

**Meaningful Use Workgroup**  
**Draft Transcript**  
**November 15, 2011**

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

Thank you, Operator. This is Mary Jo Deering in the Office of the National Coordinator and this is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. It is a public meeting. A transcript will be made and there will be opportunity for public comment at the end of the call. I'll start with roll call. Paul Tang?

**Paul Tang – Palo Alto Medical Foundation**

Here.

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

George Hripcsak?

**George Hripcsak – Columbia University NYC**

Here.

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

Michael Barr?

**Michael Barr – American College of Physicians**

Here.

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

David Bates? Christine Bechtel?

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

Here.

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

Neil Calman?

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

Here.

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

Tim Cromwell? Art Davidson? Marty Fattig? Joe Francis? David Lansky? Deven McGraw? Judy Murphy?

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

Here.

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

Greg Pace.

**Mike Zephir – Social Security Administration**

Mike Zephir for Greg Pace.

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

Thank you. Latanya Sweeney? Rob Tagalicod? Charlene Underwood?

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

Here.

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

Amy Zimmerman?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Here.

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

Thank you all. Over to you George and Paul.

**Paul Tang – Palo Alto Medical Foundation**

Great. Thank you. Let me go over a few things for our agenda just see if there's any additions. I thought we would start off with sort of a debrief of the feedback from HIT Policy Committee, see if that has any implications in terms of additional focal areas as we called them. Neither of the smaller groups have met since then, so we won't have really an update from them at this point, but also talk about methods for gathering more information. Do we need additional hearings? Do we need to re-activate any of our other Workgroups such as Quality Measurement or the Adoption Workgroup for certification issues? And then talk about whether we need additional small groups. So how does that sound as sort of some of the agenda items for this call?

**George Hripcsak – Columbia University NYC**

Good.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

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

Hey Paul, this is Charlene. The other thing is, I know the numbers just came out from CMS yesterday so I don't know if anyone is on the call that can share those, but they are pretty impressive.

**Paul Tang – Palo Alto Medical Foundation**

Oh, so who knows about them?

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

Do you want me to forward the numbers to you?

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

Okay I'll do that that real quick. Okay. Charlene, sorry...

**Paul Tang – Palo Alto Medical Foundation**

Great. So when you say impressive I'm imaging there is a big, big.

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

Over a billion now, 1.2.

**Paul Tang – Palo Alto Medical Foundation**

So that would be my guess is that even in the next couple months, you can report up through February at least for the EPs.

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

Yes, yep.

**Paul Tang – Palo Alto Medical Foundation**

And I really think there is quite a bit of pent up demand. So I would expect even the next couple months to still be quite an increase and then continue on. It just takes a while to get big programs like this going.

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

...is going.

**Paul Tang – Palo Alto Medical Foundation**

What I could do to kick off the discussion of the debrief from the Policy Committee meeting is just go through some of my notes and then people can chime in. How does that sound? So I'll start out with an interesting comment from Mark Probst saying, you know, in terms of this, this has to do with the theme of how prescriptive versus how flexible we are with the objectives and quality measures. And a couple of the areas where he thought that there were enough drivers already in the market that we didn't have to be terribly prescriptive. One was, I guess, a reaction to our discussion of HIE and that the fact that there's still really a lack of business driver for the HIE, sort of the HIO, Health Information Exchange Organizations. Another area where he thought there were enough drivers already are dashboards for the clinician and clinical decision support. Now, let me just go through all of these and then people can react because I don't know that some of those things are already there.

Gail mentioned needing to get more information from the field and we've talked about that.

We even talked about hearings that concentrate on folks who are struggling rather than people who have already attested early. The whole dealing with specialists and being able to harmonize the measures and programs, things we've already talked about. Joe mentioned normalizing the quality measures into one, now I have written down corporation and I don't know what I meant there, but trying to harmonize all of the asks of all of the providers.

**George Hripcsak – Columbia University NYC**

Cannot roll up data due to local variation is one of the things Joe said, I think.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Christine talked about wanting to make sure we connect the CQM activity with the NQF MAP, Measurement Applications Project, I think that's what it refers to.

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

Partnership.

**Paul Tang – Palo Alto Medical Foundation**

Partnership. And needing to have a test bed at ONC, particularly for things related to patient information and patient reported outcomes. And that we want to also make sure we have some kind of handoff between this group, the CQM group, and the Quality Measure Workgroup. So I will make comments on a few of these just to elaborate. So Christine and I talked afterward and so she is added to the CQM Workgroup, a small group, so that we can keep that connection with MAP. We certainly want to be harmonized with what's going on as well. And that, I'm sorry David Lansky isn't on this call, but we do intend to hand off the CQM activity over to the Quality Measurement Workgroup, sort of reactivate that. They were sort of waiting for some activity from the ONC contract with the quality measurement developers. Larry talked about a...

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

Paul?

**Paul Tang – Palo Alto Medical Foundation**

Yes?

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

This is Charlene on that one.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

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

Because of the interplay, and I know you've referenced this in your analysis between the cost to data capture and the measures, how are we going to play that line if you will? So that's just a comment. You can kind of go to that later on, okay?

**Paul Tang – Palo Alto Medical Foundation**

Okay. Okay.

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

Thank you.

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

And Paul this is Christine. Just to clarify one thing I said, I was not saying that ONC needs a test bed for things like patient reported measures. I was saying they have a test bed, they funded a test bed that we need to make sure we connect with, which is through the Dartmouth folks and the beacon collaborative up there who are fielding patient reported measurements through health information exchange and through EHRs and so it was actually a question, which is we just need to make sure we're connected with that. They're field testing more than just that too. So, you know, from the work that all the Tiger Teams did under the Quality Measures Workgroup I believe ONC, and maybe Josh or somebody could enlighten us, but I believe ONC has actually led a couple contracts around measure development and those would be the ones that we really need to keep an eye on.

**Paul Tang – Palo Alto Medical Foundation**

Correct. And Josh, do you have a way of updating us on those contracts?

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

Yeah, we can. Allen is probably the best person to give an update.

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

Yeah, Paul, of course and I think that it is worth noting that we have asked to include some members from this group, in particular you, Paul, so I hope you don't mind, and David Lansky on the technical expert panel for those quality measure contracts. We are underway in the contracts, there are a couple of things that we are just working out as far as the intent of some of the measures from the Tiger Team and then from the recommendations from this group. So, again we'll work with yourself and David, and anybody else that you see necessary to make sure that those are aligned as we move forward and we're really hitting the intent of the measure.

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

Paul, this is David. David is on this call as well. I'm on now too.

**Paul Tang – Palo Alto Medical Foundation**

Wonderful. Any other, I don't know when you joined, David, we were just trying to make sure the small group for CQMs afterwards sort of digest the hearing information passes this information onto your group.

Do you imagine sort of reactivating your group once you have more information about the contract activities?

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

Right and I think, as Allen said, we're trying to make sure that you and I are plugged into the work going on in those...but I think to Christine's point, we also need to have a better understanding maybe from Allen and Josh of what the process will be for this test bed to be used.

**Paul Tang – Palo Alto Medical Foundation**

What's your understanding of when you feed into the final rule, obviously the NPRM is probably what, going through clearance now? Will your Workgroup be feeding into the final rule or what's the thought there?

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

I would think so. At this point I think we left things waiting for results from the measurement contractors hoping we could have some input at that process, but as far as how we want to respond to whatever comes through the rule, we haven't had that conversation. I guess we would reconvene at that point and discuss it.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So do you see your Tiger Team to be the receiver of the output of the CQM small group from this group as a result of the hearing?

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

I don't know structurally if that's the case. I guess it makes sense given the way we've setup our committees.

**Paul Tang – Palo Alto Medical Foundation**

So somewhere along the line we should probably give feedback and recommendations to ONC and CMS on the quality measures that clearly was the popular item to talk about at that hearing.

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

Yeah this is Josh. I guess what I would say is, you know, obviously having both you from the Meaningful Use Workgroup and David from the quality, although of course you are overlapping, I think it's really important to make sure that there is sort of some consistent feedback to the measure development work directly, but then there obviously should also be some interaction as more progress is made, you know, on sort of periodic updates and feedback loops. So what we envision is that there will be, if you remember the Stage 1 proposed rule had a larger set of measures than were in the final rule. Between the proposed rule and the final rule there will be certain measures for which we anticipate enough work being done that there will be actual e-specifications that we would look to Workgroups and Policy Committee for feedback as well. And we would look for your input at that time and that would be in the spring.

**Paul Tang – Palo Alto Medical Foundation**

In the spring. So it seems like there are two receptor sites for this. One might be more strategic policy oriented, and so that is feeding into your final rulemaking process. The other might be more tactical and feed into the quality measure developer contract. Have I described that clear? Does that make sense?

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

Yeah, Paul, this is Allen. I think that makes sense and I think for the more technical side that is where we'll need some continuous feedback.

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

And starting soon as right now the contractors are really going through the measure concepts and trying to figure out what is feasible and what is not feasible and then again, we'll need your feedback as to if they're suggestions on the concept of the measure is accurate and really leads to your intent.

**Paul Tang – Palo Alto Medical Foundation**

Okay. So, how about if in the small group on CQM we come to closure in the next call and try to make sure we nail down some of these attributes that we described and some recommendations related to quality measures that particularly pertain to quality measure developers and then use David and I sort of as a conduit to this active project and that we pass those strategic policy recommendation kind of responsibility over to the QM Tiger Team that David leads and that will work its way into recommendations that input into CMS and ONC in the spring as you described.

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

This is Neil. I have a question.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

So where is the discussion about how many and what the requirements will be? I mean, I understand we're developing measures and there is a lot of work around that, but where are we going to have the discussion about how many or few of these to require and sort of how to deal with the primary care specialty issue and other stuff. Where is that discussion supposed to take place and when?

**Paul Tang – Palo Alto Medical Foundation**

Let me check with you, David. Do you think that is better held at this Meaningful Use Workgroup or in your Quality Tiger Team that reports to the Meaningful Use Workgroup?

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

Well, there is a calendar issue I guess or a scheduling issue. We already spoke to this question that Neil is raising, you know, in the recommendations we made last spring.

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

And we advocated parsimony by trying to populate that matrix, that grid, and how CMS chooses to operationalize that is, obviously, unknown. Because there are not very many good measures in some of those cells it's likely they will continue the practice of probably having too many measures reported in the process measures world and still too few in the other domains that are of interest, but that's not where we would want to end up in Stage 3. So, part of it, I think Neil, is for us to have a pretty, if we had better measures in the library, then I think we could probably all agree on a pretty parsimonious, you know, advocating a pretty thin set. So, I also wonder whether we should have a conversation at the Meaningful Use level in this committee or at the full Policy Committee even, about, you know, once again, what are we trying to achieve with quality measures in the Meaningful Use program and as distinct from other programs that have a different kind of responsibility. Because if we agreed more sharply on what our purpose is, we could probably help meet Neil's goal of parsimony.

**Paul Tang – Palo Alto Medical Foundation**

So I wonder if we should tee up. So what's changed since the Quality Measurement Tiger Team submitted their recommendations as we have had this pretty strong feedback from the field. And I wonder if we can tee up a discussion at this group, Meaningful Use Workgroup between the what do we recommend, what's the activities going on, and how do we incorporate the feedback from the field and sort of at least explore the policy issues around that. Does that make sense for like a follow-up meaningful, MU call?

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

Yeah. This is Neil again. I think that what we're struggling with is this sort of schizophrenia about whether or not what we're really trying to do is get people to show that they know how to meaningfully use some information that can be generated on quality across their system, you know, from their systems and trying to prove to the country that electronic health records improve quality, you know, and having to have lots of measures across lots of domains to basically show that, you know, that we can measure it, that we can report it, that we can, you know, improve quality across a whole field, and I think it really gets down to the most fundamental question about, which is exactly what David just said, you know, about what it is we are trying to accomplish. And I think given the feedback that we've gotten from people that this is sort of the most, you know, difficult part in the sense that CMS, you know, is still going to, I guess there was a report, wasn't it, in the last couple days that they're still going to allow attestation because there's still not a way to really collect this information electronically and, you know, I think we're just Never Neverland here.

And so I go back to thinking, how do I stimulate people to find some information that's meaningful in their practice and getting them to engage in a quality improvement activity that can show that you can use data to actually improve quality and doing it in a way that is demonstrating the capability and getting them moving down a path rather than trying to measure things across, you know, lots of different domains. And I think the work that is being done to delineate these measurements is critically important because what we want to do is put out a fairly large set of things for people to pick from so that people, you know, it's like the diner menu, you know, you want to make sure that when you walk in the door that there's something there that is meaningful for as many people as possible. And I think that then to allow them to select a few things that are most meaningful and try to get people to move down an improvement path is where we should really be headed. So, I think we need to have this conversation in earnest if not at this committee at the full Policy Committee.

**Paul Tang – Palo Alto Medical Foundation**

Well let me propose that the CQM small-group work toward a set of recommendations and tee up the policy implications for the subsequent MU call so that we try to get to some set of conclusions and recommendations for discussion at this group level, and then we can decide how to triage that after that call. So what parts would be, you know, sort of ongoing tactical input to the current contract work and what parts need to be raised back at the Policy Committee in terms of our approach to quality measures. Its limited options for Stage 2, but we want to already start working for Stage 3, because we are going to produce those recommendations in several months. Makes sense?

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

Yes.

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

This is Charlene.

**Paul Tang – Palo Alto Medical Foundation**

Is that okay with you, David too?

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

Yeah, I think you're right. The key thing I think is that we develop a more organized down version of this conversation that we can really look at closely.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, agreed.

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

Hey Paul, this is Charlene.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

I support what Neil said because what we find is certainly just creating the means to engage providers in process improvement is key and doing them across tons of measures isn't going to work. However, on the other side from the vendor perspective, it means, and Neil knows this, there's a lot of measures that we've got to put out there, and there's a lot of work to do that. So that needs to be considered in the process and framed as we kind of create a roadmap going forward. I think it makes a lot of sense, but as a strategy then we just need to put some guard rails around it, if you will. The second piece of that would be, and again, this is just as part of the measurement concept, and I know this might be a stretch for you guys, but the feedback I am getting is it's the same kind of process, which is field testing and validating the measures could be applied to actually the performance measures. Did you achieve, you know, 30% of medication orders, 80%, that process also would also make sense because they're a type of measure and the more those can be embedded in the overall thought process behind measures, that would also be more effective than the current state.

**Paul Tang – Palo Alto Medical Foundation**

I may have missed it; can you state the last point?

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

Yeah, the last point was, and this is just some feedback I'm getting some, you know, the measures that we've got to, for instance report, to be able to meet the objective.

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

Those in a similar way need to be, if you will, standardized such that we all do that in a common way. So if there's a way to consider measures to be measures, the measures of the objectives, so this involves the measures of performance that would be helpful to the community.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

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

It may not be possible, but I can always put it on the table.

**Paul Tang – Palo Alto Medical Foundation**

The other thing we talked about, and this may be something that the small-group tackles, is right now the whole notion that these things are hardwired, which leave so much open to interpretation by an individual vendor or provider, that if we go more toward this flexible platform, however, that is constituted so that we have to worry less about the number of measures than the ability to get standardized data reported, however measures evolve, that's something we could probably work toward to try to relieve this, you know, hardwired stuff. Okay so we'll have a full agenda for the CQM group, but the goal is to streamline it and sort of distill the options and the questions to put back before this group and then ultimately it may end up before the Policy Committee. So it's clearly one of the challenges but also one of the biggest opportunities in terms of how we shape the use of these tools for future payment systems.

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

Paul, when does the CQM group meet next, do you know?

**Paul Tang – Palo Alto Medical Foundation**

I don't know. Mary Jo do you know?

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

The eCQM meets on Tuesday the 29<sup>th</sup> and I believe it is, I can tell you exactly what time it is.

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

I got it 10:00 o'clock. Got it.

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

Yeah 10:00-12:00.

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

Great. Thank you.

**Paul Tang – Palo Alto Medical Foundation**

Okay. And do we have our next MU call?

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

Yes. And the next Meaningful Use call is not this month but it is, oh we've put it on I thought, yes. I'm sorry I'll have to get back to you on that. I don't see it on my calendar.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Hopefully, it's before the meeting, although, we're not reporting out at the Policy Committee meeting.

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

That's correct. I did not put you on the Policy Committee for December.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Okay, Judy Faulkner asked something, which is related to this conversation we just had. How do we measure, define and measure success for this program, this MU program?

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

Oh that's a great question she asked.

**Paul Tang – Palo Alto Medical Foundation**

It is a great question. So it is 10, 20, 30% successful at getting MU qualified or is it most people having a certain amount of success? I think the first answer is it is some percent that qualifies fully, because that's the way the program is designed, that's even part of the restrictions in the statute. But then what number is that? Kate was pointing out, Kate representing Patrick Conway from CMS, it's nice and easy to say we should get all these measures to align, but, you know, there are a lot of restrictions that these various programs have and so she was pointing out that it's not always that straightforward. Some of the questions posed though are still, is it tracks or is crosscutting? And I think we have always been, in the name of parsimony, trying to get more toward crosscutting and that's what our smaller group has been working toward as well.

And then Neil was talking about what he just mentioned, which is making sure we try to have harmonious, parsimonious look at measures and not keep increasing the burden. Additions to those kinds of summary points and other thoughts on how we deal with some of these?

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

Well, one more quick point, Paul.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

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

And that is that we talked about the relationship between the measures and the workflows that produce them.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

I was in a discussion yesterday with some folks and we were trying to figure out why the measures from our two different systems looked so different even though we're reporting out exactly the same data. And you know, one of the things, I'll just give you a very concrete example, because I think it just drives this home. So, you're looking at the percentage of people who are depressed to determine what percentage of them are put on medication and what percentage of them are followed up three months later, within three months for people who are diagnosed with depression. So our data looks horrible. We have over 90% of our people screened for depression, so we're picking up lots of people with minor depression, lots of people who actually probably aren't necessarily going to get follow-up in three months, and lots who don't require medication. The people we were comparing it to were people who don't really do much screening for depression. They're reporting exactly the same definition of depression. The vast majority of their patients are on medication and are getting followed up monthly. So, you know, depression is depression. We both have these populations, the difference in the data is completely around sort of the workflow and how wide you're casting your net, how much you're screening, how much you're bringing people into the system.

And I think that is where, you know, I feel like we are trying to develop a calculation to four decimal places when, you know, we're multiplying by an integer, for those of you who remember math, you know, it's like the least number of decimal places determines the extent to which you can refine the number. And so we're not looking at the workflow issues that are producing the data, we're trying to refine the requirements, the numerator and denominator requirements, but without looking at the workflows that create it, we're going to have vast differences in the measures themselves and we're pretending that they're actually going to make a difference when you compare site A to site B, but they're really not because the underlying production of the data is so different.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

And I feel, you know, there's so much in the literature now about that, that it's just kind of like, that's why I don't, I think we have to get away from obsessing around the measured definitions, not that we're not doing something that's important, but we have to realize that it's not going to be precise and I think that's why people are so afraid of these measures, because, you know, they don't really measure what we think they're measuring in so many cases.

**Paul Tang – Palo Alto Medical Foundation**

So that's a really good point. I think it's a lot the denominator problem. So, I wonder if we actually have to go back and make sure we have highly reliable and accurate primary data of the high leverage kind? So, for example, problems, meds, allergies, those kinds of things, because those are the drivers both for the report, but also for the decision support. Then I wonder, so remember some of the objectives we planned on for Stage 3 is to make sure the problem list and med list, for example, are up-to-date. So we, in Stage 1 it's basically present, but it has nothing to do with measuring whether it's complete or accurate. And we talked about some ways, and there could be very innovative ways of trying to either assess or keep these problem lists and med lists up-to-date. Maybe we need to start talking about that as we plan for Stage 3, because that really is going to drive that problem you just spoke of, Neil. So it's the denominator, you should get credit for identifying your patients with depression and acting on them and clearly the accuracy and completeness of the problem list would drive some of that denominator.

So if we had innovative ways to capture some of these diagnoses, depression might not be as easy, but hypertension, diabetes, obesity, there are a lot of things that are easy using other information in the EHR. Comments about that? I mean, basically its saying can we make sure that we direct the objectives to things that would feed into accurate management and reporting about our patient populations?

**George Hripcsak – Columbia University NYC**

This is George. In our phenotyping projects on the biological side, you know, this is what we do when say Sinai and Colombia have two informatics groups and they're trying to match their definitions and it's hard for them, you know, we're actually a diabetes, chronic kidney disease, hypertension are three that we were talking about just yesterday, and so figuring out either from the problem list, the ICD-9 codes or the meds or anything, we all do it differently, and our paper is how different they are. So expecting the lone practice clinician, so I don't know how to do something that isn't, like it's informatics research to do that well.

**Paul Tang – Palo Alto Medical Foundation**

All right George, let me ask. So for renal insufficiency or diabetes, or I forget what other you mentioned.

**George Hripcsak – Columbia University NYC**

Hypertension.

**Paul Tang – Palo Alto Medical Foundation**

Hypertension. Even if you use different ways can't you, so I'm not understanding how you couldn't agree on a way of fairly reliably picking up those diagnoses using other information in the EHR.

**George Hripcsak – Columbia University NYC**

I am saying that, we in Vanderbilt II, did it ourselves and came up with very different methods that come up with different groups.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

**George Hripcsak – Columbia University NYC**

And because some of it, because it's a fuzzy definition, and that was actually probably a lot of it. In other cases it's because different EHRs and different workflows, as Neil said, collect different things, you know, it's all pushing towards Neil's concept of let's make sure people are doing local quality improvement rather than comparing and doing deltas perhaps as opposed to comparing absolute performance metrics.

**Paul Tang – Palo Alto Medical Foundation**

Yes. Yes.

**George Hripcsak – Columbia University NYC**

I think it's an important area. I don't know what I would put as an objective in Meaningful Use to make it better though, that's my question, other than, you know, try to make objectives that force you to do a better job on your problem.

**Paul Tang – Palo Alto Medical Foundation**

Well, what about common definitions which have as part of it, you know, the workflow aspects of it.

**George Hripcsak – Columbia University NYC**

Well I guess that's precisely what David Lansky is working on right is the definition for the CQM is in fact defining the nominator, which is usually something like diabetes. So I guess that is that work right?

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

But that doesn't really take into account the workflow that produces the information.

**George Hripcsak – Columbia University NYC**

No, right I agree there's that added stuff, but even like, there's a group working on as much common definition as you can come up with, I'm thinking a second. Go ahead.

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

To me the major reason to develop these precise definitions is not to be able to compare sites to one another or to some standard because that's driven so much by the populations and by the workflow, but just so that the vendors can capture the information, you know, have very specific ways of capturing the information, at least we can get that right, but what I am trying to say is that from that point on what you focus then on is getting people to be able to take one or two, or three measures between Stage 2, and Stage 3 and be able to demonstrate that they've engaged in an improvement activity around those measures and that they have been able to improve those measures. That's the process that we are trying to get electronic health records to stimulate.

**George Hripcsak – Columbia University NYC**

So, Neil that's a good way to put it that this is for the vendors, not that we can compare groups, and so I just realized now my answer to Paul, you is that I think what we should do is say, you know, it would be nice if we could do this. The problem list that says diabetes is the thing you should use in your denominator and it's up to the vendors and the local group to figure out how to populate that problem list, be it semiautomatic or not, as opposed to us saying, the denominator in anyone who has diabetes on the problem list or is on an anti-diabetes medication or has a glucose of 300 in the last year, like I don't want to start defining those rules because that's outside of Meaningful Use.

**Paul Tang – Palo Alto Medical Foundation**

Yeah. So we have to get this tool to work well for us to produce our results. And I think the whole world would be better off if we could get, if we could motivate the EHR developers to give us tools that would help us maintain accurate, reliable, complete problem list, med list, allergies, etcetera, some of these high-valued data elements. And, then like you say, George, I mean, have people develop measures based on those and then, you know, they can innovate on the measures, but we've got to have a way to get some of these high leverage data elements in there reliably and easily.

So I think we're starting to talk about what are the attributes of a good Meaningful Use objective and it's really we're trying to get the leverage, we're not writing the final rules, we're trying to write some of the requirements for a meaningful use of this tool and to the extent that the tool can deliver consistent results, and again, it's at the data level, then they'll have the tool to measure things that would be helpful to them or their external environment. It's interesting. It's almost like we started looking at desirable attributes of a CQM. Maybe we need to step up a notch and say they're desirable attributes of a useful Meaningful Use objective and that clearly balances the value over the cost.

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

We did something similar, Paul, I was just trying to remember what it was. We did do something similar and it was a ranking exercise. I'm going to guess maybe four or five months ago and we sort of stacked things up. I mean, it wasn't the easiest process, but it might be worth looking at as a way to think about what you're describing. I don't know if you recall what I was talking about. I think it might have been in the context of patient and family engagement criteria.

**Paul Tang – Palo Alto Medical Foundation**

Yes. So you think that's an agenda item developing those kinds of attributes of a Meaningful Use criteria for Stage 3 would be a useful exercise for our next call?

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

I think so.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Okay, other comments on the feedback we received from the Policy Committee?

**George Hripcsak – Columbia University NYC**

A lot of people, this is George, commented on special, you mentioned it along the way, but there was a lot about, we have to do something for specialists. There was CMSs plea for parsimony though.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**George Hripcsak – Columbia University NYC**

In other words don't do a million different things for specialists, we have to do something but we can't be a million different things. And also, Gail had mentioned what changed for specialists before the NPRM, I am blanking on what that was, remember that we suggested a change for specialists.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, that was overruled.

**George Hripcsak – Columbia University NYC**

What was that?

**Paul Tang – Palo Alto Medical Foundation**

Yeah I didn't remember that either.

**George Hripcsak – Columbia University NYC**

Anyone remember what that was, because I didn't write it down.

**Paul Tang – Palo Alto Medical Foundation**

Unless it was the, one of the things we had for crosscutting was the feedback from, you know, the referral loop.

**George Hripcsak – Columbia University NYC**

Referral loop, yeah.

**Paul Tang – Palo Alto Medical Foundation**

Yeah. And we did not get that so maybe that's what she was referring to.

**George Hripcsak – Columbia University NYC**

So we have a small group that's going to be meeting on the 28<sup>th</sup>, but...

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

Paul this is Allen. Are you referring to the clinical quality measure in the referral loop?

**Paul Tang – Palo Alto Medical Foundation**

Yes.

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

So there is still work being done on that from our end. We took that and CMS was working with Mathematica on a measure that may be what you're thinking.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

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

So, again, sorry I'm just not totally aware of exactly what you're talking about, but if that's the case then again that's something we can talk to you and David about during the process of reviewing the measures, but that is in there.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Good. So, if you don't mind I thought I'd go through some of the findings we had from the hearing and see how we want to triage this stuff for further action, which could be, you know, we just did our reporting and that's it, but now I'm looking at the slide that says summary findings from October 5th hearing and begins with number 1 and this has to do with clinical quality measures. So under those, the first four A through D, it seems like this is still further work from our CQM small group. It's really refining, how can we make this, how do we move this objective of being able to reliably capture or make use of quality reports from your EHR and your quality improvement activity to improve care, it was our lengthy discussion. So right now I think we're having this small group develop that further and present back sort of conclusions and some recommendation options for this group, the MU Group to discuss further.

The next one has to do with this whole certification area and wondering whether we have more work to do on this or is this something we pass off to the certification workgroup, that's the notion of, the rules say that you have to produce things out of your certified EHR when a lot of people are using other systems and particularly reporting in data analysis systems to do this. Forcing them either to certify their method that's done outside of the certified EHR or to adopt the vendor supplied method, which creates this workflow problem where people are actually having to change their workflow to match the vendor's assumptions, that whole thing and including they don't even test for accuracy, and they only checked 9 out of 44, all those issues. Is that something we want to deal with here or is this something we activate the Certification Workgroup to look at?

**George Hripcsak – Columbia University NYC**

Paul, this is George. I think the 9 out of 44 is Certification Workgroup and in the past we've done things because certification is driven by Meaningful Use.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**George Hripcsak – Columbia University NYC**

So add to the sentence whatever the objective is we say do quality measurement it doesn't say more than that. If they do quality measurement by whatever means available, you know, like you would just add a phrase that makes this the trigger for the Certification Workgroup that they can't force you to use the certified technology.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**George Hripcsak – Columbia University NYC**

And so those are the two ways to go and it's really, I don't know, I welcome ONCs advice on which way we should go, just hand it to certification or put down a rule that triggers certification.

**Paul Tang – Palo Alto Medical Foundation**

Well I don't know that we need more certification. We're saying the current...

**George Hripcsak – Columbia University NYC**

You need certification to change it to the lack of certification.

**Paul Tang – Palo Alto Medical Foundation**

Or to do it, yes, either your numbers have to match what was available in the EHR and you are always subject to audit and that's okay for the quality measurement reporting, I mean, I'm making that up, that's an alternative then asking for everything to come out of the EHR. And the other aspect is this whole accuracy.

**George Hripcsak – Columbia University NYC**

I'm saying that we can state the high-level version in our objective, which is that people who are far ahead on certification, in our letter say that accompanies the matrix, people who are far ahead should be able to continue doing it even if it is by an alternative means that uses the EHR data, but is not the EHR itself, like we could state it, well that's already getting too detailed, but say that at the high level what the goal is, you know, and Certification Workgroup turn it into, you know, the certification policy.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**George Hripcsak – Columbia University NYC**

Or we can just hand it straight to the Certification Workgroup to fix in effect.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy. I think it's more powerful if there is a way to be mutually reinforcing. So if the details can be done by the Certification Workgroup, but I kind of like your idea of having some sort of overarching objective that gives the Certification Workgroup the guidance in terms of how to be flexible with this.

**George Hripcsak – Columbia University NYC**

Yeah, so it would be a modification to the existing objective, right.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

Okay, so do we feel like we can make that up right on the spot here, or do we want to, you know, George, you want to take a stab at trying to say what we learned and what we think some of the options might be as a sort of a charge over to the Certification Workgroup?

**George Hripcsak – Columbia University NYC**

I was thinking it would be good if we could take whatever we come up with or I come up and hand it quickly to the Certification Workgroup to tell us, no, if you give us that, that'll be trouble for us. So that would be good.

**Paul Tang – Palo Alto Medical Foundation**

Okay. If you want to put something together and then we can float it by the group and say, hey look that sounds like what we discussed and then we can see whether they're, or we can pass it off to them.

**George Hripcsak – Columbia University NYC**

Yes.

**Paul Tang – Palo Alto Medical Foundation**

We talked at length about the CQM and the growing the number. The alignment we are certainly sensitive to. The notion, and it did survive on our focal area, is having CQMs provide real-time benefits to clinicians, that's the whole dashboard versus retrospective reporting and the use and improvement activities, like Neil was talking about. So this whole area we actually now, we kept that as one of the focal areas and I assume we don't have a change of heart about that.

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

I think that's really important.

**Paul Tang – Palo Alto Medical Foundation**

Okay. The next area is this whole patient engagement and I wonder if, I mean it's certainly going to be in Stage 3 and I wonder if there is a small group that looks at this whole issue. I mean, we had some sort of unintended consequence in terms of let's say the 50% and today the way that most people are meeting this is by printing out paper. So, have we already corrected this through our Stage 2 recommendations about the view and download? Maybe this is already an issue that's going away with Stage 2, at least if

they follow our recommendations, but just to relook at this notion of how do we make sure patients have access to and take advantage of information that is derived from electronic sources. Do we feel like we've got this covered in our new approach to Stage 2 or do we need further work on this I guess is the question?

**W**

What do you, and Eva was at the hearing so she may have more, but what do you mean by the covered in the new approach and I apologize if this is catch up.

**Paul Tang – Palo Alto Medical Foundation**

In the hearing we said people have to make sure that 50% of the folks that they see are given an after visit summary in a sense and so what we heard at the hearing was some folks, let's say nothing changed, no change in their plan yet they wanted to make sure they met their 50% so they were essentially forcing them to take this paper or output and they found unfortunately some of them in the trash.

**W**

Right.

**Paul Tang – Palo Alto Medical Foundation**

And that of course creates a separate issue. So did we fix it by going over to this view and download and make sure that we have, you know, 10%, has that fixed this problem?

**W**

Oh boy that's a good question. I'm not sure it has because I'm not sure that we actually got rid of the visit summary, which is the problem. The problem wasn't online access to information, which is what view and download addressed.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**W**

I think didn't we maintain the after visit summary recommendation for Stage 2?

**Paul Tang – Palo Alto Medical Foundation**

Actually, you may be right. I'd have to look that up.

**W**

And if we did, then no it doesn't fix the problem.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

Yeah, the summary of care efforts is still there.

**Paul Tang – Palo Alto Medical Foundation**

No this is on clinical summaries. This would be for clinical summaries.

**W**

Oh, yeah, yeah. Yeah.

**Paul Tang – Palo Alto Medical Foundation**

I mean the fact that it's still is so confusing to us is a challenge.

**W**

Yeah, but that is still in there.

**Paul Tang – Palo Alto Medical Foundation**

So would it be fair for us to have a small group just to relook at this, because we want to make sure that, you know, because we still have a chance with Stage 2, you know, the NPRM will come out and we can have additional comments.

**W**

Right. I think, you know, I'm not sure it's worth a small group, but we definitely need to go off and think about it. I don't know that it's that complicated. I mean, I think the problem is what we really meant was at least 50% of patients are given this piece, you know, are offered either a paper, and this is where we need to clarify, either a paper or electronic copy of their visit summary, but if they are, you know, using the portal, they can do it that way, they don't have to force the paper on them, and so I think that's an operational almost issue that needs to be clarified. But then we also meant, you know, so if we have, you know, a patient who is coming in twice a month to manage a chronic condition and they get the same thing every time, you know, they're like come on. So we did mean, you know, appropriate patients in a way, you know, so I think we need to give some thought to how we are going to that and I think it changes things that view and download, if view and download become core. So, I think, I don't know that it's worth a small group having to go off but I think it is something we need to think about and bring some ideas to on our next call.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**George Hripcsak – Columbia University NYC**

So, Paul, on Stage 2, just a comment, this is George, Stage 2 does say electronically accessible for viewing counts. I mean we're trying to address the portal in Stage 2 which we didn't do in Stage 1.

**Paul Tang – Palo Alto Medical Foundation**

Well it was accessible in Stage 1 the trouble was the 50% and people were not at 50%.

**George Hripcsak – Columbia University NYC**

...provide as opposed to offer and if you just offer how do you count? And the...they don't want the electronic version and they don't want the paper version, they want neither, and then I haven't provided it to 50%. You could lower it to 10% or you could say offer, but then you've got to worry about how you're counting.

**W**

Yeah, but I'm not sure that's right, because I am not sure that every piece of technology works this way, but to me when I log into my portal, I don't see, you know, 14 visit summaries for the last 14 offices. I see my health information and it is my last visit information is integrated into that.

**Paul Tang – Palo Alto Medical Foundation**

So actually, so in our portal you do see one for every visit.

**W**

Okay. Well, so but what does it hurt anybody if it is there all the time and is it a matter of practice for you to put them all there or does the patient have to say, yes I want it there.

**Paul Tang – Palo Alto Medical Foundation**

No, no, no it's a matter of practice. So actually I'm trying to look up the actual criteria, because we do use the term provide and I don't know why people are necessarily, I wonder if people are doing more than they are actually asked to do.

**W**

Right.

**George Hripcsak – Columbia University NYC**

First of all I have it right here, provide clinical summaries to patients for more than 50% of all office visits within 24 hours pending information such as lab results should be available to patients within four days of becoming available to EPs (electronically accessible for viewing counts).

**Paul Tang – Palo Alto Medical Foundation**

So the problem is the word provide. I think what we meant was that it exists if they want it. So, in that case you wouldn't actually force anybody to take it.

**W**

Right.

**George Hripcsak – Columbia University NYC**

Well, you know, in the past, we have said offer to mean that, and we took back offer because they couldn't count it. So what you mean, remember? Because we had said offer in some places, I forget where.

**W**

Right.

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

So that's how we came up with the number.

**W**

But all I was saying is it should, under today's rule, and it fixes the problem, I think, it's in Stage 2, everybody has to do view and download. If that becomes core, as we've recommended, then the provision can happen on paper if they want it, but if they don't, it just goes into their portal/PHR or whatever their mechanism is.

**George Hripcsak – Columbia University NYC**

Well as long as, right, so, I mean that would be a solution is that make sure it is available on the portal.

**W**

Right.

**George Hripcsak – Columbia University NYC**

And obvious to the patient and they don't have to count that 10% downloaded or anything it just has to be available on a portal if they choose to use it. Then the providers and vendors would be happy with that because they don't have to count 50% of patients getting their notes.

**W**

Well, no I'm saying it would count for 50% of the patients to have the notes because they've done it, they've provided it electronically.

**George Hripcsak – Columbia University NYC**

Well do they have to have them log onto the portal to count though?

**Paul Tang – Palo Alto Medical Foundation**

No. No.

**W**

No.

**Paul Tang – Palo Alto Medical Foundation**

It's provided.

**W**

Right.

**George Hripcsak – Columbia University NYC**

Okay so it's really just offering and the way we count is that there's a portal if they want it, then that'll be easier for the doctors.

**M**

For the professionals.

**Paul Tang – Palo Alto Medical Foundation**

So here's one of the questions that came up. So, it is there for anybody who wants to take advantage of it but 50% of my patients have not gotten their login, does that count? I think this could be an FAQ kind of thing. The notion is that we wanted to have accessible, and this is an EHR adoption program, we want to make sure they have this information available and in our case it is available electronically. You are not responsible for making sure that, at this point, 50% have actually availed themselves of that access.

**W**

Right you've provided it.

**Paul Tang – Palo Alto Medical Foundation**

Correct and so I think this is really a clarification of our objective so that we don't actually have to back track on the objective at all or the criteria for qualifying, we just have to clarify that what we meant is you need to be able to make sure that the information is there within three days in Stage 1 and within 24 hours in Stage 2, but it is not synonymous with saying 50% actually had to even have a log in, as long as they all are aware of this. So is that consistent with everybody's thought about what we meant? Because that's what I thought we meant.

**W**

Yes, it is. I mean, I want to be careful how we describe it only because I don't want people to stop offering paper visit summaries, you know, stop offering them period.

**Paul Tang – Palo Alto Medical Foundation**

Right.

**W**

But, yes, I mean, I think that's the right approach.

**Paul Tang – Palo Alto Medical Foundation**

So, I don't know, is it Allen, to ask this question, should we go ahead and try to draft some language to help CMS clarify this and perhaps it will actually end up in the CMS FAQ.

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

Yes, language like that can certainly be included in the rule and to address Christine's question, we can always, the language can always be, for example paper summaries should not be eliminated...so that language, yeah, can certainly, if you want to provide a simple paragraph that could be included we can pass that along and suggest that in the rulemaking process.

**Paul Tang – Palo Alto Medical Foundation**

Well it's not even rulemaking this is clarification on Stage 1. I think people got tripped up in Stage 1, and we didn't intend for that.

**W**

And I'm going to look up the specification sheet now, because it might, I mean this was a problem that we've heard about for actually a while.

**Paul Tang – Palo Alto Medical Foundation**

Yeah. Well George...

**W**

In a slightly different version, but at our first hearing that we did, I don't know, six months ago, several of the folks who testified said, you know, it wasn't clear to us whether we could meet the requirement through the portal.

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

Oh, I see, so that is addressed in one of the fact sheets from CMS, but certainly if you believe it's worth an FAQ, I can certainly pass that onto Rob at CMS to have him see if they wouldn't be willing to publish an FAQ on their website.

**Paul Tang – Palo Alto Medical Foundation**

I think that would be definitely worthwhile. We definitely got that feedback from the hearing and other people seem to agree.

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

Certainly and then I can pass any language you give me on.

**Paul Tang – Palo Alto Medical Foundation**

Well actually, I mean, they can make up their own, it's just that we're pointing out to them that people thought...

**W**

So they did that. I have it now. So on the FAQ on the website; it says the clinical summary can be provided through a PHR, patient portal on the website, secure e-mail, electronic media such as CD, USB, or printed copy. And then if the EP chooses electronic media they would be required to provide the patient a paper copy upon request.

**Paul Tang – Palo Alto Medical Foundation**

So, I think the misunderstanding is that people thought the 50% meant that even if they offered it electronically through a portal, that meant they had to have 50%, and in fact I know people said it on the panel.

**W**

Exactly.

**Paul Tang – Palo Alto Medical Foundation**

That they meant they had to have 50% already signed up and that's just not true. So maybe can you pass that on Allen or is that something you need more work from us?

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

No I can certainly pass that along and it's also worth noting that we can have some of our patient engagement contractors create a fact sheet or spec sheet, if you will, that will help market and publicize this information.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Okay so I think that was the main, that was clearly something that was challenging for folks and I think it was just a misunderstanding.

**W**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

And that generated actually at least two of these comments. Okay. For the next comment about surrounding HIE, I think one approach is that we await the NHIN governance proposed rule or ANPRM to come out and then maybe we can comment on that, that's an approach to dealing with the HIE issues that came up.

**W**

What HIE issues Paul? Because that doesn't make total sense.

**Paul Tang – Palo Alto Medical Foundation**

Well when we said for people to test and that occurred in two areas, the coronation of care and population of public health. They had trouble, I mean it seemed like a small thing, but they had trouble finding somebody to test with.

**W**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

And so in one, the public health, not all states have these, not all local localities have agencies that are able to accept this, and in the HIE they didn't necessarily have an organization that they could test it with. And the comment is, and it was borne out by a recent article that still there is a business model problem for HIE organizations.

**W**

So the NHIN governance rule, I mean, Mary Jo could probably, or somebody from ONC could probably help us understand, but I'm not sure that the scope of the governance rule is really going to be terribly related to the business case for information exchange. As I understand it, it's going to be like literally around governance and policies, and practices around how you make decisions for access use disclosure of health information. So I'm not sure the NHIN governance rule is the way to go. I mean, I think we knew that the test idea for public health was going to be hard, because that was the point was to begin that conversation with eligible providers or eligible hospitals and public health departments to say, do you have this capability, no? Well are you ever going to get this capability? You know, well here's, you know, so those conversations are beginning and I think that's a good thing.

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

This is Mary Jo. I think what I would suggest is maybe sort of two-for approach. Obviously, I can't say too much about what the governance proposals might include, but I do think that Christine is right that they're certainly not going to directly address the issues that were raised in the hearings. So, to the extent that you can consider some other approach to what you heard that you feel is within your scope, you know, you certainly should do so. And then when there is a public comment on the governance rule then certainly you are most welcome to comment on anything there that is also pertinent, but at this point in time I certainly wouldn't hold back.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

This is Amy. On the public health side, I mean, obviously, providers aren't being held for meeting Meaningful Use if the public health department can't accommodate.

**W**

Right.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

So there's exemptions there and even if it becomes core if there's no capability, then the exemption holds and I think that's appropriate having been in a health department where we have had challenges in getting capabilities in place, etcetera. On the general HIE side, it's hard for me to, maybe it's sort of my reference point, but with the promotion of direct and other secure e-mail messaging, I mean this doesn't necessarily mean having to submit data to an HIE system. It means having to exchange data, as I

understand the Meaningful Use criteria, having to exchange health information electronically period. So, while there may not be a business case for more of sort of the HIO, HIE, I mean, you know, are there things we want to think about in terms of using Meaningful Use to promote direct or other, and if we don't want to be specific on the direct protocol, on other secure e-mail messaging for the purposes of sharing information electronically.

**Paul Tang – Palo Alto Medical Foundation**

Well-meaning organizations had trouble finding someone to test with, whether it's public health or clinical trading partner. So you could be trying to go for your Meaningful Use certification, but the hospital you admit to or the provider group you work with isn't. They just basically, what they said is they spent a lot of time looking to find someone and that was the problem. And one of the reasons people don't have the, so if there was this HIE organization than that...but they didn't have them because they don't have the business model for operating them. So, it just became a challenge.

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

It's Christine again. You know, part of how think we, this was an area that we, as you know discussed at length toward the end of our deliberations on Stage 2 and I think part of our strategy, which I still believe is probably the right one, is to really focus on the care coordination uses of information exchange, particularly, now that we've seen the final rule for the ACO program and the pioneer...program is getting off the ground, there's also a whole bunch of, you know, lots of other federal programs like the advanced primary care initiative where they're really going to need to have the capability to exchange information and it doesn't have to be fully through an HIE, but the ability to do basic information exchange, whether that's messaging through direct protocols or whatever, as we were just talking about.

So, I think it might be worth a look to see if now that we know what's in the ACO rule and the requirements and now that we have a better understanding of the fields, so to relook at the care coordination kind of elements and make sure we are doing all we can to promote information exchange.

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

This is Neil. The other side of that is that all of these initiatives are stimulating something that may make it less important for us to be making requirements in this area as stringent, because I can tell you at least in the environments that our practices are in, everybody is all of a sudden there's the huge demand on the HIEs to start being able to produce stuff, including being able to do things that are really outside the scope of the electronic health records, like real case management kinds of exchanges of information and other things. So, I think that we're also looking at, you know, we've always said that we need to pushing on things that might not get pushed otherwise or as quickly. And again, I think this is an example of where the vendors need to be able to produce the capability, but the imperative for this is going to start being very apparent from other sources.

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

Yeah, Neil, it's Christine. I mean, I thought about that a lot and I think in some areas where there is HIE infrastructure that's really true, but I also think that there are a lot of areas that don't have that infrastructure, regardless of what it's capable of. And what I was trying to think about was, you know, given the amount of care coordination, ACOs and the other kinds of initiatives need to do, how do we make absolutely sure we have created the capacity in EHRs that are certified writ large to do care coordination and information transition that is robust enough to facilitate meeting those needs and I'm not sure that is really the case outside of places that may have an information exchange.

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

Yeah. I would agree with you. I mean, I wasn't trying to imply that we didn't need to push this as a requirement of the EHRs.

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

Yeah.

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

But I think a lot of this requirement is going to come from other places.

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

Yeah. I agree. And we better make sure we get the capability built in. I think the impedance is external in a lot of ways. I think that is right.

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

Even when there is no RHIO the hospitals are going to be looking at their network of providers saying, we have to be able to exchange information with you somehow. You know, what can the systems do? So, I think it's important that the systems are ready to do that.

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

I agree and what I'm worried about is that suddenly in, you know, small pockets of the country we're going to be burning up the fax lines, you know, shoving medical records all over the place or they're going to create totally separate workarounds to the fact that, you know, they may have EHRs, but they don't have a robust enough information exchange capability between them to do it. So, I think this might take some more thoughtful work by people who really have the deep experience in information exchange and care coordination, but I think it's a use case issue of folks on care coordination to move information around rather than focus on the business case for HIE.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

I would agree with that. I mean, I don't know whether the issue is sort of a generation of something like a CCD or it's the ability to move it, or it's the ability to consume it, disaggregate it and put the data in the correct data fields. I mean, there's all different, in the workflow of just moving information, you know, do we want to push sort of secure e-mail messaging as an integrated component of EHRs and let it go with that, or do we want to take it a step further? And is that sufficient or not. This is Amy.

But for those places that don't have RHIOS or sort of HIEs, you know, the sort of secure e-mail messaging route is a way to be able to send care summaries or clinical documents or, you know, health information and get it somehow incorporated into the EHR either as a document or be able to disaggregate the data and put it in the, you know, actual fields in the EHR. Obviously, some are much more complicated than others.

**Paul Tang – Palo Alto Medical Foundation**

So we may come back to this discussion once we see the NPRM that is coming out in the next couple months.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

The NPRM for the HIN governance?

**Paul Tang – Palo Alto Medical Foundation**

No for Stage 2.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Oh, Okay, yeah.

**Paul Tang – Palo Alto Medical Foundation**

And they'll react to, we now, I think we had three clinical, you know, transfer with three clinical trading partners. They'll decide something and then we can reengage on this discussion I would guess.

**Arthur Davidson – Denver Public Health Department**

Paul, this is Art. I've been listening. I'm sorry I joined late. It seems like at a minimum, we want to encourage that there be some standard by which EHRs are able to exchange data with, whether it's a clinical trading partner, whether it's the local or state health department, whether it's the HIE, or whether it's a PHR. I think Amy's comments are something that we should be able to at least establish that floor, you know, that there be, whether it's direct or some messaging service, you know, secure e-mail. I don't

know the answer, but I think we should at least agree that there is this minimum that we believe should happen with or without the presence of an HIE.

**Paul Tang – Palo Alto Medical Foundation**

Well that was, in fact, our point of even having this objective. I guess we're just recounting the challenge that people went through in trying to meet this objective, which was really just to get a certification criteria in there, but the challenge of actually conducting the "test" was hard.

**Arthur Davidson – Denver Public Health Department**

Right, but I think part of it is the absence of this CDA architecture, you know, the CCD or CDA, whatever, that can drive the EHRs to say, here's the standard, now I know how to do it. The tests were set up in local environments that didn't have enough specificity I think.

**Paul Tang – Palo Alto Medical Foundation**

Yeah. Okay, well.

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

Paul, this is Charlene.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

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

I think what Art said together with the need for some policy around the broader exchange are both critical items to kind of, I mean, again, we need the incentives, right, but the incentives are still a voluntary program, they're not mandatory. Clearly, people see the writing on the walls. So the more we can get the pieces in place which include the governance linked to policy together with the ability to have that standard infrastructure, those two things will facilitate what you're trying to do. It's just all those pieces have to be lined up and they're not and I think that creates confusion in the market. Direct takes a step in the right direction. The feedback I get is not sufficient, it needs to go farther. But the pace of accelerating that I think is confused at this point.

**Paul Tang – Palo Alto Medical Foundation**

Okay. I wonder if we can move toward considering the focal areas we left off with on our last conversation. This is toward the end and it's marked initial draft focal areas for Stage 3. We need to look at this in the context of where we were, having slept on it, and getting feedback from the committee and see if these are still the right areas or whether they can be consolidated. So the first was to concentrate on getting more of this information, now that we're getting it into the record, getting tools so that the end-user clinician, folks in the front lines managing care, have information that they can use to continuously improve and that's sort of this, sort of like the clinical performance dashboard, behind-the-scenes adverse event detection and prevention, and mitigation reporting, and just finding a way to continuously learn from the information you're gathering about your individual patients and the populations to be able to both learn and improve. That's a lot of what Neil has talked about. Making it work for the folks that have to use it on the front lines and making decisions.

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

Paul, can I ask something about that?

**Paul Tang – Palo Alto Medical Foundation**

Yes.

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

Maybe Neil can address it. I have difficulty sorting out in my own mind the role of public policy on that one versus the role of the normal vendor customer relationship in developing tools that are high-value to the customer and I wouldn't think we would want to have any kind of uniform imposed dashboard or

reporting mechanism there, but we would want to feel reassured that clinicians are getting that value from their product as implemented. What is it that we're not doing that we need to do, without being overly prescriptive, to support that objective?

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

Well, I think it goes back to what Paul's been saying about the availability of the measures and tracking those measures over time that enable the providers to begin to use the data internally, you know, for improvement activity. So, I think there is a way without being prescriptive about what the dashboards need to look like and the dials and whatever to begin to call out that the information that's being collected, you know, needs to be able to graphically demonstrate trends, you know, these are things that have been, you know, there's a decent amount of IT literature that shows that, you know, presenting things graphically people can incorporate that information much better than they can seeing it in a chart or text format. You know, I think we can begin to sort of look some of this stuff because otherwise it looks like we're, you know, what the providers think is that all of this is just one big hurdle that we have to get over to get our money and I think what we've got to start doing is saying that this is about utility to you. The hurdle is to get you to understand how to use this tool that's going to be incredibly valuable to you for years to come.

So, I think that's where the clinical performance dashboard comes in, and I think we could specify, you know, certain parameters around that without being overly prescriptive or telling the vendors exactly how they need to produce it. You know, the reporting stuff we talked about this in the patient safety, whatever it was, I guess it was a Sub-Tiger Team or whatever, but, you know, just the ability of being able to, you know, report on adverse events and things like that electronically but also to be able to capture that information. I think these are all things that we should be, you know, thinking about as we move forward.

**Paul Tang – Palo Alto Medical Foundation**

So, I guess David part of it is saying, this kind of functionality is not coming to us naturally and by creating certification criteria places an emphasis on that area.

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

I'm wondering if there is an analogy and I'm not sure about this, to the public uses need, that is in both cases the clinical users and the public users, whoever they are, want the data platform to be capable of generating useful reports, call it reports, whatever format they are in, that are flexible, not rigid and prescribed. So, in the case of public reporting, you want to be able to, you know, respond to different kinds of requirements and generate data from the database that could be then transformed and completed for some purpose or public health purpose. And in the case of clinical users, you have a very diverse array of possible presentations and calculations, some of which are very standardized and some of which are very ad hoc and we want the products to be able to do both of those kinds of reporting, but not say we want you to do X-Y and Z exactly. We want you to have a capability to produce a lot of different kinds of reports that those users find valuable.

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

Well, you know at the Policy Committee meeting I brought this issue up, that we have no requirement that certified systems have any kind of flexible reporting capabilities. And, you know, that's one of the things that people request a lot and I think that, you know, we are calling out a lot of things about the systems need to report on, but we are being very specific about what those quality measures are and I think a lot of this could be covered by, you know, a flexible reporting system where we really could get fairly prescriptive about, you know, certain things that we need people to be able to report on and by, and trend, but other things that they might be able to use that same reporting system to produce reports that are more relevant to them that might not be, you know, that might not be predictable by us at a policy level but might be proved to be very useful to them at a practice level. But if I were to add anything into this it would be something around setting out specifications for a flexible reporting system.

**Paul Tang – Palo Alto Medical Foundation**

Do other people want to weigh in? Is this an area we should be concentrating on for Meaningful Use qualifications?

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

Again, this is Charlene from the vendor perspective and again I cannot speak to all of the variations of reporting capabilities out there, so I won't try to do that, but what I do know is that if you can be specific in the outcome that you are trying to approach, and Paul, I appreciate that even if you define the outcome, you might not get it, you know, so I don't know how to kind of step to that step. But, again, then that will stimulate, you know, the vendor community to try to approach to meet the needs. So, you know, is it the flexible reporting system, then that vendor will compete a little bit better? I think that's a really powerful concept.

Some pieces have to be put into place to do that, but, on the other hand, to understand that we have to support through the process, and Neil you've said this, the identification of what needs to be improved, the ability to report on that, the ability to be able to put online real-time processes in place to improve upon that, and to show the level of improvement to allow that to be localized to the individual area, to allow providers to attest, yes I am doing a performance improvement process, and here's the area I've done it on and here's the improvement I made. I think those are the kinds of things that will tell the vendor, okay, you've got to build those capabilities in to help your customers do that, and then each of the vendors will be able to build that within their current architecture as they're available. So it's not quite as prescriptive, but I think, again, that provisioning I think will set the pace to kind of what the intent is that I hear on the call.

### **Paul Tang – Palo Alto Medical Foundation**

I think that is the intent and it would be interesting to see how we can write the objective that's non-prescriptive but for which you can satisfy in a number of ways. Maybe it has something to do similar to our CDS objectives. Here are some attributes of it without limiting it to just one way of providing decision support. Okay so it sounds like there is some support for this kind of feedback, more real-time feedback back to clinicians. Okay the second area is continuing on our empower patient mission to consider other ways that now there's more on the contribution side, we've done a lot with access, now how can we contribute both patients to their own record, but also how does that get incorporated into the record that the provider can use to help manage that person's health, and making sure that we derive from it now. It's almost the complimentary side to number one, the measures that matter to patients. Does that still sound like a good area for us to concentrate on in Stage 3?

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

Well it's Christine. I think it is because I think we're seeing a lot of it coming up in the landscape or in ACOs and things like that and a lot of activity around patient reported data.

### **Arthur Davidson – Denver Public Health Department**

Yeah, I agree. This is Art. And I think we need to figure out a way or encourage a way that the EHRs are capable of consuming that data or somehow integrating it to be useful to clinicians.

### **Paul Tang – Palo Alto Medical Foundation**

Correct. Okay that sounds like...

### **Amy Zimmerman – Rhode Island Department of Health & Human Services**

I think going down that road, this is Amy, going down that road I think just thinking through how to do that and distinguishing that from what a patient may be considered an amendment. So there are just, I mean, I think it's important to do that and I think there's a lot of added information. Obviously, tagging or noting what the patient recorded versus not, but, you know, a lot of places have formal policies for request to amend records. And I just think there's some legal implications and some process and policy implications going down this road that are going to have to be thought through. Putting the requirement and the capability and tagging it is as such is one thing, but the implementation in the process, it's one thing to add data that's not there, it's another to contest data that is there, because that gets into a bunch of legal matters, as I understand it.

**W**

Well so, I think, I actually think, and we've talked about this before in the past, that the idea that we are giving so much more access to health information to patients buttressed by the fact that we're hopefully adding in health information from other professionals in the system to the patient's record, there are going to be more and more errors in the record, and I think it's absolutely worth having a discussion about how we deal with corrections. And my suggestion would be that since Deven is on both this Workgroup and Chairs the Tiger Team, you know, that if we get to a point where we really need some guidance on requesting corrections and things that we engage in and Deven will engage obviously on that. But, I think it's an area that we do have to get to because just the volume of data that we should be seeing over the next let's say five years, there are going to be a lot more in accuracies that patients see.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

You know, I absolutely agree. I'm just making the distinction that when you are talking about patients contributing data I think there's a distinction between someone picking up what they believe is an error, which may or may not be accurate, and adding brand-new data that is not there, which may or may not be, and I'm not contesting that patient information isn't accurate. I'm just saying I think there is a distinction and I think going down this road that distinction needs to be made.

**W**

Yeah. I agree. I think the question that I'm starting to formulate in my mind is whether there is a functional capability around corrections that we ought to think about.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Different than a functional capability of adding new data. Yeah. I think we're saying the same thing.

**W**

Yeah. Yes, but they are definitely two different things. Yes.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Can we wrap number three in with this, the emerging sources of data? I think it's related to, it's like 2b, it's the out of hospital, out of office data capture. I just wanted to check if that's okay with folks.

**W**

I think that is fine.

**Paul Tang – Palo Alto Medical Foundation**

So I will just put it as a parenthetical to 2b.

**W**

Yeah.

**W**

Yeah. I don't remember what the emerging sources of data, non-patient reported was referring to.

**George Hripcsak – Columbia University NYC**

It could be monitors. I don't know.

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

Paul, this is David. I have another question or round that. It maybe the point Amy's making. What I'm wrestling with is what is best folded into the Meaningful Use incentive program in the next stage, Stage 3, consistent with the statute and the requirements of EHR or systems technology, qualified technology versus what's part of really the Policy Committee's opportunity to speak to the information ecosystem more broadly. And my fear about putting too much of this into Stage 3 is that it sort of aggravates the paradigm problem of fragmentary office space EHRs as the places where data goes to be managed and not part of whether it's HIE or longitudinal health record or whatever, personal health record. And so in terms of the patient centricity, the more we take this bucket of numbers 2 and 3 here and sort of impose them upon a solo practice EHR, for example, it doesn't really kind of make sense to me. It doesn't really

ring true. And I feel like there's a policy problem we haven't wrestled with yet. I don't think we know the answer, but putting everything into the individual EHR is not the answer to it. So I'm a little hesitant to just throw this all in a bucket and say we'll sort of stick it in Stage 3.

**Paul Tang – Palo Alto Medical Foundation**

Good point.

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

And hopefully as we look at mobile tools, we look at 2015 and the proliferation of Smart phones and whatnot, we have the opportunity to talk more about the patient as the center of their own health information rather than have re-fragmented doctor and provider and network and we haven't really done that yet, and so taking the patient engagement concept and saying it's going to be driven from the doctor's EHR I think we should be very wary of encoding that in our regulatory structure.

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

I agree with David. I think that's a great point David.

**Paul Tang – Palo Alto Medical Foundation**

It is a good point. Is one way to handle it to make sure that people have the opportunity versus requiring patients contribute to, you know, should they have the opportunity? So for enlighten health providers would they like to interact with the patient in a broader context than just the medical model of viewing things.

**W**

I don't think we can require patients to do anything, but putting the capability there, whether it's the capability to note an amendment or the capability to contribute additional data that you want that provider to know, if that data then goes into that providers EHR, to the extent that that EHR is interoperable with HIE or other data, it sort of gets uploaded. I'm not sure that there can, I mean unless the model is sort of a fully patient controlled personal health record that they give access to whoever they want whenever they want it, I am not sure you can control that it doesn't get incorporated into individual EHRs versus only an HIE model. I mean, I think that it's going to be very variable based on the landscape and environment. But having the capability there I think is what we're talking about on the EHR site.

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

Yeah. I kind of agree. Maybe it's about both the data...part of it, which is making sure the data from each EHR is widely available to other, you know, professional or lay systems, and then also looking at the standards which we haven't done as much about, so that let's say a patient captured data could be transmitted via a standard to the EHR. So that capability is there for acquisition of data, but it's not imposed, we don't want to force patients to share that personal data if they don't want to, but it would be nice if your phone could easily transmit your blood pressure or whatever it is you're capturing on your phone to your doctor because the standards were in place.

**Paul Tang – Palo Alto Medical Foundation**

So, I think by number 2, considering David's point that this is creating the opportunity for such data to make its way into health record, which makes data a more full-bodied health record, but we want to do this in a way so that it's not misconstrued as furthering the medical model of doing things and detracting from any other more community-based and patient controlled storage and use of information. Did I get that right, David?

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

Oh yeah, I agree with that, I wasn't so much concerned about the medical model as much as our actual real life medical model is so fragmented and, you know, disorganized now that I don't want to have the patient depending upon that.

**Paul Tang – Palo Alto Medical Foundation**

Correct. Okay. So we just want to be careful how we word this. In a sense we're trying to make sure that this is possible in the context of HIT systems that are used by EPs in hospitals, but it's not tethered.

**Arthur Davidson – Denver Public Health Department**

So is the third bullet now something more akin to emerging models for aggregation of data? Is it that we're now talking about different ways that the EHR may contribute to community-based engagement with patients?

**Paul Tang – Palo Alto Medical Foundation**

No, that wasn't originally the thought behind it. It was more data that originated from the patient and kept finding its way into HIT systems.

**Arthur Davidson – Denver Public Health Department**

Right, but, so this is where I thought heard David talking about something a little bit different than that about the various other sources, you know, we say patient related reported outcomes, yes it could be their BP, but it also could be, as we heard in testimony around public health, about knowing about what's in their community. What are other resources for that patient? What are other organizations that might be able to help that patient with a particular disease or condition, or behaviors and that's what I thought I was hearing in David's comments and maybe he wasn't saying that?

**Paul Tang – Palo Alto Medical Foundation**

Well I think he wanted to support that, but that wasn't something we had sort of jurisdiction over.

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

So...you can read anything you want in it Art its fine with me.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

**George Hripcsak – Columbia University NYC**

I mean think, this is George, I think David's comment limits a little bit of what we can do, reasonably limit what we can do, don't expand our scope beyond what is feasible. So I think we just have to be careful not to, anyway.

**Arthur Davidson – Denver Public Health Department**

But I look at this as the EHR should be able to communicate if there were a care management system if there were community health workers there should be a way for the EHR to contribute to those efforts and that those efforts somehow contribute back to the knowledge of the provider at the point of care. That's what I thought you meant by community-based efforts, Paul.

**Paul Tang – Palo Alto Medical Foundation**

All right. I think what David is saying is more caveat to this point rather than to eliminate it.

**Arthur Davidson – Denver Public Health Department**

Okay.

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

Yeah, I think what I'm trying to get at is kind of a filter on how we answer this goal and we keep it in perspective, that the environment which we're operating with this program is pretty specific and by law we're not really allowed to go as wide as we might wish. But the Policy Committee can do some of those things and probably should.

**Paul Tang – Palo Alto Medical Foundation**

All right. Okay. The next area is CDS domain. Now we've always said that CDS is one of the main effectors of the benefits of these HIT systems, particularly on the provider side though it doesn't exclude patients. And we adopted the approach of identifying attributes rather than identifying particular

methods in Stage 2. Anything further we want to do in Stage 3? Yeah, do we want to do anything further in Stage 3, in a different manner, or do we want to place any emphasis on these three kinds of things? Prevention, disease management, and safety?

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

Do we know the extent to which certified systems give users the ability to enter new clinical decision supports that would be relevant to their practice or based upon new information? Charlene do you know that?

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

I don't know that, Neil. I could maybe find that out.

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

I mean, to me I would go toward what we were talking about with reporting here. I think the critical issue here is the ability for a provider to incorporate new information that they have into a clinical decision support because these are so specific to specialty and, you know, to practice. We use this functionality all the time and I think others would use it if it was the kind of thing that a user could establish.

**Paul Tang – Palo Alto Medical Foundation**

So, Neil is your question about whether the customer organization can change CDS, is that, I'm not sure I understand.

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

Yeah, can establish, can a provider in an office, you know, who sees some new information that they want to be reminded of, can they establish a clinical decision support in their system? Can they write it into their system? You know, does it require a programmer or can they, you know, it's the corollary of the flexible reporting system, you know, the flexible decision support system that enables you to say, for this group of patients I would like to be alerted if X happens.

**W**

It's basically a rules engine. You want to be able to add rules.

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

Thank you, whatever.

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

Neil, this is Charlene. I cannot make a definitive statement, but generally the approach across vendors has been to, if you will, define that type of concept and then it's pretty flexible. Linking it to reporting has emerged. I don't know to what extent that linkage is there. So again, I think that's just something we would need some more information relative to, or I would need to gather some more information relative to.

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

So I guess my point is I would rather see this as some sort of requirement for a capability that could be flexibly used and to encourage some sort of attestation that some people have developed one decision support using this capability, if we're talking about sort of moving to Stage 3, then for us prescribing exactly what decision support is going to be relevant to a particular type of practice.

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

I agree with Neil's suggestion. I think in my dream world, it would also have the quality measure associated with it, would be to show a change in the clinical outcome or at least the conformities evidence based practice because you picked a rule, you've created a rule, and you have a target improvement in mind and you can show the baseline and 1 year later or whatever it is, change in delivery of evidence-based care because of the rule, that would be a win more so than just that you have a bunch of them.

**Paul Tang – Palo Alto Medical Foundation**

Well let me just make sure I understand. So, Neil are you saying that the customer organization should be able to write rules or are you saying the individual doctor and every doctor write rules?

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

Well I'm thinking about the range of people, well the customer organization for sure, but now I'm thinking about, what about a doctor in practice, you know who...

**Paul Tang – Palo Alto Medical Foundation**

Aren't they still the customer organization if they're a still in practice?

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

Yeah or a solo practice, you know, a provider should be able to do this. I mean, otherwise what we're really doing is, you know, we have these capabilities in our larger organizations, but we don't give the provider's capabilities of doing this in their offices. And I think that's where the real value. You're absolutely right the real value from, in terms of improvement comes from decision supports, but those are different in different areas.

**Paul Tang – Palo Alto Medical Foundation**

I just wasn't familiar with the system that didn't allow customers to...

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

Well, we can, but, I mean not all of your providers could probably program a decision support, right?

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

So if that system was in use in a private doctor's office they wouldn't have any capability of doing that.

**Paul Tang – Palo Alto Medical Foundation**

Okay, so you do mean closer to the true end-user.

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

Yeah. I do mean that.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Okay so that stays. And the final one is population health tools to drive policymaking.

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

What does that mean, Paul?

**Paul Tang – Palo Alto Medical Foundation**

Amy you want to explain this one?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Well, it may somewhat go back to, I mean I asked to call it out last time specifically, because I think it's important, you know, a lot of data is being collected at the individual level used for patient decisions and direct care, but at a state or policy, or public health perspective, being able to utilize that data, being able to get it out and being able to aggregate it across EHR platforms and look at communities and, you know, whether it's the clinical quality measures or whatever and then be able to understand the healthcare needs of the environment to help drive policymaking I think is critical. So, I'm not sure I had really, it felt like it was a gap, although I am not sure I had real clear ideas of what those objectives would or should be in terms of the capabilities of the EHR and what the providers need to do, but, and part of this goes back to harmonization of metrics and definitions, but it seems like the ability to aggregate across EHRs, because there will be such a wealth of information there in order to be able to, in an aggregate level, be

able to understand health indicators, health outcomes, changes in those to identify gaps and needs and to think about how to target resources and drive policy just seems to be a natural. And I didn't want that to get overlooked. It seems like it would be sort of sinful not to think about how we can do that.

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

This is Allen. Do you mind if I chime in really quickly just to update some folks on some work we're doing here that may provide some insight to the conversation?

**Paul Tang – Palo Alto Medical Foundation**

Sure.

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

So I'm sure a lot of you are aware of the popHealth tool just recently the ONC announced a grant worth \$100,000 to create a popHealth module that can use the data within the popHealth tool to look at new ways to measure clinical quality data and one specific area that we're targeting is population health and so we're really looking for folks to generate a really cool tool or module that can use the clinical quality data and suggest other ways of looking at population health data and then aggregate it across either region, provider, state, so on and so forth, but we are going to leave that open to the creative minds not like me.

**Arthur Davidson – Denver Public Health Department**

This is Art and, I mean, maybe just to add to what both Amy and Allen have said, it seems like the EHR, where we have some purview, should be contributing to aggregated analysis at jurisdictional levels beyond organizations. I think that's what meant to me when I heard that or read that again.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

That's a simpler way of saying it Art, thank you.

**Paul Tang – Palo Alto Medical Foundation**

Any other comments? I sort of think it falls out of the reporting requirements and I'm not sure.

**Arthur Davidson – Denver Public Health Department**

See that's where I think it could be a reporting requirement. We've limited reporting requirements for public health primarily to the three measures that we all know, but there are many clinical quality measures that have tremendous population health value and could be aggregated, and I think I mentioned this during our testimony, that the community transformation grant that we are trying to do in Denver will take many of the same things related to clinical quality measures or blood pressure readings for large organizations to create a vision of what's going on in Denver in terms of blood pressure control or cardiovascular disease risk. Taking data from EHRs that are capable of sending it to us because of Meaningful Use.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

And I would say in Rhode Island, there's efforts that our state designated entity and through our beacon community, which is the same organization, to, again take numerator and denominator data out of EHRs with a lot of standardization and harmonization of metrics and identification of where the data needs to go in the EHR to be able to build across providers and then across practices, not just to, I mean there's a value to feedback to the individual practice and provider and benchmark against each other and do lessons learned on how to improve areas, but if you take a step higher back, if you get enough practices and EHR submitting that data, then on a community-wide basis it's a very powerful to begin to understand what are your rates of different conditions, diseases, outcomes, improvements, etcetera. So it is a function of reporting, but I didn't want the use of it and the focus to be lost. We can put it back as long as we know that there is, from the uses point of view, that it's not just on the individual or provider level, but that it's very important to be able to do this.

**Paul Tang – Palo Alto Medical Foundation**

I think that's fair, but I think it's in a broader objective of reporting on populations. Okay we have a remaining few minutes. I just want to ask a couple questions. One is, is there any need for a further hearing on any specific topic in detail?

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

You know, Paul, it's Christine, the one that I think I am still perplexed by is the information exchange stuff, which is probably a mix of care coordination, which we did have, you know, people testify on that before, but I just feel like we've got a big gap there.

**Paul Tang – Palo Alto Medical Foundation**

Yes.

**W**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

And other request that we came up with ourselves was hearing more from the strugglers.

**W**

Yes.

**George Hripcsak – Columbia University NYC**

Paul, George. I'm sorry to raise this issue but we should just, and the specialist subgroup maybe should look at this first and see if it's worth discussing further, but since Stage 3 could be three and a half years off or four years off at this point, is there time to do anything related to imaging by then, and if we think there's anything worth doing in a 4-year time scale for imaging that might be a hearing if we decide to go further.

**Paul Tang – Palo Alto Medical Foundation**

So how about if the specialist small group work on this question. We have had a number of hearings including on imaging and let's try to distill all that and figure out what's the question which remains. I think we're sort of looking for what it is, is it to make sure that you can access patient specific imaging data or at least the reports via the EHR? Are they asking for a...system to be in every hospital? If we can get down to the options to discuss more concretely, maybe that would be useful.

**George Hripcsak – Columbia University NYC**

Okay.

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

Paul and George, this is Mary Jo. I'd like to let you know that at the Standards Committee meeting in December, they're going to be looking at imaging standards issues.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

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

So they're going to be teeing up sort of a parallel track.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Can someone come back and report that to us maybe? To the specialist committee perhaps? Whoever is organizing that?

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

I mean, I would be happy to try to report to you myself, but I suspect you would really like one of your members to be listening in?

**Paul Tang – Palo Alto Medical Foundation**

So if someone could summarize what their thoughts are from that as a result of that, whatever it is, panel.

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

Right it will be a panel and it will only be a virtual meeting, so.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

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

And its 9:00 to 1:00 and right now the exact time of the panel isn't set.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

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

And it will be on December 14th.

**Paul Tang – Palo Alto Medical Foundation**

Okay and so maybe one of the specialists' small group members could attend and report. Okay. Anything else before we open for public comments?

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Yeah, this is Amy. I don't know if everyone saw the e-mail from Jess Kahn, and I don't know whether we consider this sort of specialist because it's really kind of primary care from a pediatric point of view, but she had some comments about CQMs related to pediatrics and prenatal but she couldn't be on the call. So I think we all have an e-mail. I just didn't want to ignore her e-mail.

**Paul Tang – Palo Alto Medical Foundation**

Okay. I don't think I've seen that, but.

**Amy Zimmerman – Rhode Island Department of Health & Human Services**

Most of what she is saying is if you look at the quality measures, you know, Medicaid is a significant payer and we have a lot of quality measures with gaps in pediatrics and maternity care which is really specific to the Medicaid population in particular. And I wasn't sure if that was actually a Meaningful Use issue, Quality Measurement Workgroup issue for David or for the subgroup of this group. I just wanted to put it out there, so.

**Paul Tang – Palo Alto Medical Foundation**

Okay.

**W**

And then Paul, you know, this is a half-baked thought, but I think we ought to give some more thought to it, but as I think about, you know, Stage 3, it feels a little bit momentous to me and I just wonder if we ought to gather information in hearing or some other format from folks who will step back, look at the big picture and talk about, okay, if we're trying to get to a patient centered healthcare system that meets the three-part aim, where are the gaps? Like, are we doing enough on cost for example that's going to help bring down costs? And actually imaging is probably something that would fit into that rubric as well, but just sort of stepping back and saying, at some point in the next year, based on what is in Stage 1 and taking into account what's in Stage 2, what's the big picture for Stage 3 in terms of the

really high impact things that technology can enable?

**Paul Tang – Palo Alto Medical Foundation**

That sounds worthwhile.

**W**

I'm sorry. I couldn't hear that.

**Paul Tang – Palo Alto Medical Foundation**

That sounds worthwhile. Okay. We only have a couple minutes. If we could open for public comment before the close.

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

And Paul, I would like to tell the committee that your next meeting is on the 15th of December between 10:00 and 12:00 and an invitation was sent, so it should be on your calendars.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Thank you.

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

Operator, would you open the lines for public comment?

**Caitlin Collins – Altarum Institute**

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

**Paul Tang – Palo Alto Medical Foundation**

Okay. Anything operator?

**Caitlin Collins – Altarum Institute**

We have no comments at this time.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Thank you and thank you all for joining this call and happy Turkey Day to you all before we see you both at the Policy Committee and the next call. Appreciate all of your time.

**M**

Take care.

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

Thanks, Paul.

**Paul Tang – Palo Alto Medical Foundation**

Bye-bye.

## **Public Comment Received During the Meeting**

1. Cross-cutting may be difficult for those EPs that don't usually have significant patient contact (e.g. pathologists).