

Right. So, I'm not following. Anyway—

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

... answer their questions not repeat our old argument.

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

Right. I guess they have a point that this would be a different requirement than the standalones. On the other hand, hospitals have additional benefits that a standalone lab doesn't have. ... trying to argue that.

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

It's not ... like anyone else read this section. So, why don't I personally find the section so that we can actually answer the literal section instead of –trying to find it quickly. It was towards the end of the thing where they said, by the way, we got rid of all these things. Is that okay?

M

Does anyone have it yet?

W

Yes, I think I do. Hold on let me read it and make sure this is it.

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

What page are you on?

W

Well, I'm on 152, but I don't know if it's the right page. Hang on.

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

It sounds like it's about the right area. Here we are, page 152

W

That's actually at the top of 153 is where I think the discussion starts.

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

For a variety of reasons.

W

They say although hospital labs supply nearly half of all lab results to EPs, they are not the predominant vendors for providers who do not share or cannot access their technology. Independent and office labs

provide over half of the labs in this market. We are concerned that imposing this requirement on hospital labs would unfairly disadvantage them in this market.

Furthermore, not all hospitals offer these services so it would create a natural disparity in Meaningful Use between those hospitals offering the services and those who do not. Finally, all other aspects of Meaningful Use in stage one and two focus on the inpatient and emergency departments of a hospital and this objective wouldn't be related to those departments. So, I don't know that we can tackle it on the phone today, Paul, but I think we should take a very close look at page 153 and sort of see—I'm uncomfortable with how the lab provides such a high volume, but I don't know the right answer either. There's not something we could do.

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

Let's table this for the face-to-face. I think the other thing to consider is there are things that are outside of Meaningful Use, lab tests is one of those, and there's no reason why the standalone labs who don't have to do this, we should impose it on people just because they're Meaningful Use for

W

I actually think a better—this is a part of the recommendation that came out of a group, I think it was Micky and I want to say it was Deven, but I can't remember who co chaired it with Micky Tripathi, I think this is something that we ought to ask that group to look at because they did the deep dive on it before and they talked specifically about using Meaningful Use.

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

No that's a good idea. I think you're right. There was a group that looked like ... group maybe.

W

Yes, it might have been, but I know Micky did it, and I know they focus on labs and it may have been the interoperability piece, yes.

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

Okay. Josh, would you mind helping us track that down?

Josh Seidman – ONC

Sure.

W

This is We'll make sure.

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

Okay. Then we'll re-discuss it next week. Let me get back to one—after lab, it's generate patient lists, we already did that. Clinical—

Neil Calman – Institute for Family Health – President & Cofounder

I have a question about that one. I'm sorry. I had to step away for a minute. It's Neil. We don't want the vendors here to just preprogram a single patient list and say well you can meet this criteria because you can make up—we have a spot list of all your hypertensive patients or something. How is it that we call out that this is something that's got to be sort of a capability of the systems to generate list that are relevant to the provider? You know what I'm asking?

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

Yes. Does anybody know—Josh would know the certification rule on this? Is it specific enough so that basically it's not that the vendor generates a list that the provider gets to cite what kind of list—it has the capability.

Josh Seidman – ONC

I'd actually have to go back and look at that one, and I will.

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

Okay, so if it's not clear that it's a capability, then we'll go back and try to address that.

Josh Seidman – ONC

Okay.

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

Next one is use clinically relevant information that the EHR has to use clinically relevant information to provide reminders for patients for 10% of all unique patients seen in the past two years. You know what? I'm sorry. Just looked down at my notes from what we proposed for the list, we did highlight we wanted it to be a patient list by multiple specific parameters. That's not showing up at least in this description.

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

This is Charlene. Patient specific parameters and high-priority health, you've got that, and it kind of says that.

M

Where?

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

In the writing, in the text, in the rule, as you read the rule. But like you say in the text of the rule, it's not in the narrative.

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

Okay, so it would still ... our whole goal was in certification that we could text this.

M

Yes.

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

Okay. So, going back to these patient specific reminders, if I recall from the text but not here in the matrix, they were pretty specific about that the EHR had to determine that it was patient specific. It wasn't as if a human could go in and say well, I want to take this thing and put it in there and solve it for this patient. I think that's what we meant anyway. So, is this written okay?

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

Are we on the reminders?

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

Correct.

W

Are we on reminders or lists?

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

Reminders Unfortunately, I went back to lists to clarify another thing, but we're off that now I think. We still have ONC's going to follow up and make sure their certifications,

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services

Is the per patient preference here related to the per patient preference of saying they do or they don't want reminders or what they want it on or that's not clear?

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

I think our intent was both. They could say they're sick and tired of us and say don't send me that stuff, but also I think our bigger intent was if they wanted it on paper, then that's how they'd get it instead of electronically.

Amy Zimmerman – RI DoH – Chief, Children's Preventative Services

Okay. I didn't catch—

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

So for example, you could provide access to all these things online, but they say I don't want to do that stuff and it's not our intent to force them.

W

Right. That's why we have the separate criterion around communication medium

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

Correct. So, is this okay with us?

W

Okay. So, just some feedback on this one, the 10% seem to—keeping it low seems to make sense, although there are some clinicians that are very—they don't feel they can even get 10% of their population because they take such good care of them that the patients don't need reminders and especially since scheduling doesn't count. So, what they'll have to do is program in like come get your flu shots or something, which is more appropriate for the 65. So there was some concern on the 10%, for those docs that really try and do a good job.

The other one is there were no exclusions for specialists. In some places, it's just not pertinent for them to do a reminder because you go see a specialists once in many cases.

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

So, I think our original one was reminder or followup.

W

As preventive or followup, and that's what the rule says.

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

That's what—in the text or something?

W

Yes, yes.

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

.... Now, if you were really good, I still think you're probably going to get reminders though, right? You may be on top of it, but patients get a reminder that they're due for X.

W

Well, but not always from your specialist. You go to see a specialist, it's often just one shot.

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

Correct. That's true.

M

That's why the threshold's so low.

W

You know what? I'm just reading the text and I actually think that this is very different than what we ended up—

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

What page are you on?

W

Page 90. So, they're actually changing the objective to say use clinically relevant information to identify patients who should receive reminders, but I worry that that doesn't mean that they actually get one. So, I think it's okay because the measure is more than 10% of all unique patients who've had an office visit within the last 24 months prior to the beginning of the reporting period were sent a reminder per their preference. So, I think that is actual sent and it's, if you've seen within 24 months, I can't imagine that you can't find 10% of people you've seen in the last two years who would not benefit from a reminder for preventive or followup care.

M

Especially a specialist

W

Now, the specialist thing is different.

M

Specialist is different.

W

I agree. Specialist is different.

M

I can't think of a specialists that where a 10% threshold would be too high. I just can't think of one.

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

Well, let's say you're an eye doc. You certainly may not need to see somebody for over two years.

M

Right, but 10% are your patients are going to have some borderline glaucoma measurement and are going to need to be followed up in three months or six months or a year.

W

But you can't do it for an appointment.

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

You can't do it for an appointment.

M

That's not really an appointment. I think what they mean by appointment reminder is that you send somebody out something 48 hours in advance and say you have an appointment on Wednesday with That's what they mean by appointment reminder, but to me this is a preventive health reminder. If it's not clear that those kinds of things should qualify, we should make it clear.

W

Well, the other thing is who's the most sub specialist who is eligible for Meaningful Use because not all specialists are eligible for Meaningful Use.

M

Let's try a surgeon. So the eye doc is probably, like Neil said, you could get glaucoma, but let's try a surgeon, and I do something, does that person need to see that patient again purposely once you've had your one-week, ten-day followup?

M

No, you've found one. No, I think that's a good example of one where you wouldn't need to.

M

... preventive or follow-up care. So, someone, for example, has a surgery that would be a number of There might be to send them for followup care.

M

But usually that's an immediate post-op period and almost soon enough that he wouldn't even be able to get them certainly a paper reminder.

W

The reality of procedural lists is that they want to be as efficient as possible and you come back for your followup visit and they don't want to see you again because that's not how they make money. It's all goodness because we don't want to go see them either.

W

Right. And we don't drive up office visits. I get that. So, I just wanted to make sure that surgeons are eligible for Meaningful Use. Josh, are they one of the categories of providers who are? I can't remember.

Josh Seidman – ONC

Sure, yes.

W

Radiologists and pathologists, they just need to consider exclusions that's all.

W

Maybe we need to cover this under the exclusion category.

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

Yes, let's do that.

W

Because you know, they did talk about anesthesiology, pathology stuff so maybe those are areas where surgeons go in there too or whatever.

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

Let's do earmark that because we already have in mind the non-patient care of noncontact folks, but I think the specialists particularly non-clinic disease folks, like ..., may not really be eligible for this or we need to have a different way of doing things. Okay, so that's a placeholder for us to discuss later. Tracking ... eMAR. They did something with this 10%. What did we say?

W

We did a unit. They did 10% of the order, and they—

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

They justified this and said, well not everybody's—may be hard to interpret them.

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

The main comment we had with this one—there's assistive technologies and conjunction with we would like them to have said to reference the five rights in some way because that was the intent, the patient's idea, but otherwise there wasn't—everyone was pleased that it was included.

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

So, do we want to reintroduce the five rights? That was actually one of our ways to define eMAR. Is there another interpretation though, Charlene, in the industry of—is there a way to do eMAR without the five rights?

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

It's just in terms of best practice. There's argument you need to have a sixth right, which is the right documentation. So, it's pretty standard out there.

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

So, it may be a bit—okay. So it sounds like we're comfortable with 10% versus unit?

M

Yes.

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

And eMAR, it sounds like it's standard to be five rights anyway. One more, and it snuck by, which is they deleted progress note. I suppose the rationale was because everybody has it. Is that true?

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

What was this one?

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

The progress note. This is our third try.

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

No, it's not true.

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

It's not true?

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

In terms of everyone has progress note capability?

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

Right.

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

I don't think it's true on the hospital side. It's still emerging.

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

Oaky. So, folks, what do you think?

M

Okay. So what they added is they said they're adding text searchable notes to certification so that's good, the ability to do that, but we still want the notes. I don't know what changed really.

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

So, it sounds like they're putting the placeholder in so that it will be in stage three and we brought it into certified product.

M

I guess the argument would be if you're going for specific quality improvement, the text searchable notes don't add to that necessarily as opposed to something like I'm going to collect this particular vital sign or that particular demographic. This is a more general thing. You'd have to link this to quality improvement. Not for me, I'm already convinced. I keep practicing it.

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

Well, I think our rationale still that it is one, it really doesn't help to have a non-complete record and that one of the advantages is not only is you can go to one place, but you can access that record anywhere you are and most of us are not always in the unit with the patient. So it's very useful to have access to all of this. So, we can't seem to figure out why you would want to have this, and the only one I heard was that they'll have it, and Charlene says they don't necessarily particularly in the hospital. The other point is maybe they even have it and don't use it, but I think we're still going for the completeness of the record and there's information there that doesn't exist other places.

M

So, I just wrote agreed with adding text searchable notes and certification. We still believe that having an incomplete record can cause errors but notes should be required.

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

Anybody disagree?

M

I think they should be required.

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

The other aspect of it is that, and again I don't think we know this yet, but some of the elements of the note are required to support measurement and even though we weren't asked specific of that getting on the table starts to align the requirements with the measurements because we get criticized that there are these hidden requirements because you've got to capture data that we don't tell them about because it's in the measure, and the notes piece will feed some of that depending on what measures end upon the table.

M

Well, it's a good thing to bring up actually. So, if you don't want to populate the measure automatically then you want structured deals that are specific to the measure you've chosen, which is a little bit different and we also want the rest of the record for that patient in the same place, which is a slightly different argument. So one is you need to enter all the data you need to do measurement and the other is with everything else that has to do with the patient, we also want that in the EHR too.

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

In one of the requirements, in order to bill, you have to have this documentation on your progress notes. So, we actually won't credit these docs with their professional billing if they have an empty progress note. So, in some sense, that's part of the measure. Is everybody comfortable with reintroducing but maybe typing up the rationale for progress notes?

W

Yes.

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

Okay. Well, congratulations. We finished category one. Did this flow—did the way we went through it, was that working for folks?

M

Yes, but I have another question, and maybe this will come in later under quality measures, but there's nothing in category one that deals with disparities.

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

Patient lists.

M

That's still not dealing with disparities.

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

Well, the way we wrote it was a bit more explicit and I'll try to look that up, but we talked about—here it is. Generate list of patients by multiple specific parameters to use for quality improvement, reduction of disparities, research or outreach.

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

The problem with that, that was ... why I was asking earlier if we were off the list piece because that's the concern I had too. I think it is what we actually wrote although the problem I think with what we wrote is that there was no actually either use the list to stratify by disparity variables or maybe that comes, like Neil said, in the quality measurement piece or that you have to generate more than one list and one of them has to look at disparities in some way. There's not a criteria that gets you to do anything to generate a list based on a condition and that's where I'm struggling.

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

maybe I can ask David Lansky, so you had a call last Friday. What's the timetable and is your workgroup going to be handling all of the QM kinds of responses?

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

Well, I think I don't know about all of them, but we'll be making comments regarding proposals for QM them. The disparities issue didn't particularly come up on that call last week. Our timeline is we're going to have a second call in the next, I'll say ten days or two weeks not yet scheduled and try to also present some comments to the Policy Committee meeting next month.

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

Okay. How do you want to deal with the disparity?

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

Well, one thing to do, Paul, might be for us to each give some thought to looking at this particular policy priority and come to our face-to-face meeting and have this become one of the first things up that we look at this for how could we use some of these functions or build on them to reduce disparity. So, off the top of my head, I can think of having a criterion for sending reminders to patients that you have a particular emphasis on, populations where disparities could exist or things like that, but we need to kind of look back through all of the things in this priority area. Neil, I don't know. What do you think?

M

Another way to look at it, Neil, is also in both ..., but I think one, we have to get the capability of reporting in ways that would use the disparity variables, but in a sense, the future way of looking at population management is going to force this issue anyway, using some of your logic.

Neil Calman – Institute for Family Health – President & Cofounder

I need to think about this. The problem we have here is a similar one that we have in other places, which is what kind of disparities were talked about. A lot of providers don't have diverse populations to begin with. So it's hard to look at disparities at that level. So, I guess we just need to think about a way to sort of call this out. I think we need to look at it at the bigger level, which is what can we do through Meaningful use and maybe it's not in the quality and reduce disparities kind of piece, but it's in another part of what we do that really addresses the issue of disparities.

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

I agree.

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

I agree with Neil that we have to look at this through Meaningful Use lens because I just don't have the face that ACOs and others are going to put the emphasis on disparities that needs to be there, but I understand your point, Paul, about getting the capability in. I think there may be some low-hanging fruit that we can do and that would address the comment that Neil just made so that for example you would

have to generate two lists, one by condition and one by a disparity variable whether it's race, ethnicity or language or gender or whatever, just so that you know how many people you have on that list. That would be helpful even if you don't have very many. You at least know how many you have. I think that's not the case today.

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

I want to follow on with what Neil was saying, that you may need to look at this in a larger context, and that I think it's interesting that we'll see down the road that the population health now includes specialized registries, and what that actually means when Rob spoke about it this morning, he talked about maybe for specialists, but there could be specialized registries that providers contribute to to look for disparities in the community. So, there may be other ways to do this rather than just say, as Neil pointed out, some practices may not have a lot of diversity, and it would be homogeneous and looking for disparities may be more found in an enterprise view rather than at the practice level.

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

Okay. We'll get some more discussion of this.

M

Paul, did we do direct advanced directives imaging or family health history, which are all part of the first section?

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

Actually, I don't know why this didn't show up in the—

M

It's under menu set.

W

Yes, we only went through core.

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

Okay.

M

ERX, so that was the fourth one under menu. We've already done it.

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

Advance directives, actually what page are you looking at?

M

162.

Paul

Okay. So, they went to 50% of over 65 have an indication, and it didn't say we had added and it's available. Now, I really didn't know the history of some of the objectives, but what he said was made some sense.

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

Paul, I actually think it is a lot more about politics than Rob could ever acknowledge. I really think this is more about the ... panel stuff, and I don't think we should let that stop us from proposing what we had originally proposed.

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

Then, actually what we can say because if I think about it what we really meant was it's not going to be structured because you have to have a signature. You're going to have a scanned document which would essentially get rid of the legal objectives.

W

I think this fell out in the last minute work on the letter, but my recollection and actually my documentation is that we also said you could either have a scan document that you could also have instructions as to where to get it, which wouldn't be the document but it might be so-and-so has it or the lawyer has it or whatever. So, we could refine that as well.

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

so, it's our impression that for the reasons that we've previously been saying that we would stay with our original recommendation then?

W

yes, I think so.

M

I do too.

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

Okay.

W

I agree.

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

Okay. We have quite a bit of unanimity. The next one is imaging results. It seems pretty consistent. George can comment on what we were about to ask the HIT Standards Committee, which is make it available to the EHR, doesn't mean store it, doesn't mean have a fax system, just if you have it, make it available.

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

It's pretty close to what we had come up with actually. It's 40% accessible but not access, that's a good thing. It makes sense for the eligible hospitals. I wasn't clear how the eligible professional would gather 40% of images ordered necessarily.

It's for both, right, EH and EP? I'm looking at ten different documents here. So, it's for both. So, I was wondering if 40% was higher, was fine for EH but might be high for EP. Then, a proposed second measure for sharing 10% with another provider, that seems hard. ... question about that.

W

There's an implication, and again, think these were added late for the Standards Committee didn't do due diligence on them on all of them. I think there's an expectation that it can be sent via direct, which is an e-mail which won't work. So, there's some stuff that has to be fixed in there.

M

So, if you're in a rural practice and let's say your radiology place that you ordered doesn't even have a ... System, how can I get the 40% then?

M

Well, you wouldn't pick it on your menu. Is there an exclusion? I've got to check. Actually, that's another question. How should they exclude?

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

So, maybe there's a qualifying 40% of all electronically accessible things, that kind of language and 40 may be high, but 40 is high when you don't need to be. You're either going to do it or you're not going to do it. You're not going to deliberately not do it, I don't think.

But there might be a lower threshold. We might suggest exclusions, and we might qualify the words because not all images from standalone radiology services presume ..., and it's not the fault of the provider. So, it sounds like we need some-- actually, George, is that something you'd be up for in terms of re-crafting this is something that your small group would feel comfortable with?

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

I think it's just a matter of adjusting the percent. Otherwise, it's pretty close and how we did it.

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

So, what about the problem of in the rural area of the standalone radiology service provider either doesn't have an electronically or doesn't make it available to the provider?

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

That would be an exclusion.

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

Okay. Got it. Maybe you could bring a draft in of how you think it might work.

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

Okay.

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

We'll look at that next time. The family history, do we have a definition of structured family history?

M

In the text they say one of our concerns was standards, but they think they're further along than we realized. But I can't remember if they name them.

W

The analysis that the vendors did, and again, I don't have the input but we did look for that standard and we went out to the CDC site because remember that's where they stored one of theirs and certainly there are elements of it that are standard, but there's not a standard family history. In talking with the vendor communities, they certainly all do it in a different way and all think they do it the best way. So, this will be a hard one. So, what's the intent of doing—I understand—

M

Yes, I have the same problem, like what's the cost benefit ratio? In fact, we're trying to move away from family histories and just to the gene type and know what the person has rather than go back to their—so we're heading back to that direction in the long-term. Then, I'm a little worried about how much time it will take to really collect a valid, legitimate family history. We find that the family history for this disease is nothing like the family history that you collect for that next disease or the next one, because you're kind of answering these kinds of questions. So, I think those were the concerns about it.

Christine Bechtel – National Partnership for Women & Families – VP

I have a question, which is, Charlene, do you know what was in the certification rule on this?

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

I'll have to do that homework for next time.

Christine Bechtel – National Partnership for Women & Families – VP

Yes because they should've proposed standards for it, and in terms of—I think this is actually important, and it has been a priority for the administration as well for clinical reasons obviously and also health disparities, but in terms of data collection, let's not forget that a lot of this is going to come from the patient. It doesn't have to come in the exam room. It can come through the portal online ahead of time.

It can come in the waiting room. There are a lot of options here. Site, I think we should understand what's in the certification rule.

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

Okay. So, there's a bit of homework to do that will come into our meeting next week, and George is going to read revise some of the ... to the ... one, and I think that covers category one.

W

Still address the hospital discharge or did we do that already, so that e-prescribing for discharge? That's the last one on the menu set in that category.

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

I think we did and extensively agreed with it. Are people comfortable with the process that we just went through?

M

The end product of which is going to be like last time a letter?

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

Yes.

W

So, Paul, the only other—this is kind of relevant to our point, the only other area that if I'm like for instance reading about demographics and those different sections, they bring up questions in the context about well should we capture disability, and there's a lot of nuance around that in terms of how you do that. So, there are some hard questions I think they really put in there. So, do we want to respond to those? I think we need to finish this process first, but it's those questions.

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

I agree with you. What I would propose is that we continue this process to get to all the categories and then backtrack. We do have our face-to-face, and I believe, Mary Jo, we have one more call after that, correct?

Mary Jo Deering – ONC – Senior Policy Advisor

That is correct. Let me grab the calendar. After your face-to-face on the 13th, you have a call on the 23rd, which is scheduled for 10 to 12, and you actually did go ahead and schedule another call on Monday, April 2nd, 10 to 12, which will be just two days before the full policy meeting.

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

That will be just a cleanup. So, I think we can get to those, Charlene, hopefully, and we'll try to get through all the categories and we may even have time to start on some of the questions if perhaps ONC can speed them up for us so that we have those in front of us, that would be great.

M

Paul, this is Just one other note on the timing because the actual Federal Register posting will be officially probably tomorrow. It won't be due for 60 days from then, which means that there will be another Policy Committee meeting prior to that and that will be very close to the due date, but it just means that in terms of the iterative process, it'll actually be a second meeting for final.

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

Right. So, we were planning to report out on our recommendations at the April meeting, which—and then get feedback and then work with that feedback to produce our final four for HIT Policy Committee approval right before the due date.

M

And I think that that still makes sense. It's just that perhaps a little less height that what it was going to be.

Neil Calman – Institute for Family Health – President & Cofounder

Paul, will we have a document that actually tracks our recommendation against the NPRM to work from? Because it feels to me like we're doing that rather haphazardly and my concern about that is that our recommendations were the result of lots of testimony and other things that people gave that sort of led to the final document. I just want to make sure that we don't lose something along the way and I also think that because we're trying to be really transparent about this process that if the NPRM doesn't address some of the things that we address, I think we need to very specifically either decide that we're going back or somehow respond to that and say yes we agree, but I think that in the places where it differs from—I guess I just want to make sure that we have an opportunity to examine all the places where it differs from what our final recommendations were.

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

I think that's a good point, Neil. There is a document that is in preparation that I think is approaching that for whatever reason I couldn't find category one, but that CMS hadn't had a chance to review yet. So, I think, Josh, do you think that'll be available for us next week?

Josh Seidman – ONC

Yes it will.

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

So, I think the short answer to that is yes, Neil.

Neil Calman – Institute for Family Health – President & Cofounder

Okay, great.

Christine Bechtel – National Partnership for Women & Families – VP

I think this was a good process. I do think that before we sort of finalize everything, it is a good idea, of course, to see it all as I think Neil is asking kind of in writing so that we make sure we're not missing anything or our understandings aren't different.

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

That's right. That's actually why we scheduled two additional calls after next week is one to have a document in front, so it's the whole thing again, try to capture some of these other questions and then even right before the clarity. Then, that's only get it in front of the full committee and then work at it again. So, we have a number of opportunities, but thanks for bringing it up. We do want to make sure we're true to what we heard and that's where we had a difference. I think he did tell me that today.

M

Yes, because we covered it, for what we brought up for sure.

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

Okay, very good. I appreciate it, everybody, and we will see you next week.

Mary Jo Deering – ONC – Senior Policy Advisor

We've got to have public comment, Paul.

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

Sorry.

Mary Jo Deering – ONC – Senior Policy Advisor

Operator, would you open the lines for public comment?

Operator

We do have a comment. Michael Peters, your line is live.

Michael Peters – American College of Radiology

Hi, this is Michael Peters from the American College of Radiology. I just wanted to chime in quickly about your encouraging discussion of imaging appropriateness clinical decision support. As you may recall from the past, the ACR is strongly supportive of more of a ... radiology requirements that include CDS pulled from nationally physician developed appropriateness criteria guidelines to guide ordering physicians and patients to the most appropriate tests for the given indications.

ACR currently makes RAC or appropriateness criteria available via web services for use at CDS and CPOE systems and other HIT. RAC is also baked into several vendor solutions that are commercially available today and have been for a number of years. I recommend this workgroup revisit the written materials from your May13th hearing on specialist in MU, where our speaker Dr. Keith Dreyer from MGH actually discussed this topic quite extensively.

Also, in terms of image accessibility menu set measure, based on the wording of the exclusion, it seems like this is clearly aimed at those specialists EPs like radiologists, cardiologists, ophthalmologists and orthopods and others too. Interpret imaging, the use of the denominator of orders of that result in imaging is probably incorrect then because radiologists generally do not order images themselves unless their interventional or radiology/oncology subspecialists. Thanks.

Operator

We have no more comments at this time.

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

Well, thank you everyone. Now, I'm properly adjourning the meeting until next week. See you all in Washington.

M

Take care. Bye-bye.

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

Thanks.