

HIT Meaningful Use Workgroup
Draft Transcript
November 23, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to the HIT Policy Committee's Meaningful Use Workgroup. This call will run from 9:00 to 11:30 a.m. Eastern time. This is a Federal Advisory Committee, so there will be opportunity at the end of the call for the public to make comment, and a reminder, please for the members to identify yourself when speaking.

Let me do a quick roll call. Paul Tang?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

George Hripcsak?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Bates?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Neil Calman? I know he's on. Art Davidson?

Neil Calman – Institute for Family Health – President & Cofounder

I'm here, I'm here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, there you are. Art Davidson?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Lansky?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Charlene Underwood?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Latanya Sweeney? Michael Barr? Jim Figge? Marty Fattig? Joe Francis? Judy Murphy is on.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anyone off? Okay, I'll turn it over to Dr. Tang.

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

Thank you very much, and thank you for all the members that are joining. It's difficult to schedule time when absolutely everybody is here, but we certainly have a lot of members here today. I also want to welcome a new member to our workgroup, Judy Murphy. Judy, do you want to introduce yourself?

Judy Murphy – Aurora Healthcare – Vice President of Applications

Thanks for the opportunity. My day job is Vice President of Information Services at Aurora Healthcare. I'm a nurse by background and have been doing electronic health record implementations for about 25 years before they were even called that. We called them just a plain old clinical information system. I am a member of the HIT Standard's Committee and co-chair of the Implementation Workgroup on that team.

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

So I think Judy represents a number of perspectives, one is the hospital perspective, another is the nursing, and a third is the tie in with the standards group where we try to send things over the wall, but it's to get certified. So welcome to Judy.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Thanks, Paul.

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

Today's agenda is the continuation of our last call, and we are marching through, not at a fast pace, but hopefully we've built up some steam, the various categories for our meaningful use criteria. As you recall, we're doing this on the way to putting out something for public comment, probably in the January timeframe. We'll have a number of opportunities for both the public and others to comment as we go towards an ultimate recommendation to the full committee and on to ONC and CMS in the summer timeframe of 2011.

As you recall, the reason it's pushed out to that point is we did want to benefit from an update on how things are going out in the field. It's a combination of the submissions that the earliest they can come in is in April, as well as feedback from the RECs. So we're going to try to get as much feedback as possible before we go on to stage two, while trying to get recommendations at least out as quickly as possible so that CMS can work on the stage two rulemaking process.

Today, we're going to work specifically on trying to finish up category one. If we do have time, it does go for two and a half hours, we may start on category two. As you all know that we have a face-to-face in

Washington on December 3rd where we'll have to finish up all of this so that we can present back to the full committee in the December meeting. What I thought I'd do is sort of recap some of the assumptions that we worked through last time. Yes?

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

Excuse me one second, I just wanted to check, Katelyn, are you able to grab my screen now, because if we do it from the beginning, it'll be the easiest? I pushed share, I'm on a different computer, I did everything, you've got it, or no?

Katelyn

I actually, I see you doing it.

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

Do you guys see the spreadsheets?

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

Right now it's just grey.

Katelyn

It looks like it's loading. You chose allow application?

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

Yes, I clicked all the options it would let me allow. I'll try again.

Katelyn

Yes, let's give it a second, and if not, I will go ahead and throw it up here.

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

Okay, all right, I tried, that was the second computer.

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

Okay, let me continue, so—

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

Just go ahead, sorry, Paul, thanks.

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

Sure. Some of the high-level working principles we agreed on, and let me just check these out before we begin our work, but it seemed to get us on a roll in terms of clarity. So one is we honor the principle of parsimony. I think there's a couple things, one is, you want to be clear and crisp and as few as possible of just thinking that every time there's a criteria, there's something that has to be certified, there's something that has to be verified, there's something that may have to be audited. There's a cost to each one of these things, so we want to do the minimum necessary, but our principle was to use exemplars to try to exercise the system. So we're not trying to predict everything that you might want to use an EHR for, but we want to have some core capabilities that an EHR can do to help you in measuring and improve outcomes.

With that said, people have talked about we don't want to have just we'll add another one here and another one over there. In the spirit of the season, not be like Christmas like decorating a tree, we really want to have very meaningful criteria that uses the exemplar approach rather than the 500 measure approach.

The second principle we talked about is using these criteria as a floor. By that we mean, not to be minimalist about it, but let's not prescribe that everybody be at some very high level. There's a certain amount of floor by which everybody has to reach a certain kind of functionality in order for the entire

system to work. So everybody has to be able to understand a diagnosis and the problem list. They have to understand and talk about the same medications, etc.

The things that are required let's say for health information exchange that everybody has to do, like the fax machines so that the information can flow and be understood, while not shooting for the sky, meaning that everybody has to be at the very high level. Another good reason for that is, not only to be prescriptive about the highest level, but also it constrains innovation. So we want to have a floor so that we can exchange data, yet we want people to be able to innovate and create new solutions that contribute to patient care and health.

The other thing we agreed to was if we want to shoot for 2015, which is the limit for the statutory incentive program, but if we can't get to that floor we're searching for by 2015, we gave ourselves the option of saying, "You know what, we may not make it in 2015, but it probably is reachable by 2017 or 2020, whatever it is." We gave ourselves sort of a time horizon parking lot where we could say, just give an indication to the country that here's where we're shooting for even if we can't make it by 2015. So we gave ourselves that sort of out as part of the ability to signal where we headed the trajectory, the roadmap.

There's a concept we talked about, and we may want to manifest it in the following way; the concept we talked about is should you be able to "test out" in a certain way? In other words, we've always been targeting the improved outcomes and we also didn't want to constrain or restrict people the approach to getting there, while taking advantage of this useful tool, the EHR or the PHR. On the way there, a lot of the criteria we have are processes. We'd like to, if someone is already achieving good outcomes while using this tool, we don't want to penalize them by having to report on all these process measures that they're satisfying.

So the concept was, are there ways when you reach some kind of high-level performance or full performance, that you shouldn't, well, a good question is, should you have to check all of your work in the process to getting there? That's just an open question for discussion, but one possible way of handling that is, if there is something where we can imagine a quality measure being able to capture the fact that you do have systems in place to reach good outcomes, should we have an ability to "test out" of the process measures.

I'll make one more comment and then I want to pause for discussion. We've used thresholds in a way, whether its 30% or 60% or 90%, and our purpose in defining these numbers is more to give an indication and be open for comment, than to say that that's the final word. So I'm just sort of throwing that out as a commentary on these numbers. So we don't have to be real precise, we can sort of get an idea that it's the vast majority or a few or somewhere in the middle. Let me open it up for discussion of those minor selections of the assumptions that where we agreed on last call, and we'll use assumptions that we agree on after discussion to proceed. Does it sound like what we agreed on?

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

I'm not going to disagree, but we got a little bit of feedback, and I don't know how we factor this into the principles. But as we set the thresholds because they're vague, there's a number that like it, and the feedback we were getting are from different parties was that you start to hit like 90%, if we go up there, that's when you start to hit the boundary cases, the things that are just going to be opt out or hard to manage and that type of thing. I just wanted to reinforce that concept of this is the lower bound threshold, because I think we can achieve a lot with that. But as we start to like hit that 90% one, then it starts to edge into a lot of those boundary cases, which makes it really complex to automate.

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

Okay. It's a bit like quality measures where you can find plenty of exceptions, but is the cost actually of measuring these things is really the cost of going to get the exceptions, so that's the same principle. Other comments about parsimony, floor, future horizon, and high performance test out.

Neil Calman – Institute for Family Health – President & Cofounder

I have a question actually on the high performance test out piece, which is whether or not it actually meets the definition for meaningful use, which is that you're supposed to be achieving these things through health information technology. So there's some people possibly even before they implemented electronic health records that they could achieve certain kinds of outcome measures. I know from a clinical point of view, who cares, but I just have a question about whether or not that actually is accomplishing what we're seeking to accomplish?

The reason I say that is because it's actually the incorporation of some of the practices into the electronic technology that sort of make these more permanent changes within systems, i.e., so it's not a couple of doctors doing really well with their diabetes management. The next crew that comes along has built in decision supports and other tools that enable them to achieve those results perhaps. So I guess, we just need to be careful there. Although, I totally agree with you that there should be some mechanism, I just think we need to call out that it needs to be technologically driven.

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

That's fair.

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

I don't think it does need to be technologically driven. If somebody really can get to very high levels of performance without the technology, I'd just say congratulations and let's move on. I don't think there will be very many of those, but I think it will help diffuse a lot of kind of community onyx. So I think it wins us points and we don't really lose anything, because those practices are already at the end that we wanted to achieve anyway.

Neil Calman – Institute for Family Health – President & Cofounder

I think we're going to end up in never-never land if we do that, because basically, people are going to start saying about everything, "Well, why should I have to do a physician order entry? We've studied medical errors in the frontend of our system and we have almost zero order errors in our hospital system." Well, that's just great, but that's not what meaningful use of health information technology is designed to provide incentives to do.

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

Yes, I would add, I think on Neil's side, the functional requirements that we're developing here are meant to be sustainable functions, that are things that can be applied to a variety of circumstances overtime and as complexity increases. If we have clinical decision support for example of various kinds, then the providers have the ability to continuously apply more intelligence to increasing complexity in the clinical environment. While I think we have the clinical measures side of this to capture performance and outcomes, and there's another debate worth having over there.

On the functional side, I would think we would want to highlight functions which lead to durable improvements and capacity, and not sub-optimize them for any specific indicator that we might think of today. Does that make sense, Paul?

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

Yes, and I think those are really good points. We certainly don't want people to teach the task to maximize any given selective exemplar, and not have, as you referred to David, the core capabilities to work on any clinical outcome. Okay, so I—

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I would just add, when I was first listening to this part of the discussion I thought, there's an argument that says that you could like say if you pass 80% of all the functional requirements on a hundred percent of the quality measures, it's probably okay that you missed the mark on 20%, that's sort of how I was thinking about what David Bates just said. But as I'm thinking more and listening to Neil and David Lansky, I agree with this notion of sustainability and just the basic core functions.

I also think, two things, one is if we're doing the job of parsimony, this shouldn't be an issue; and that secondly, there are many of these capabilities where if you think about it in an isolated environment, doing order entry for example or electronic lab results, that we might say later, "Okay, well, those are functions that are important, but if you're hitting quality measures, you're figuring out how to do it." Except when I think about a broader environment of information exchange where that stuff does need to be in the system in order for other providers or a private care team to do the best job that they can for a patient. So I think I'm with David Lansky and Neil on this in the end, which is to say I'm not sure that that high performance principle is the right one, particularly if we're doing a good job with parsimony.

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

I think that's another added dimension, Christine, that's a good point. Even if you were able to manage lots of things let's say on paper, not having it available to other care providers outside of your organization or the patients would be a deficit.

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

Paul, this is George, there may be a difference between incentives and penalties. So a high performance system, does it need the incentive if it's not using EHRs, but maybe it shouldn't be getting the penalties? If it's for achieving high performance, why are you penalizing them, but do you really need the incentives to achieve something that they've already achieved. There may be a difference between how you treat the incentives than how you treat the penalties in this regard.

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

Okay, I think this has been a good discussion, it raised key points on both sides. What I propose is if we stumble across one where we say, "Wow, this could be one where you'd want to test out," we could try to identify it and apply the points that were just raised. So we'll keep that as an option, but it may not be one that we find a good use case for.

Alright, so where we left off, we had finished CPOE last time and drug/drug interaction, and the next row on our metrics is E-Prescribing. On stage one, I think it's set at 40%, and we had put stage three as 90%, and then stage two as 60%. Any comment on that draft? As you know we've gone through all of these once before and now we're doing a little bit of a once over and applying some of our principles.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I have a question, which is as I recall the discussion around this one, we were wondering what the latest status is of the DEA rule that would permit E-Prescribing of controlled substances. I'm sad to say that I haven't gone and looked at it independently, but I'm wondering if maybe staff or anybody else has.

Josh Seidman – ONC

I can look into that, I do not have the answer.

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

Actually, it's not out yet.

Christine Bechtel – National Partnership for Women & Families – VP

What? I think it was out, so that's why I was wondering.

Deven McGraw – Center for Democracy & Technology – Director

I thought it was out and implemented in 2011, but we should confirm that.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I'm okay with these thresholds, but as a double check, we should make sure we know what's happening.

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

Right. So the effect on that would be changing the percent, because controlled substance are something like 10% or 15%. So we'd obviously want to adjust the percents in the thresholds if it isn't up yet. Okay, so that can be a placeholder, sort of a parking lot, something to follow up on.

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

What setting are we in? Are we talking about both settings in patient

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

EP for provider outpatient.

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

Okay.

Christine Bechtel – National Partnership for Women & Families – VP

This I think—

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

Well, I noticed—

Neil Calman – Institute for Family Health – President & Cofounder

If the DEA thing is an issue, we're going to have to look at, we should just park the issue of the fact that there will be certain providers that for whom controlled substance is way over 10%.

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

Right.

Neil Calman – Institute for Family Health – President & Cofounder

People in chronic pain—

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

Oncology, right.

Neil Calman – Institute for Family Health – President & Cofounder

—or things in oncology and other stuff, so we're going to need to figure that out if that's an issue.

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

Right.

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

This is one that will be tricky for the primary care providers versus the specialists. We just looked at it for our network and we're at 97% for the PCPs, and about 20% for the specialists.

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

What underlies that?

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

I think that they just are later to the party, but I anticipate some complaining about this.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I hear that. But I also keep getting push back from specialties saying, not a lot of the criteria apply to me, and so here's one that actually would. I think it's okay to ask for more progress, given even if their baseline is less.

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

I think so, too. Whoever made the point in the beginning, Neil, so some of the pain docs for example, which could be a very large proportion of their prescriptions.

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

Okay. I assume, George, you're capturing this even though we're not seeing your screen, right?

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

I'm actually checking with, I thought Katelyn was going to write down what we actually write, and I'm going to double check it.

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

Okay.

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

So we'll do it in parallel.

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

Okay. So Katelyn, are you editing, so this is something that would appear in the comments column.

Katelyn

Just let me know what you want to edit and I'll go ahead and do that for you.

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

Okay, so in the comments here, we need to check on the status of DEA controlled substance and eRx, and a question mark, different penetrates in specialty care.

Marty Fattig – Nemaha County Hospital – CEO

Hey, Paul, I am sorry I'm late, but I did want to let you know I'm on the call.

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

Thank you, Marty. Okay—

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

Paul, this is one of those places where the feedback was, those cases where we've got integrated pharmacies, hardware that's not there, all that kind of scenario for 2015, and I don't know the specialties where that 90% threshold kind of brings a lot of those situations, the controlled drugs out. So again, I think this is one where we might reconsider that threshold, I see it at 90%. I know we had a lot of feedback when we hit it high the first time through, because of some of the boundary condition challenges as opposed to the capability.

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

Katelyn, it's eRx like in stage three, it's a small E and capital R, yes. Okay, good point, Charlene. Why don't we go ahead and deal with that topic, since that will come up over and over again, and it's a fair topic. Is 90% too close to the boundary cases and invokes all of the specialty, except in handling for checking qualifying you against the criteria, so is 90% the right number?

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

I think it's a good number. We've just looked at it in our network and we have been able to get to that; although, it's taking a lot of time in getting people up.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, the other thing I would say is just reminding us that this is the document that we are asking for public comment on. So I'd rather leave in these types of things and maybe Katelyn could make a note of any specific questions that we have that we want to make sure we get some feedback on.

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

Okay. What we could do is ask for specific comments about the threshold number and the counter proposal instead of just the complaint about the number. We'll try to find what that sweet spot is.

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

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

Our intention is capturing everyone without burdening on the boundary conditions. Good, okay, row 13 is the demographics, and this is to help us understand the disparities in healthcare and then target things for improving upon the disparities that is reducing them, working towards eliminating. Here we have 90% and 80%, which is an increase from the 50% in stage one. Any comments versus the same kind of question?

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

I think it's fine.

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

Yes, I think it's fine, too.

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

Good. Row 14 is, let's see here, this is the reporting of the key one measures electronically. I don't know that there's anything we have to do about that. I think CMS basically determines when you have to do that and they're anticipating in 2012 actually.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I don't love the idea of stage two is blank.

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

See, I don't know what we meant by that.

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

Yes, I don't remember.

Christine Bechtel – National Partnership for Women & Families – VP

I think we were saying we were going to wait for some signal from the Quality Measures Workgroup. We were thinking through these issues with the mechanism whether you send it to CMS directly from the EHR, kind of akin to PQRI registry reporting or whether you could use a third party like an HIE or something else. But I think that probably we should signal something for stage two that we're looking for 60% or something like that.

Neil Calman – Institute for Family Health – President & Cofounder

I think the other issue was that we weren't sure that CMS would be ready to accept measures reported electronically.

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

This was something else. This was some extra thing, not just reporting your meaningful use quality measures to CMS, which is scheduled for 2012. Because look, we say maybe redundant with quality reports themselves. We were thinking of something else, but I cannot recover what that was.

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

I mean, CQM stands for this clinical quality measure, would it be fair for us to just defer to CMS for all stages.

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

Yes.

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

Because they right now have a very aggressive goal, which is to be able to receive these in 2012. If we meet that, that's great, but it's really going to be dependent on whatever they can do, their systems can do.

Christine Bechtel – National Partnership for Women & Families – VP

The only reservation I have about that, you'll be surprise to know it's Christine again, is two things, one is, the capability needs to exist and be in the pipeline and so I'm not sure where that's at today. But I don't want to not be feeding the certification, develop the pipeline; and the second thing is, these systems need, particularly as we think about the broader environment of reform in ACOs and different delivery models and all these multi-payer demonstration projects, that CMS is going to test and hopefully expand. These systems have to have the capability to report electronically whether that's to CMS or to a different kind of initiative, like the private payer initiative or a multi-payer initiative.

So I'm a little bit concerned about not having something in here that gives these systems the ability to do it, whether or not CMS can receive it, they will fix that of course. I mean, they will say, because this isn't the rule obviously, so they will say, we don't want to do this because we're not ready or we do because we are whatever. I think we ought to leave that to them and still signal that the systems need to develop that.

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

I'd rather leave something in here too for the same reasons.

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

I'm with you.

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

So you want to just copy stage three into stage two then.

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

Yes or we can make it a little lower threshold like 80% or something.

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

The challenge at least on the hospital side is there's just not an alignment between what hospitals have to report today and what they have to do in their measures. So the consistent feedback we're getting and maybe you make this future state, is like they have to align with CMS. This is the policy piece, it needs to align what hospitals report today with what they have to report electronically, and they shouldn't be two separate streams. So we would hope we'd see that sooner rather than later. So I don't know if we could put that in as, this is electronic, but that's the push back and feedback we're getting.

Christine Bechtel – National Partnership for Women & Families – VP

We could signal, we could still have the threshold be 80% or whatever, but then also signal and ask for comment or whatever in the RFI, that we hope that there will be good alignment between the measures that are part of other public reporting programs than the measures that are part of meaningful use. I mean that's part of what the Quality Measures Workgroup and the interagency taskforce at HHS is looking at, are ways to streamline and align. But there won't be electronic clinical quality measures for everything that hospitals need to report anyway. So I think this is a way that we say report as much as you can of your other ... or whatever measures electronically, but we've got to have these systems be capable to do that, so that the burden does decrease overtime as the alignment grows.

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

Yes, because the feedback for today's measures, even though there's ways to think through that's starting to automate the capture of those. So it would have been a nice place to start.

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

I think there's another layer of this one that we should parts out somehow, which is the export of data that will be used to compute measures. In particular, as we start getting to the care coordination measures

and the cross setting measures of various kinds, readmissions and so on, we're going to have an expectation that there's some intermediate aggregate of whether it's an HIE or somebody else that is looking at multisource data.

So back to Christine's earlier point, part of what we want to do is have the expectation to the vendors and the providers that they have a capability in house of computing some of the measures that are very setting specific. But they also have to have the capability of transmitting data which will be used to populate a measure, like an example of ACOs or other vehicles, that could be exporting to registries and we also have an unfinished conversation about registries and longitude and electives or it could be to some aggregate or complication, etc.

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

So George, I hope you're capturing this, because it's a little bit hard to put on the screen. So there's a couple of major points I heard, one is, CMS is really determining whether these specific measures as part of meaningful use or whether they're capable of receiving these electronically; but two, that we need this capability anyway for organizations to be able to share this kind of information with others, other trading partners, whether it's the setting of ACO or other measurement, so that it's a requirement for the EHRs.

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

Okay, I'll just point out one thing, here we are talking about parsimony, and wherever we can lean towards outcome measures, and the one place that's actually about quality measures, we're going to have a functional measure for it. So I don't know, I mean, so I agree with the comments, but I don't know what to put under stage two and stage three. Like if we're not going to have parsimony here, where are we going to have parsimony?

But I guess, it's about how you report and I guess that's why we said that's really CMS' job. We can't actually recover what we were thinking of when we wrote this, because I can tell by the old comment that we still have this as not necessarily redundant with what CMS is already doing. That maybe what David was just talking about with trade partners.

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

I think this trading partner thing, that's our contribution. Because the statute even talks about, one, CMS' ability to receive this, but also CMS' responsibility to have it aligned or at least reconciled with their other programs like PQRI, etc. So that's actually built into the statute, and I know that's their intention. We don't want to be duplicative with what's already there, but our additional contribution is, yes, this information is important to transmit to the administrators of meaningful use, but also as part of the care process, the core care coordination.

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

Paul, I'm thinking, George is making a point I like, which is we have the benefit of parsimony if we defer to the quality measures. If the quality measures are in place that require this kind of data to be available for whoever is enforcing the quality measures, then we don't actually have to specify a functional requirement. It's implicit in the obligation to produce a quality measure, so to the extreme, parsimony, to just be silent on this, because we know it's going to be implied by an external requirement.

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

Yes, I totally agree with that. I think we're almost making an annotation that says, don't forget the other uses of it—

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

Yes.

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

—as part of care, not just qualified for meaningful use. Hopefully, it's not in addition, it's a commentary.

Josh Seidman – ONC

I'll just point out that in line 13, that it's also implicit in that, that if you can produce stratified quality reports.

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

Yes.

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

Paul, I have a question, we're talking about all this data being reported to CMS, what about will the state's Medicaid agencies be receiving any of this data?

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

No, that's correct, every time we say Medicare, although Medicare is going to be the majority of the incentive program, we should be adding that for Medicaid, the states receiving agency.

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

So what do we put down under stage two and three? Remember in stage one we're saying it reports CQM electronically as the objective is what we have listed here in the final rule. Is that what the final rule does or do I just leave it implicit? I've got to double check. We have to put something down here.

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

I think of it as a commentary, is that fit other people's after hearing the discussion? It's a combination of the quality measures will exercise this, as well as CMS and the state's ability to assess whether you qualify for meaningful use, but our commentary is that this is important for care coordination.

Marty Fattig – Nemaha County Hospital – CEO

Yes, if I might ask, what's the requirements for a certification of an EHR? Because if you have to be able to submit all measures to be certified, you're going to be submitting all measures anyway.

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

I agree, I think, is someone familiar enough with the details of the certification? This should be already in there for stage one.

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

I would call it just—

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

I have a comment, in stage one, we have to demonstrate that we can produce the reports for each of the 15 measures on the hospital side, as well as the ambulatory side. We have to show that we can enter something in the system and actually create a measure that reflects that.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes, that's correct. You have to be able to run the reports and know what your numerators and denominators are, but you will not be submitting that information in 2011.

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

So I think that means that the EHRs need to be capable, which is one of our goals here.

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

Yes, that's where I was headed, yes.

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

I still think this is more a commentary and that we should not be duplicative with what's already happening.

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

Yes, I would concur with that as well.

Christine Bechtel – National Partnership for Women & Families – VP

So Paul, can you repeat the proposal?

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

The proposal is that we comment that in addition to the requirements for qualifying for meaningful use that is submitting quality measures electronically, that these data are important for care coordination at the provider level.

Christine Bechtel – National Partnership for Women & Families – VP

But we would eliminate the reports CQM electronically?

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

Well, it's almost not even part of—

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

It's already a requirement to the program.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

That would not be the duplicative part.

Christine Bechtel – National Partnership for Women & Families – VP

I know, I get that, but then I thought I just heard somebody else say that it's attestation again in 2011.

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

Well, that's true, but David's already signaled that they tend to be received as electronically by 2012. So in the EHRs, the capabilities are already required to be certified in 2011.

Christine Bechtel – National Partnership for Women & Families – VP

Alright, I got you. Alright, that makes sense.

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

Actually it's not a signal, it's actually a mandate, because it's not stage two, that's stage one. So we just leave the objective the same—

Christine Bechtel – National Partnership for Women & Families – VP

Oh, yes, right.

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

—because it actually doesn't quantify the percent, you just have to do it, so we're not changing it I guess in effect. But CMS is willing to, they can do it however they want to do it. The 90% doesn't make any sense to me. I don't know what, it's supposed to be 100% now, so why are we dropping to 90%?

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

So I think again, it's already a requirement almost

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

Yes, yes, yes.

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

—to the statute. Let's just comment that it's not just used in fulfilling the meaningful use criteria.

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

Okay, good.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Okay. We need to move on, I'm going to try to move us on, because otherwise we'll never finish. Row 15 is the problem list, and here the concept at least is to have up-to-date problem lists. The current stage one is, have one or none. So it's a fair reach to get up there. But our goal originally with our original metrics was to have up-to-date problem lists, because that's what's useful to clinicians and patients. So our stage three then milestone was 80%, we just picked the number, 80%, problem lists up-to-date. Does that still stand with people?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Who's going to define this?

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

Yes, we already had that argument in our last comment.

Christine Bechtel – National Partnership for Women & Families – VP

Maybe that's something that we ask for public comment on.

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

I mean, I've done as much research on this as anybody—

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

—and I have no clue how we would define it. You can see when the last edits were made, you can see whether certain problems are there.

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

We do have a manual way that we used to do this, which is, it was part of peer review. So when you come up for peer review, one of the things you had was five of your charts randomly selected, and a peer reviewer is to look at the medical chart and see how complete is the problem list. So it is possible to do and potentially that's one of these and you could be audited for that. But obviously, everybody agrees that this is one, problem list diagnoses are key pieces of information, both for use in clinical care and for driving decision support. Even if it has to be an audited sample, we need to see how people can achieve that up-to-date status.

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

Paul, I had a couple other comments on this one, too, in terms of David's question. One suggestion, and again, this up-to-date, and this is just a process measure that it was reviewed at least once during the reporting period. So again, it's an actually process measure that can be captured in the system.

Another suggestion was to think through a little bit and maybe we link this care management or care coordination, was that we think about the process of medication reconciliation. You can also think about a process of problem list reconciliation. So as we're starting to inborn the different documents, continuity of care document or whichever one it is, it contains a problem. There's going to have to be a process in

the system to reconcile that problem list. Si there was also a recommendation to think about it in the context of a problem list reconciliation function similar to medication reconciliation function—

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

Yes.

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

—as we're kind of thinking this through. So those were the two pieces of and trying to figure out what up-to-date meant, research that I collected.

Neil Calman – Institute for Family Health – President & Cofounder

I think that's really a great idea. It deals with a couple of concerns I have about this issue as well, which is that there's all kinds of encounters people have now with patients, office visit encounters and telephone encounters and electronic encounters. And up-to-date as of what, as of the last office visit, as of the last time you had a telephone encounter with a patient? So I think there's a lot of parallels between this and the medication reconciliation. I think we need to call out what we mean by up-to-date. I think we need to be as clear as we can about this. So whether we're talking about up-to-date as of the last face-to-face visit with the patient, then I think you have a process where a problem list reconciliation really does make sense.

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

I like the concept, too. Problem lists are so key to care and the finished report.

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

Yes, this is a very helpful discussion for me, this is David Bates.

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

I think we can have a small group go offline and try to incorporate these into something more precise. I think we do have to be concrete. But the notion, the concept we're introducing, and hopefully we're introducing it in stage two, is the notion of up-to-date, and we have to define that. But right now, having one or none it harkens back to the days when it was just something you did and had nothing to do with improving care.

Neil Calman – Institute for Family Health – President & Cofounder

But we might want to just completely change the title of this, just like we did with the meds. Basically, what we're calling out is the need for a problem list reconciliation.

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

Are there a few of us that would volunteer on trying to create the definition, one, what's the problem list, and two, what's up-to-date?

Neil Calman – Institute for Family Health – President & Cofounder

I'd be willing to work on that as long as somebody else coordinates the call.

Judy Sparrow – Office of the National Coordinator – Executive Director

I can coordinate the call.

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

I'm willing to work on it, too.

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

Yes, I am, too.

Judy Sparrow – Office of the National Coordinator – Executive Director

Who was that last person?

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

David Bates.

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

David Bates.

Judy Sparrow – Office of the National Coordinator – Executive Director

Okay, the three of you?

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

Yes, this is really important. Okay—

Judy Murphy – Aurora Healthcare – Vice President of Applications

Just a quick comment, we may want to consider making that multidisciplinary or calling it out as multidisciplinary with that word as well.

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

So you volunteered?

Judy Murphy – Aurora Healthcare – Vice President of Applications

Sure.

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

Paul, I would be willing to work on that as well. I think that's an important part also of patient engagement, because when you talk about multidisciplinary—

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

Absolutely.

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

—then the patient and their caregivers should also be part of that reconciliation.

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

Absolutely. You can see how PHRs would help that.

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

Yes.

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

That they could even be designed to make it easy for that to happen, just like we're trying to get it easier to do med rec. Those are excellent points.

Neil Calman – Institute for Family Health – President & Cofounder

A great concept.

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

Yes, that's a great concept. Okay, let's move on to active med lists. We might have the same kinds of principles applying here. Now you recall in stage one, it's another one of those one or none kind of things. We need accurate up-to-date problem lists and med lists, it's just so key. There clearly is already a med reconciliation process that's even part of the accreditation programs. So how is the way we're stating it there and maybe we need the same group to work on the concept of what's up-to-date I guess?

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

Is the end here the patient or the med, so is it 80% of medications or 80% of patients have to have an up-to-date medication list? That's the way I would interpret that.

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

Yes.

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

That's the way it's written in stage one and we can let the small group also decide how to propose this, but stage one is 80% of patients.

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

Paul, I pondered on that one, this is where, this one med list, maintaining the med list, we're managing, like as you raise the bar to CPOE, where are we at in CPOE in that time period, like 80%? Then if you raise the bar there to effectively do CPOE on medication ordering, let alone the rest, you have to have an up-to-date med list. It's by the outcome of that process. So that was kind of the feedback we were getting.

If you've got med reconciliation and if you've got med list and you've got CPOE, you don't need all three of those, maybe you just need two of those to get to the outcome you're trying to get to on this particular one, not problem list, but this one is different, because of what we're doing.

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

So your proposal is not to have this?

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

I think you're going to get it as a by-product is what's going to happen, because to be able to receive CPOE, you have to have a med list.

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

Actually, Charlene, the other side of it is discontinuing and whether they're taking. There's a concept of one active from the point of view intent from provider, and the other is what the patient is taking. So there's a lot of concepts that are wrapped into this. It's not just was an ordered place.

Neil Calman – Institute for Family Health – President & Cofounder

Well, I think that's the point, if you do the order and you do the reconciliation, then you don't need this one, I think is the point Charlene is trying to make.

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

Yes.

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

This one also is brutal to define. I wouldn't define it the way we have defined it here. We might even want to talk about this with the same group that talks about problem lists.

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

Right.

Neil Calman – Institute for Family Health – President & Cofounder

I'd agree, let's do that.

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

That's my proposal is that we assign it back to the same group. So go back to this, it'll be a couple questions here, too, what's an active med list and what's up-to-date? Okay, let's see if we add another task to this group, which is row 17, the active med allergy list.

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

I think we should.

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

Yes.

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

I agree.

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

These are extraordinarily important items in there, so let's put a little thought in it. So the small group will report, gosh, we're going to have to, do we think we can actually report out in e-mail and get agreement before we present back to the full committee? Oh, no, we'll have it, so the small group needs to have this by our face-to-face on December 3rd.

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

Correct.

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

Okay. Is any member like David Bates want to take the lead, not the actual organization of the call, but the little group?

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

I'd rather not actually.

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

Another person?

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

Right now I'm struggling with care coordination as it is.

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

That's right, okay, so anybody else want to step forward?

Judy Murphy – Aurora Healthcare – Vice President of Applications

Paul, I could do it. As a new member I want to follow all the processes that you guys have already put in place.

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

I think it's sort of just organize, not

Judy Murphy – Aurora Healthcare – Vice President of Applications

Organize it, taking a pulse, etc., sure.

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

That's right, yes.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Judy Sparrow, you're setting it up, right?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, I will.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Thanks.

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

Great, thank you.

Judy Murphy – Aurora Healthcare – Vice President of Applications

I'll do it, yes.

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

Okay, number 18 is the vital signs, just to set the top out rate of 80%, and I figured that this should be early, same thing in stage two. There wasn't anything really preventing that.

Neil Calman – Institute for Family Health – President & Cofounder

What vital signs are we talking about? I think as we go forward, we're going to have to be more and more specific, talking about blood pressure, pulse, temperature, weight, what are we talking about?

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

BMI—

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

I think this is actually specified in the rule.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, height, weight, blood pressure, calculate and just the way of doing BMI, plot and display growth charts for children 2 to 20 including BMI.

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

Gosh, you're supposed to do height for adults every year is that what you're saying?

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

That's crazy, what?

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Well, we should have to do height after 65 when people start shrinking again.

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

Yes, but this is not the prescription of medical practice, this is sort of trying to get a floor.

Neil Calman – Institute for Family Health – President & Cofounder

No kidding.

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

Yes.

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

The bigger issue from my perspective is when it says 80% of patients, it should be the patients who are seen. What about, there are a very large proportion of patients who don't need to come in.

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

I think this is of seen, David.

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

Okay.

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

If somebody else knows the details, but I think this is of seen.

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

If it’s of seen I think it’s fine.

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

We might want to deal with this and record it during the reporting year. This might be our chance to comment on, and I don’t think that everybody should get a height every year.

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

I don’t know whether this is the right time, this is Art, but I know there’s an effort within the public health community to get temperature, as Neil said, I don’t think that was in stage one. They wanted to see that maybe in stage two or three.

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

Can we form another group that takes some of these details offline and reports on? So this is one of them, what were the vital signs and do we have a difference of opinion either on the frequency or what vital signs?

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

Actually, some of these vital signs we need to do CPOE, right? So some of them are by-product, at least the blood pressure and some of those. It probably should be part of that other group that you talked about would be my recommendation, because I think some of those things will fall out of that process because they all kind of interrelate.

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

Right now we have a problem list, med allergy group, I think this is a little bit separate. I don’t know that we want to essentially load all of these issues.

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

That’s something to achieve, also just capture it as a by-product and doing this ... not all of it, not all of it.

Neil Calman – Institute for Family Health – President & Cofounder

I think we could probably resolve this really quickly right now.

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

I think so, too.

Neil Calman – Institute for Family Health – President & Cofounder

We’re basically saying heights, once, adults; and the rest of it, I think the issue of temperature, we need to hear more from the public health folks.

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

Right. So let’s make sure and pulse annually.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I mean, that to me makes perfectly—

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

I think we have to look at the rule, because I’m digging through it now, and it’s hard because it’s the comment/response, comment/response, but so it does talk about seen by the EP or admitted to the eligible hospital. So I think some of this is just a question of digging back through the rule and making sure that those details are in there.

Neil Calman – Institute for Family Health – President & Cofounder

But I think annual for blood pressure and pulse make sense.

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

Yes, but on the other hand, well—

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

I think this is what—

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

It's not that it's just, that it's totally held hostage by my doctor for, because they want to see you every six months whether you want to or not.

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

Well, that's ridiculous.

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

I know it is, tell them that, but then they hijack your prescriptions, so anyway.

Neil Calman – Institute for Family Health – President & Cofounder

Oh, oh, oh, it's one of those.

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

Okay, so let's—

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

Oh, yes.

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

This is sort of why we're, can we just put it on a parking lot for right now, Katelyn, and we'll see if there's a group that can deal with some of these details. Okay, same thing with smoking status, now here's an issue, one of the issues is how often a smoking status should need to be recorded. Let's say for a nonsmoker, do you need to ask a nonsmoker every year whether they're smoking or not?

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I think, yes.

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

I think that's what ... for example has requested did.

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

I did get the final answer on vital signs. It is for more than 50% of all unique patients age 2 and over seen by the EP or admitted to the eligible hospital or community access hospital, inpatient or emergency department, claim service 21 or 23, height, weight, and blood pressure are recorded as structured data, that's the measure.

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

Does it say per year? It just says, well, I think that means recorded for that encounter.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes, I think it's each visit.

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, actually—

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

But it only has height, weight, blood pressure of recorded structured data, which leaves a question in my mind about calculate this blood BMI, and then growth chart. So anyway, so I think you're right, Paul, and I don't want to be relevant competition that there's a parking lot of sort of tidying up the details where a small group needs to figure out what the heck is in the rule and it should be the healthcare professionals doing that, because—

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

Correct.

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

Yes.

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

So let's do that so that we can have something to react to and decide on December 3rd. So smoking status are we okay with recording it each encounter?

Neil Calman – Institute for Family Health – President & Cofounder

No, that's ridiculous.

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

The comment, if you're going to say during the reporting period in the other one, the recommendation was that you also say during the reporting period. That doesn't say every encounter.

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

The implications, Charlene, that you can't predict the future. I'm positive this person will come in by this administratively determined reporting period. It turns into a de facto every encounter.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Paul, every encounter, I mean, just imagine sitting with a patient you've been caring for, for 14 years, who's never smoked and saying, check for their monthly blood pressure check, and saying, "Well, have you've started smoking since the last time I saw you last month?" I mean, we're getting kind of ridiculous with this. I think an annual update is probably more than adequate.

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

I agree.

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

Now wait, when you say annual update, implicitly that means checking every encounter, because you do not know when the next encounter will be.

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

The reason it's 90% is because you'll occasionally miss one because of that.

Neil Calman – Institute for Family Health – President & Cofounder

No, no, no, it's for people that have been in, in the past 12 months.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

That there's been at least one recording. So if somebody hasn't been in, in the last 12 months, they're not in the denominator.

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

That's right.

Neil Calman – Institute for Family Health – President & Cofounder

So basically for people who've been in, in the last 12 months, that there's been at least one recorded smoking history update, that's how I would put it. Therefore—

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

But then the patient, Neil, is that you would have had to ask every time.

Neil Calman – Institute for Family Health – President & Cofounder

No, you wouldn't.

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

What would make you not ask?

Neil Calman – Institute for Family Health – President & Cofounder

Having asked last month.

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

So you have to go through the process of knowing whether you asked this last month, whether you should ask this, this—

Neil Calman – Institute for Family Health – President & Cofounder

But that's exactly what I have done, the system will tell you when the last time the history was updated.

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

If it hasn't been updated in a year, you just go ahead and ask them.

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

Okay.

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

Guys, are you sure that the rule is saying that you have to do it every year, as opposed to you just have to make sure you've done it at some point in the past on everybody you've seen in the past year? Because I can't find what you're saying in the rule.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I think it might, wouldn't it be at whatever point in the stage?

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

It's in the core measure.

Christine Bechtel – National Partnership for Women & Families – VP

....

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

The definition is in the— From an evidence point of view, I don't know this number, but my guess is that the percent of adults, who have never smoked, who smoke later on in their life, I think is really very small.

Neil Calman – Institute for Family Health – President & Cofounder

It's very small. We did this study with the New York City Health Department in terms of planning a really well thought out decision support. There's all different risk periods, obviously for adolescents you would want to ask it every visit. For people who are recently stopped smoking, you would want to ask it every visit. But for people who are never smokers—

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

Right.

Neil Calman – Institute for Family Health – President & Cofounder

—the percentage of people who start smoking after that is infinitesimal.

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

Yes, I agree.

Neil Calman – Institute for Family Health – President & Cofounder

The measure is just the percent who have had a smoking status recorded, so it doesn't necessarily need to have been in that year.

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

Right, the measure is very short.

Neil Calman – Institute for Family Health – President & Cofounder

So why don't we just leave it the way it is, which is complex enough for most people and the change of behavior for a lot of people.

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

So wait a minute, are you sure, because I thought I did look that up, the core measure I think you had to have recorded something during that measurement year?

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

It just says that it has been recorded, not that, so it could have been—

Neil Calman – Institute for Family Health – President & Cofounder

Recorded previously.

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

Correct.

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

That would be fine, okay, I'll have to go check that again.

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

I don't know how CMS interprets it.

Neil Calman – Institute for Family Health – President & Cofounder

It says 80% of patients have smoking that's reported on our list. I think we should leave it that way, and we can come back and see how it's in the—

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

Okay, we can put that on the parking lot, just make a detailed check.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

Okay, good. Can you scroll down, put parking lot there, please, Katelyn, and then scroll down. Okay, so this is the one CDS rule, where we stood was to try to enumerate the types of CDS, which would turn that into requirements for the EHR systems, but not to prescribe one of this and one of that and that kind of thing, which it just seems like it restricts people's ability to get the job done. If you've seen the comment, it says basically, that's what we meant by certification insurers that the EHRs have the capabilities to prescribe CDS types.

Now, we have not defined and maybe this is a small group activity, what are the "CDS types?" I think people understand alert, they understand reminders, they understand drug/drug interaction. I had used the phrase coloring choices as an indicator. There are lots of ways you make doing the right thing obvious. It can be literally the way you color something in an order set for example or providing an asterisk. There's ways to indicate a preferred choice and that's what was meant there.

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

As you walk through certification, let's say you have two of those three types in your system and you can still help the provider accomplish it, would you have to be certified to all three or what are you thinking there, because there's multiple ways to do this as you suggested?

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

I think this is something we should come up with specific, and perhaps we can put a draft out there for public comment and get more input, but one goal would be something like you said, Charlene. So let's say we enumerate six CDS types and the EHR has to be certified to be able to do four of those six, let's say.

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

Okay, something like, yes.

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

Something like that.

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

Yes. If you want, I could work on that work, just the responses that apply.

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

That would be great, and I'm happy to help with that as well.

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

Okay, alright.

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

So wait, people like direction. Yes, Paul, but can you restate it again?

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

We would enumerate types of CDS'.

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

Right.

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

CDS approaches, and we would imagine that the certification requirement might read something like they fulfill four out of six, they'd have the capability in their system to do four of the six types, I'm just making that up. But there's a little bit of, one, we can't predict all of the kinds of ways you can do CDS; and two, any one system doesn't have to do everyone. But the fundamental approach is that we're prescribing that

we have capabilities of various sorts, not that you must use this kind of capability and that kind of capability.

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

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine
And what's an example of a type?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A drug/drug interaction, a health maintenance reminder, an alert, that's a little bit harder to define, but it's one of these "pop up" kinds of things. It could be drug disease, it could be drug—

David Bates – Brigham and Women’s Hospital – Chief, Div. Internal Medicine
So those are the categories, that was different than what I was thinking you were getting at.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, well, that's what I mean.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So we don't mean order set, reminder, whatever, I can't think of six of them?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, I think—

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

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Those are included. So order set—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But you're going into finer granularity than that. When you say six, do you mean you're separating drug/drug interaction from drug disease interaction reminder? Well, that has to be defined, let's put it that way.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, it has to be defined, that's exactly right. So we have to come up with something, and that's why this is another small group activity where it could be handed over to the standards committee to further define and incorporate in the certification criteria.

Marty Fattig – Nemaha County Hospital – CEO
I'd be happy to work on that with Charlene as well.

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

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

Christine Bechtel – National Partnership for Women & Families – VP
I don't want to complicate things, but my memory of this was maybe different than what I think I'm hearing, if I wasn't hearing wrong, and that was I think this was an area where we talked about local health systems sort of declaring what they're four priorities would be.

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Right? Or did I—

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

That's another aspect.

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

That's right.

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

We're trying to create the capabilities in the EHR system and that gives the local institution organization system the ability to say, here's what's important in our locale, and we're going to use, they get to choose what kinds of CDS approaches they want.

Christine Bechtel – National Partnership for Women & Families – VP

Alright, great, sorry. I must not have followed that part of the conversation.

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

Again, the feedback kind of from the people looking at this, early feedback, they actually liked this one, they liked to define their own. They just feel like it will be an application, someone needs the certification tools, but you need an application process, I forgot which one.

Christine Bechtel – National Partnership for Women & Families – VP

I think actually, it might be interesting to think about ways to link this to performance on quality measures, so if they choose a ... a high priority condition that they're going to do alerts and reminders around to see then what their performance data might look like with respect to that would be interesting.

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

One of the things we talked about is using the national quality strategy output, which I think is due in January as a way to define what "high priority" conditions.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. I think actually at the local level, they may have a natural incentive to pull from that as well.

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

Correct.

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

So wait a minute, what are high priority conditions as opposed to quality measures that the Quality Measures Workgroup decides are high priority and the differences?

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

There's some conditions for which this has already been shown to work. It works for diabetes, it works for coronary disease, it doesn't work for asthma or congestive heart failure so far. So that's what I thought we were saying.

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

That's correct, that would be "HIT" sensitive characteristics. So I think in the end, ...

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

There a lot of quality measures that are not H— Alright, anyway go ahead. It probably should be quality measure otherwise.

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

Yes, I think that's sort of the point I was just about to make and asking David Lansky as co-chair of that group, there's a concept of HIT enabled that is, this helps you do this to measure this, and there's a concept of HIT sensitive. The HIT sensitive means there's evidence that the use of HIT, and particularly CDS, enables you to improve your performance on a particular quality measure. So I think that the Quality Measure Workgroup is working towards measures that fit that HIT sensitive attribute. Is that right, David Lansky?

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

Yes. But we had so far punted on the question of condition specific measures after they were recommended by the NQF Gretzky Group report. We have not really come back to that question.

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

So the high priority conditions, we're waiting for a couple things, one is, the national quality strategy from HHS; and two, the quality measure that is presumably HIT sensitive. That would be a good measure for that. Are we good on this now?

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

Yes.

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

I think that we're good with it, okay. The next one is implement drug formulary checks.

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

Paul, I've got to know what to write down. So what's already there under stage three is that then correct? I don't know where to put it.

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

I think so. Yes, I think it is.

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

I think in stage two is the same thing, only you want to number them as four?

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

Okay, let's ask the group. We want to push this functionality into EHR by stage two, by 2013. How do people feel about that timeframe?

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

Yes, so I think you should put the EG the same in the comments column, right, and then just—

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

Put the what thing?

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

Put the EG in the comment column, right?

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

Right.

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

Then we can specify.

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

Sure, we can do that.

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

Stage three, just put that over to comment column.

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

Okay, I can do that.

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

But don't we want that to be in stage two, that's the next question?

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

But I think you say in the comment column that you referred back to in stage three, unless you're going to add more in stage three.

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

Should I just make stage three and two identical for now?

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

I think except for the number of conditions, yes.

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

Okay.

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

The number conditions, won't the number of conditions actually be determined by the quality measures that are reported? You know the basis is not a given.

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

It's not given.

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

Yes, it's not a given. So I mean, it's an interesting concept. What we said is to use CDS to address four determined, HHS has to determine a list of high priority conditions. That concepts pretty good. Do we want to attach a number to two and three? So we're at one right now, do we want to put a different number for stage two?

Jim Figge – NY State DoH – Medical Director

Paul, are you referring to putting a number in for certification purposes or for actual use by the practitioner?

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

No, actual use by the practitioner. So use CDS to address blank number of specific high priority conditions that will be determined by HHS.

Judy Murphy – Aurora Healthcare – Vice President of Applications

I like the four.

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

Going once.

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

Alright, I'm going to leave it as four for both for now.

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

Okay.

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

Can I, so that we can finish something, smoking it says that when you update it, it's up to the provider, so it could be from the previous year. Just so you know, the final rule says, we do not intend that an inquiry

be made every time a provider sees a patient, the frequency updating of this information is left to the provider.

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

Is that in the functional criteria or is that in the measure?

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

The measure just says recorded, it doesn't say whether now or in the past. The commentary says, we don't want to say how often you need to do it.

Judy Murphy – Aurora Healthcare – Vice President of Applications

I think—

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

For the measure?

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

Well, the commentary reports, it is on both the measure and the objective. The commentary is like the bulk of the document. So I think we can, I'm just letting you know that's what it says, so I'm leaving it like that.

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

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

But did you really want, I didn't hear what we wanted to end up with on smoking, 80% and 90%, or just leave it at 80%/80% or what?

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

I think given that there's no frequency, 80% and 90% is good.

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

Okay, good, thank you, because I just like finishing things, so we don't have to come back to them, good.

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

Right. Then I think we can take that off the parking lot, is that correct?

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

I think so.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

Okay, that's the manifestation of it being "done." Okay, we're on row 21, drug formulary checks. The current measure is, it's enabled. Do we want to say anything more in stage, so what our draft says is 80% of med orders are checked against relevant formularies, so that's a tall order. One interpretation relevant to formularies is that means you have to know the formularies of virtually all of your patients for all of the plans and then make sure that they're checked.

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

I think I would favor just leaving it the way that it is now. That seems like a reasonable threshold.

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

Is it, well—

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

Maybe Charlene should comment.

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

Yes.

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

This is on stage three that we’re on right now?

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

Yes.

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

Yes, I think the feedback again was, what does relevant mean, because in these hospital formularies in the hospital, unless it means an outside formulary that adds more complexity, so it’s just the definition.

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

So I think the hospital, yes.

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

So that, if it’s the hospital, but if it means that you need to go out to the health plan formularies, then that’s a challenge. So it was really more specificity than as what the feedback was. Then what you do with non-formulary, too, was a question that was raised.

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

I think for inpatient hospital is pretty easy, because it’s controlled by the hospital.

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

Yes, I’ve had that in outpatient, too. We already do this, and it’s a pretty big pain in the neck to do it, but it is possible to do it.

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

What is formulary?

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

You do a formulary for all your plans?

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

Yes, there’s one company that basically keeps track of all the formularies in the country, and we buy and update from them, and then just import it into our electronic record.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes, that’s for eligible providers in the ambulatory setting, that’s exactly how it works. You use a clearinghouse.

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

But it’s one thing to get the formularies from the various plans, it’s another to know the right plan for this patient.

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

Well, you’ve got to keep track of that or you’re going to go out of business.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes, we check ours dynamically when we do the adjudication itself, it’s not like loaded into the EHRs, it’s actually a dynamic check.

Neil Calman – Institute for Family Health – President & Cofounder

But the issue with that is that you can have 12 different pharmaceutical coverage types within a single health plan.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

And second of all for us, there's 18 local Medicaid managed care plans, and they've never been in those databases.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Now I haven't looked in the last two years, but we stopped using it just because so many of our patients were excluded from it, and we just took it out. So I don't know, maybe they're in there now, but the local plans were never in there.

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

That's the kind of thing that maybe we should, there could be local issues and maybe we should be a little more due diligence about it or have somebody due diligence about it.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes, this is a little bit of a stretch, because I know a lot of the electronic health records do not have this functionality, Allscripts is an example that's had it for years, Cerner just added it this year.

Neil Calman – Institute for Family Health – President & Cofounder

What's the purpose of this?

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

It's a financial perspective, I mean, this is—

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes.

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

—the things that are important—

Judy Murphy – Aurora Healthcare – Vice President of Applications

For the patient.

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

Yes.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes.

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

Society at large.

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

Yes, the feedback that I got on that low end is only 30% of the patients have a formulary available to them, that's probably, Neil, a little more to your case where that's ... of it. Where it's just, the data is not in the automated yet and/or the system doesn't have that capability yet built in.

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

Who has the most active to data that this prevalence coverage kind of thing, is that you, Charlene?

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

Mine was more of just talking to the different vendors relative to their experience with this, so that was kind of what I was referring the information from. But I could certainly drill down and find out what their experience has been, it's like July said, it's Cerner's, it's eMed, it's a range of them out there.

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

This really only adds value if it's the patient specific formulary and if it has all the other criteria, such as does this need a PA, is there a step therapy, etc., etc. So through a plan, you have to know exactly which pharmacy benefit the patient has at that plan in order to be able to do any of that. So if it's not the patient specific formulary, it adds no value.

Neil Calman – Institute for Family Health – President & Cofounder

Furthermore, with some of these new drug promotions that some of the big box stores and others are doing, people can buy medications off formulary at lower prices. There's so many complications to this issue in relationship to not just making it a headache for the providers that adds very little value.

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

But there's so much money in this. When you do the modeling of what the potential benefits of electronic records are, this ends up being right at the top. I mean, I know it's a horrible—

Neil Calman – Institute for Family Health – President & Cofounder

Right, in what way, I'm not clear on what you mean?

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

Because providers today make a lot of choices that are not the best choices in terms of efficiency with respect to their patients drugs.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

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

So there's just a lot of money to be saved where they're equally effective drugs.

Neil Calman – Institute for Family Health – President & Cofounder

So aren't you talking about generic substitution then or—

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

No, I'm talking about—

Neil Calman – Institute for Family Health – President & Cofounder

—or some ability for the systems to be able to recognize drug pricing or something like that?

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

The systems won't know the drug pricing, Neil, because there's a lot of backed up deals with the PDM. So what you have to be able to do is get the patient specific formulary from the plan or the plans PDM and then that will tell you if there's five brands which one is going to be the lowest tier, the lowest co-pay or whatever. So if it can't get that information, this doesn't give any value to either the patient or the practitioner. If you can get the information, it adds value, but there's a price. Some intermediaries charge up to a dollar per transaction to do this. So it can get very expensive, too.

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

So this is meaningful use, I mean, my advice is, although I agree with David, there's money to be saved only aligning incentives will solve this. Whether we make this, sorry about the phone in the back, whether

we make this just what it is now, which what you have to do is versus 80% is not going to either make or break whether we save a billion dollars.

So my vote is that we keep it simple and not pick a number like 80%, because I don't think going to 80% is going to be the key thing that saves the nation the money. There's a lot more that has to be done to get there. Hopefully, we'll get there because there's so much money to be saved and not through meaningful use necessarily. I think the marker isn't, I mean, my opinion is that just saying you have to be able to do it, make sure that you have certified technology that's capable of doing it, and that we don't need to pick a threshold necessarily.

David Bates, what do you think?

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

I could buy that and I don't know what the right threshold is and it probably does vary by region.

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

So right now, the effect of moving this into core—well, actually, it's probably even in stage one, is that EHRs must have the capability to deal with formularies and check them against orders. Do we want to do any more than that?

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

Yes, I think we should, I would appreciate maybe talking to a couple of health plans of CDMs and getting more clarity about potential or were any of the implications operationally doing it, because I think David knows a lot about it. I do think it's a valuable one to keep in and give some attention to for the reasons David Bates described that I'd hate to pass it off as just a capability without some expectation of using the capability.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I mean, I think—

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

I don't know if this falls into the clinical quality measures side very well.

Neil Calman – Institute for Family Health – President & Cofounder

For community health centers that have like an average of 40% of their patients uninsured, there's a whole other type of decision support here that comes to play in terms of trying to help people pick cost effective medications. If we're going to get into this field, I definitely think we should at least focus attention on that group of patients, because they're the ones who have the most out of pocket risk and stuff in terms of cost.

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

But Neil, would that be more under clinical decision support, you would build those rules for that population?

Neil Calman – Institute for Family Health – President & Cofounder

But it actually gets built in the formulary part.

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

But still those patients don't have a formulary.

Neil Calman – Institute for Family Health – President & Cofounder

Right, you have to create the formulary, but it gets built in the formulary part, you can't have a clinical decision support for every single drug. I mean, you couldn't build them

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

You can have generic decision support for evidenced-based best practices for hypertension, diabetes, etc. So you can have disease-based clinical decision support for a selection of the best medications.

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

So may I suggest moving this to a parking lot? I think this does have huge impact, both at the appropriateness of the drug selection, as well as the cost. But I don't know that we can do it just by writing down these words, because relevant formulary I think is a big deal. So we can put this in parking lot, Katelyn, and then we'll ask for volunteers to work on this, because it needs a little bit of homework.

Okay, record advance directives; we did a pretty good job on this one I think.

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

So there were two things that I think we should talk about and we have flagged it and we needed to review it in detail. But one was the age consideration and one was the actual content of the advanced directives. So as you guys may recall on the face-to-face workgroup, Tony Trenkle flagged this—

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

Yes.

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

—as something that we needed to revisit, because I think the agency has gotten a lot of push back from consumers, and also from folks on Capitol Hill, who wanted to see more than just is there one. They want to be able to know that this content can be accessed and viewed at the moment when it's needed. For us to figure out what about people younger than age 65. I'm not sure where to go from here, but those are the two priorities that I think are important. Now the state statute issues play in, and I don't know how to address those.

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

I think he actually asked us to have a more public hearing—maybe we can, Katelyn, indicate this is one of the topics that we may want to bring to a "hearing," not specifically only on this, but there's some miscellaneous topics where we might need further discussion in the public forum.

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

Yes, Paul, would you remind me when the RFI people would go out and come back, likes what's the comment period, the 30 day, 60 day?

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

Yes, we were thinking about releasing it in January and receiving it back in February, 30 days, and then working off of that.

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

So it might be a good idea to signal in the RFI/PC, whatever it is, that the policy committee is interested in expanding the age criteria and in documenting the content of the advanced directives so that they can be available for appropriate members of the care team and ask for public comment on specific questions around state statutes, appropriateness for the ambulatory setting. The things that we have flagged in the comment field that we could start with a series of questions, and then from that decide if we need to do a public hearing, and we may have some really thoughtful comments from different viewpoints that we could draw from for the hearing. So that would be one approach.

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

Well, if there is the possibility of a hearing, we might want to have the hearing first before we put out our draft.

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

Yes, it's not enough time with the holidays.

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

Well, this would be in January then, so if we can flag this as one of the potential topics, Katelyn, then we could come back and see if we have multiple, and see if there's something to have even a part of a day, like before a meeting or something.

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

A quick comment here, the current state of this, like you record it, but most hospitals that automate maintain a scanned copy of it accessible. Where it gets really complex then is you say, okay, what is your standard for your advanced directive, because that's where the variability. So again, I think we can have, if you will, a low bar that says it's not only recorded, but there's a scanned copy of it in there, which provides lots of benefits.

As you start to drill to that next bubble is what's the standard, that's where I think it's more relevant for instance in primary care, maybe not specialists if that's the case. But I think there's a step we could take that would get us along way just by saying, you can actually look at it, but not start to encode it, that's when the bar goes up.

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

I think we intended that in our stage three comment where it's not just, it exists period, but as an exist then, you click and you get to the link to the scanned document so then it can be available.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Well but ,Paul, I thought that was like more structured data. I'm not sure we had that structured data, but I'm just not okay with the idea that stage two is just simply making it core, given all the push back we've seen, I think we ought to at least signal that. I don't see why you can't at least from a hospital perspective, except this criteria applies only to hospitals in stage one. But in stage two, the hospital would actually have the scanned copy in stage two, and that we would apply this to EPs in stage two, at least the former objective of the ... the present.

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

So that's what it says. It goes to core, which includes EPs.

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

Yes, so that's already in there. But can we say that for hospitals that it would include the content and whether that scanned copy or not, that's fine?

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

I'm fine with that, what does others think? In other words, move the availability of the AD to be electronic.

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

Right.

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

Do people agree with that?

Judy Murphy – Aurora Healthcare – Vice President of Applications

I like it, it makes the patient centric—

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

Yes.

Judy Murphy – Aurora Healthcare – Vice President of Applications

—and allows us to just confirm rather than recollect it every time.

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

Right. Okay, George—

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

Then I'll just add that we would ask for questions about the policy committee is interested in expanding the age range and needs to understand, blah, blah, blah.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes.

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

So Katelyn, I think we want to add, you can almost copy, let's see—

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

What I have, Paul, this is what I wrote down, move current measure to core, including EPs for hospitals, a result of an advanced directive discussion and the directive itself if it exists. Record the—

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

Why would it be just hospitals? Why wouldn't everybody, I mean, people move from outpatient to inpatient, so that's when you need to have the existing AD.

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

Paul, wait a minute, I thought we said that for EPs they were, didn't we just say for EPs that weren't ready to actually scan this thing yet in stage two? And I hope they were, I'm sorry, it could be, did I misunderstand?

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

Well, I'd prefer that they scan it if we think that they can. I think that's effusively much better. It was our intent for stage one the first time around before it got pulled out over some other issues.

Neil Calman – Institute for Family Health – President & Cofounder

I think scanning capabilities are pretty much universal.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes.

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

Okay, so I'd rather put it in there.

Neil Calman – Institute for Family Health – President & Cofounder

There's all kinds of documents that get scanned into the electronic health records.

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

Yes, I think it's a huge step, at least it's there. It's beginning to encoding it, then we'll get into this whole debate, a big low consequence.

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

Well, we'll get comments, what percent do we want, 60%?

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

Well, right now it's 50%. And what we said is we're moving it to make mandatory and to include EP, so that's a tall order for one jump.

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

So I'll leave it at 50% for stage two where they actually have to have the results.

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

Right.

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

Then I'll leave it at 90% for stage three for now.

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

For now.

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

One maybe nitpick, if the advanced directive is sitting in a third-party repository and there's just an appointment to it, are we saying the document has to be scanned and available inside the EHR or just that it's accessible to the

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

I think it's the latter. I mean, the idea is that it's accessible when you need it.

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

Right.

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

Yes.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Yes.

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

Okay. Well, of course, David, how do you certify that then? You're not certifying that it exists somewhere in either, that's probably an issue.

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

Well, I think you're just certifying the ability to attach a scanned document is what it sort of sounds like. I don't know, we can ask for public comment on that.

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

Yes, I just think they are increasingly a number of states that have repositories and then there's some private vendors like medical institutes that have repositories.

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

Yes.

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

That's actually more useful in a lot of ways—

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

Yes.

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

—you have patients who may be seeing multiple providers.

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

That's a good point. So as long as they have the capability to link out.

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

Yes.

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

Maybe to Christine's point, the link has to be there in the records to release the source document.

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

Right, okay. Okay, 23 is lab results. Here I think for example everybody agrees that lab results, that's everything cultured and encoded formats is useful. The fact that it's 40% probably is dealing with small practices and multiple labs. So what we did was in stage two made it core, since there's so many of them right now, and then up to two, some high number. Do people still agree with that?

Jim Figge – NY State DoH – Medical Director

Paul, this is almost impossible for us to implement in New York State, because there's no infrastructure out in the rural areas. So even the stage one is going to be a big stretch for rural providers, because the reality is, they use small hospital labs that can't deliver the results as structured data if they're even lucky to have any kind of HIE connection. The timeframe here is totally unrealistic when you look at the rural population. I think this is one of the 2020 goals and we need to move much more slowly on this.

Marty Fattig – Nemaha County Hospital – CEO

I would totally agree. This 90% needs to be one of those future state goals and we need to back into this a little more slowly.

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

Okay, you want to offer a number, remember only we're not the final determiner of the number of course, but is there something that's more reasonable?

Neil Calman – Institute for Family Health – President & Cofounder

Why don't we just put in the qualifier where available again. I think this is something that's going to require access staging anyway, because you can't measure the ones that don't come in electronically and aren't available as structured data. So since it's got to be by attestation, I think we should put where available in the network or however we want to word that. But I would not want to reduce the percentage in places where it's readily available to be done, because of the huge implications this has on quality decision supports, all kinds of other aspects of care.

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

So one of the considerations, Neil, is for the people where it is available. First of all, once you get it, you get most of it, wouldn't they automatically, even if we put it at 70%, they're not just going to stop at 70%. So the people who can make it available, because it's electronic, and then it's a small number of lab vendors then, won't they automatically get it? I mean, that's one way to look at it.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, that's fine, but the 70% still doesn't deal with the question of a rural area where it's not available at all. You're still creating a criteria that people can't reach. I actually suggested it for the opposite reason, because I think in places where it's not available, there shouldn't be any percentage requirement, because we don't want people to fail out of meaningful use just because their labs can't provide this kind of data.

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

I see.

Neil Calman – Institute for Family Health – President & Cofounder

Didn't we use that in other measures, too? We have a couple of other places didn't we, where we still have something that says where available?

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

Well, we do that with care coordination and public health.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, so I don't see any reason why we can't do that here as well.

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

Marty and Jim, how do you feel about that modifier?

Jim Figge – NY State DoH – Medical Director

It works for me.

Marty Fattig – Nemaha County Hospital – CEO

Yes, it works for me. My belief is that when people start reporting lab results in structured data form, regardless of what percentage you have there, they're going to submit them all.

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

Yes, okay. Are we good with this?

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

The caveat, in column three you have it connected to the structured results, and there was some push back in that space where, and again, if you could just make it where available, because there's cases. For instance, if you can reconcile it, an order goes out, but sometimes those orders go out manually. There's no standards yet for those orders. So that adds a lot of complexity, so that linkage to the structured order I think, it reconciles with the structured lab order is a challenge. In fact

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

So wait, Katelyn.

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

Yes, how we had to build it in our system was to make them independent. You can show the results, if there's an order that's fine, but if not, you can still get the result.

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

So Charlene, the motivation behind this, it doesn't mean it's realistic, but the motivation is that when you can't link it, you don't have any closed loop, you can't ... that it hasn't been done.

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

I don't know if you can say where available there, too, because I mean, there is again, as you look at trying to automate that transaction, in many cases we've got to push to get that standard in place so that we can get that standard outbound to those different laboratories, that's one of the gaps here.

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

Which is probably one of the reasons we put it in stage three is to make it happen in the next five years.

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

Okay. Well, I'm just giving

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

Yes, I know. Others want to weigh in on this?

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

Paul, I just want to understand, is there another line where we talk about structured lab orders?

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

No, I think she just used the wrong word, it was structured lab orders.

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

No, but I think what Charlene was saying as it's now stated in stage three, it's reconciled with structured lab orders, is there another place, not 23, where we say incorporate structured lab orders?

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

Up in CPOE.

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

So how have we dealt with that as Neil was saying where appropriate or where applicable? Is there some where applicable in CPOE?

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

Well, wait a minute now, the structured lab orders are structured from the doctor side, so they can always structure their orders and print out a piece of paper that then go to the lab. The problem is, how do you reconcile the lab with the result—

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

Right.

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

—that's a little more, then you need the accession number to link the two or whatever, that's where you get more complicated.

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

Right.

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

But when we did our order entry, we didn't have a by-directional interface yet. So you could be structured on the doctors side, because that way you could do decision support that says, you know you just ordered this CBC yesterday, do you really need it again today?

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

Right.

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

Or what, yes, labs.

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

Right. So you've got the date captured in your system, it's that by-directional piece that's the challenge.

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

So what I just wrote down is 90% of lab results are stored in structured data in the EHR and are reconciled with structured lab orders where results in the structured lab orders are available, so that's what I called it.

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

Okay. What this is doing is effectively putting a signal that the vendors need to work towards that kind of capability.

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

Well then, it's receiving labs, I hear you.

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

Yes. Well, this is one of those, we've got to get the issues out there through public comment, and we still have the problem of lab vendors are not part of meaningful use, yes.

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

Yes.

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

If we don't move, we won't get there.

Deven McGraw – Center for Democracy & Technology – Director

Well, they're not— Didn't we also think about this issue in terms of while the lab vendors are not in the meaningful use programs, the extent that hospital labs are used by physicians pretty often, there's a way to loop that in. It's an argument that didn't work well in stage one.

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

Yes, but your issue there is most the health plans require you to go to the Quest and LabCorp and those places.

Deven McGraw – Center for Democracy & Technology – Director

I don't think that's right, Charlene, that's not the evidence that we got in our Information Exchange Workgroup hearings on labs. Notwithstanding that there is a major lab company, there's still a pretty large percentage of providers who get their labs done at the hospital.

Marty Fattig – Nemaha County Hospital – CEO

One of the things that I, I'm a laboratorium, and one of the things that I have found is being able to supply this data in a structured format as a competitive advantage for the big players. I think they'll come along.

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

Exactly, again, when we do the models, it turns out to add enormous value.

Marty Fattig – Nemaha County Hospital – CEO

Yes.

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

So I think it's important that we send a signal, and I'd just put the goal posts a ways out as we are.

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

Okay.

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

I think this feels right. It feels like this is what we need to get done for the value proposition. Okay, 24, generate patient list, let's see here, for high priority health condition. So our first in stage two, we said move it to four, and stage three, we linked to the quality strategies whatever AD decides our high priority health conditions.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I had a question on this one, that just comes from not having used one in practice. I was reading, we did a lot of work around the ACO standards that security put out and I was thinking about meaningful use and making sure that it lays the groundwork for the kinds of things we think are likely to be asking providers to do as an ACO or medical home.

One of the things is to be able to look, not just at silos of, okay, these are my patients with diabetes, these are my patients with congestive heart failure, but to actually be able to say, alright, these are patients who have multiple chronic conditions that might be at risk for various things and do better care in these managements. The ability to generate patient lists for specific conditions, would that include the ability to generate a list of people who have multiple chronic conditions, are the highest cost, highest users, often with the worst outcome?

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

Well, I think we're specifying a capability, and this again goes to the floor comment. People can create any mixture of criteria for your query to generate the list like you're talking about.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, so it again is absolutely possible to have a list with multiple dimensions?

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Well, not necessarily. I mean, I think there are simple reporting systems built in to some of the simpler EHRs that just say, pick this or pick this, but we could make this very simple and just say, generate patient lists for one or more specific conditions.

Christine Bechtel – National Partnership for Women & Families – VP

So I like that better.

Neil Calman – Institute for Family Health – President & Cofounder

And that way, because I'm hearing what you're saying, and almost all the work that's being called out about high cost patients is being called out in relationship to people either with multiple chronic conditions or co-morbid mental health—

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

—and other chronic disease conditions. I think that it would be helpful to make sure that people can do what you're saying.

Jim Figge – NY State DoH – Medical Director

I agree, because you're going to need it for the Medicaid health homes.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

Jim Figge – NY State DoH – Medical Director

You'll need it for accountable care organizations.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

Jim Figge – NY State DoH – Medical Director

I think to align with those concepts, we should move in that direction.

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

Okay, so George, I think what we're doing is moving to core, and then modifying that word, instead of for specific conditions, one or more specific conditions just to be clear about the capability.

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

Wait, say that again, where?

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

So the mod is, in row 24—

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

Yes.

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

—the verbiage in column A says, generate a patient list for specific conditions, and the mod that was suggested was one or more specific conditions.

Neil Calman – Institute for Family Health – President & Cofounder

Actually, I'm going to take effect, I don't think that does it, because maybe that might actually be misinterpreted. I think we're saying for specific conditions, including the capability to report on multiple conditions simultaneously or something like that.

Jim Figge – NY State DoH – Medical Director

How about if we say multiple co-morbid conditions.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, yes, because I think the other way it sounds like if you just do hypertension, you could satisfy the one condition piece.

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

I'd like for you to clarify, and it seems to be attempting that this row should be about the capabilities to generate lists and set a number of criteria to do so. The fact that we're now talking about conditions is the only criteria that's required by the meaningful use program, it seems a little odd to me.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

Now that we're getting into those problems defining whether they're multiple or co-morbid gets us into a kind of ... advantageous. Is there even from a management point of view what condition is the right framing for this environment?

Jim Figge – NY State DoH – Medical Director

How about say something like patient specific parameters, arbitrarily defined patient specific parameters.

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

And then you say multiple—

Jim Figge – NY State DoH – Medical Director

Multiple, yes.

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

—patient specific parameters.

Neil Calman – Institute for Family Health – President & Cofounder

No, that's good.

Christine Bechtel – National Partnership for Women & Families – VP

Locally defined maybe.

Neil Calman – Institute for Family Health – President & Cofounder

No, that's better.

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

Locally defined instead of arbitrarily.

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

Well, no, the functionality is to be able to produce a list that meet multiple patient specific conditions.

Neil Calman – Institute for Family Health – President & Cofounder

That's good.

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

Alright, did you get that, George?

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

Not really, generate patient lists for multiple—

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

For satisfying multiple patient specific conditions.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

Jim Figge – NY State DoH – Medical Director

Parameters.

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

Parameters, sorry.

Neil Calman – Institute for Family Health – President & Cofounder

That's good.

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

Okay.

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

So they take the parameters?

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

Yes, so that it's not just, because we sort for drugs, let's say for recall, there's all kinds of things.

Jim Figge – NY State DoH – Medical Director

Yes.

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

The point is, many of the systems already do this, but a Neil pointed out that some systems are, just pick one disease and then

Jim Figge – NY State DoH – Medical Director

For example, I want to see all my diabetic patients with a hemoglobin A1C over 9 who are not on insulin.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

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

Yes, exactly.

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

Okay, generate patient list for multiple patient specific parameters.

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

Correct.

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

And then maybe move to core.

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

Core in stage two.

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

And then stage three?

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

The same thing, but you manage patients with specific conditions that we were saying determined by HHS.

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

Okay.

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

Okay, good, good mods. Number 25, this is the patients, to send patients reminders.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, my reaction, I think I'm wondering if we didn't capture this right, because I thought we had a discussion about the percent being low because the denominator was the entire universe of patients.

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

Right.

Christine Bechtel – National Partnership for Women & Families – VP

But that's not what this says. This actually says 20% of patients who preferred or received reminders, which is not the entire universe.

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

So there's two notions, one is, the denominator is the universe; and two is, you don't want to bother people who don't want to receive reminders.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

So those are the two concepts.

Christine Bechtel – National Partnership for Women & Families – VP

Right, but—

Neil Calman – Institute for Family Health – President & Cofounder

The reason it's 20% is because not all patients need reminders.

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

Right. All of your young patients may not have any eligible reminders, so that's why the number is low.

Christine Bechtel – National Partnership for Women & Families – VP

But I just want to make sure I'm getting this, because I don't agree. This is reminders for preventive care or follow-up care among patients who want to get them.

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

Correct.

Christine Bechtel – National Partnership for Women & Families – VP

So why is this only 20%?

Neil Calman – Institute for Family Health – President & Cofounder

Because you might want to get a reminder, but you might not need a reminder right now.

Christine Bechtel – National Partnership for Women & Families – VP

In like a two-year period?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, if you're 35, yes.

Christine Bechtel – National Partnership for Women & Families – VP

Oh, well, so why is my doctor hassling me about coming in every six months and I should have—

Neil Calman – Institute for Family Health – President & Cofounder

Because he needs your money.

Christine Bechtel – National Partnership for Women & Families – VP

I know.

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

He needs, yes,

Christine Bechtel – National Partnership for Women & Families – VP

I know, but my point being, everybody ought to have an annual physical, right?

Neil Calman – Institute for Family Health – President & Cofounder

No.

Jim Figge – NY State DoH – Medical Director

No.

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

No.

Neil Calman – Institute for Family Health – President & Cofounder

Absolutely not.

Christine Bechtel – National Partnership for Women & Families – VP

I think this is low, I just think this is too low, for a follow up and preventive care, I just think it's low. But since I evidently appear to be the minority, maybe we could ask for public comment on it.

Deven McGraw – Center for Democracy & Technology – Director

Yes, it seems low to me, too, Christine, but I'm trying to figure out how to structure it so that it's, we're getting people reminders that they should be getting, but not creating a number that artificially encourages reminders where they're not needed. I can't tell you the last time I had an annual physical to be honest, a physical exam, certainly as a woman, there are annual exams that I do get reminders for.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

Well, but those are not evidenced-based.

Deven McGraw – Center for Democracy & Technology – Director

Well—

Christine Bechtel – National Partnership for Women & Families – VP

What?

Deven McGraw – Center for Democracy & Technology – Director

You assume they are not. They may not in fact be non-evidenced-based.

Christine Bechtel – National Partnership for Women & Families – VP

So I just want to apply for people, there is no change in this recommendation over stage one to stage two or stage three, it just stays flat, and I don't love that idea.

Marty Fattig – Nemaha County Hospital – CEO

This is Marty, to me the important thing here is being able to send the reminders. I think the percentages will take care of themselves.

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

Right.

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

And this one I'm also, because most of these are also under the quality measures a little bit, the capability that's demonstrated by the 20% if they're not getting their patients in to achieve good results in the quality measures, that's where they're going to get dinged for this one.

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

Right.

Christine Bechtel – National Partnership for Women & Families – VP

Alright.

Neil Calman – Institute for Family Health – President & Cofounder

Then there's always the financial incentive to get patients in that I think that you've printed out repeatedly.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I have been victimized by that, thank you, so keep going.

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

This was to create the capability and that's why it's flat. Okay, what do we got, I think there is 28 that's not labeled, but 28 is to make another pitch for progress notes basically.

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

Okay, and you're going to skip, I'm sorry, did we conclude, what did we do with, I probably got an old sheet.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, electronic insurance eligibility and electronic claims submission before progress note.

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Is that—?

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

Okay, so yes, I don't know what happened, so I see what you're saying.

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

They're in column—

Christine Bechtel – National Partnership for Women & Families – VP

Two.

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

—B.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Column B, that's why, there you go.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, yes.

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

Okay, that's—

Neil Calman – Institute for Family Health – President & Cofounder

It's just column A is the stage one final rule.

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

Okay, so going to row 26 I guess that is, the insurance eligibility. I don't know why, it certainly doesn't improve outcomes. I think the original reason for putting it in was we didn't have any efficiency measures. What came out didn't have these, but it didn't have our clinical efficiency measures either. The question is, do we want to entertain putting in these clearly administrative efficiency measures? There's a couple things, one, it's administrative; two, not all of this stuff is stored in an "EHR."

Christine Bechtel – National Partnership for Women & Families – VP

No.

Jim Figge – NY State DoH – Medical Director

Alright, this might be in a practice management system.

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

Yes, exactly.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I agree.

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

I'm not a great fan of leaving these two in, I'm reintroducing that.

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

We definitely agree. The issue we talked about it originally was we would not require specific patient of these, but to add this into the certification, for the value I think we're going to get as a nation, unless they dramatically improve care, this doesn't seem to make sense.

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

Right.

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

The one thing that this makes me think about is when we get to talking about disparity reduction, and what I don't know is, what the percent of practices are that link their practice management systems to their PHR such that they can draw those reports. Because if your demographic data is held in your practice management system, then all your clinical data is in your EHR, and they're not linked, there's no way you're going to be able to draw a report.

So should this be something, not what it is, but something to the effect of linking practice management in the EHR or is that then even feasible for this, given that that maybe more of a market kind of feature? I don't know, what concerns me about this is the ability to do a lot of the other things we've talked about, particularly with regard to disparity.

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

I think there is a certain amount of scope to the meaningful use program, and I'm not sure it's reasonable to ask the EHR vendors to make sure that this gets in their systems.

Jim Figge – NY State DoH – Medical Director

I think this is really getting out of scope, we're talking about more about administrative function.

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

Yes, this is a CMS signal, but didn't we also have a workgroup on eligibility, and should we pull from them or check with them?

Judy Sparrow – Office of the National Coordinator – Executive Director

We do, we have an Enrollment Workgroup.

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

Yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

So maybe create a call with Paul and with them?

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

Yes, I don't know if they've made any recommendations that are specifically related to meaningful use.

Judy Sparrow – Office of the National Coordinator – Executive Director

No.

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

No, they did not? Okay, well that takes care of that I guess.

Judy Sparrow – Office of the National Coordinator – Executive Director

Not yet.

Marty Fattig – Nemaha County Hospital – CEO

Not meaningful use measures, I think that would be getting out of our scope.

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

Yes. I don't see a value in bringing this back into EHRs. It was sort of misplaced anyway I think. Okay, so can we move down to progress note then, that's row 28?

Judy Murphy – Aurora Healthcare – Vice President of Applications

Paul, I need to disconnect, I apologize, I couldn't forgive my last half hour, thanks.

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

Okay, no problem, thank you.

Judy Murphy – Aurora Healthcare – Vice President of Applications

Goodbye.

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

How do we feel about, do we want to bring progress notes back in?

Neil Calman – Institute for Family Health – President & Cofounder

I do.

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

I think it will come into care coordination one way or another. I mean, what good are we if we can't communicate this kind of information.

Neil Calman – Institute for Family Health – President & Cofounder

To me, this is a critical feature of patients having access to their records, and also in terms of the care coordination. I think we've got to put this in.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I agree with that, and I think it's not a huge stretch in stage two to have it at 30%. I think it's so huge for transparency and trust as Neil talked about before.

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

So Katelyn, could you please hide column B and D and E and F again so we can see what's on the right side?

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

No, C, D, and E.

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

C, D, E?

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

Yes, we need B, right?

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

No, actually, we need C, so sorry, we do need C, that's what we're looking at, D, E, and F.

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

Right.

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

Okay, so we were saying 30% and 90% that has the electronic progress notes.

Jim Figge – NY State DoH – Medical Director

Have we defined what an electronic progress note is?

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

There's a lot of definition of it in the past certification criteria, so there's been a lot of work done in this space in terms of kinds of progress notes. But the main point I think, this is Charlene, the last thing that we tried to do was at least make it specific in terms of defining the types of progress notes rather than what they are. What's the intent of the progress note?

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

Should we go so far as to say a physician progress note?

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

I think it would be better not to.

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

Okay.

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

Because it's not just physician notes, it's the nurse practitioner notes, PA notes, etc.

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

Okay. So what would you not have then, that's certainly the question we've got?

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

Does it correlate with like the licensed professional, the words that we put under CPOE again, is it the same as that?

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

That might be fair.

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

Yes, I think I like that.

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

I think it's fair.

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

Okay, how do people feel about progress notes of licensed professionals?

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

Well, wait a minute here, for the EP, you want the EPs own note, right? So now for the hospital, you're saying, what do we want here, is that where we're going?

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

Actually, let's stick with row 28 first, so this is for EP, that's a good point. So is EP already defining the notes we're asking for and would that simplify it, because there is a definition of EP?

Jim Figge – NY State DoH – Medical Director

I think I'm asking are we looking for structured notes, free text notes, dictated notes that are converted to the electronic notes, what exactly are we looking for?

Neil Calman – Institute for Family Health – President & Cofounder

It doesn't matter, any notes.

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

I don't think it matters.

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

So just it does a lot of work on—

Neil Calman – Institute for Family Health – President & Cofounder

We're looking for electronic recording of the note that's being written so that it can be shared.

Jim Figge – NY State DoH – Medical Director

Could it be a scanned in note?

Neil Calman – Institute for Family Health – President & Cofounder

It could be scanned, it could be anything, but it needs to be shareable electronically.

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

So David Bates, what do you think about EP as the definition of who's notes we're interested in?

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

So that's fine.

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

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

As opposed to nursing notes?

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

Well, in the outpatient setting, yes.

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

How?

Neil Calman – Institute for Family Health – President & Cofounder

I don't know, I think that what you're going to end up doing here is we're going to end up, first of all, I don't think anybody is going to do that. I mean, once you start recording stuff, are people going to actually— we've now required them to put orders, lab results, advanced in progress notes of EPs into an electronic record, are they going to keep a separate paper chart for nursing notes?

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

No, no, no, this is a floor, Neil, nobody prevents anyone from doing anything, this is just a floor.

Neil Calman – Institute for Family Health – President & Cofounder

Right, but I think we've gotten to the point now where there's so much stuff in the electronic health record that we don't want people to have multiple records. I mean, I think that's a real quality issue. I think it's a quality issue in hospitals, but it's a quality issue and an efficiency issue in office practices as well. At this point, we're expecting people to document what's going on in an electronic health record and not have a need or a reason to maintain a concurrent paper chart. That's the direction we're moving in, right?

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

We don't want people to have paper charts and electronic records.

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

So that's why this is a floor, nobody is preventing anybody from doing anything, it's just that what we're measuring is that the EP progress note is documental, it's not in shareable electronic form.

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

Yes, these are presumably visits to the EP, right?

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

I don't know, I don't understand why we wouldn't just say that all progress notes. I mean, you want a complete medical record, what would that mean in terms of the people being able to maintain an electronic copy of their record if part of their record is on paper and part of it is now electronic?

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

That's really not the point. The question is would if there's one note that's misfiled, do you want to not get your meaningful use payment?

Neil Calman – Institute for Family Health – President & Cofounder

Misfiled where?

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

Look, notes get misfiled on our electronic record all the time. It's under some other date. We actually do a check where we make sure that there are a hundred percent notes, one note for every visit. And four times a year, I have a note that gets misfiled.

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

It strikes me like a note for a visit seems to make sense. The feedback we got is if you put all in, they're not specific enough, you got to add the specificity in.

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

I agree with that. And so if we go with EP, which is the target of the main ... remember it's a floor, that at least gives some clarity to it and nobody is being stopped from doing anything.

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

Right.

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

So I think are we agreeing on document EP progress notes electronically?

Neil Calman – Institute for Family Health – President & Cofounder

So then presumably patients are asking for an electronic copy of their record in the format that they desire, whatever that wording is that we're going to end up with, presumably that those pieces of that record that are missing that they'll have to ask for in a different format. Is that what we're going to—

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

I don't know, Neil, don't you think when we say 90% of orders, so does that mean the other 10% are on paper? There's nowhere where we're saying 100% of everything. It seems like the drive will be to do it all electronic once you have the chart. You're afraid that they're going to be practices that maintain paper charts just for the nurse, but not for the doctor?

Neil Calman – Institute for Family Health – President & Cofounder

Or for the diabetic educators or for the whatever, I mean, the idea is we're trying to create a uniform record, right? I mean, not uniform, but a record that contains all of the information in it; otherwise, you're potentially sharing incomplete information.

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

Well, I think we all agree that's the goal.

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

We all agree, right.

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

I just think we have to check for that.

Neil Calman – Institute for Family Health – President & Cofounder

Okay, I give in.

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

Okay. I think we have this one. Twenty-nine is now moving into the inpatient setting. Now we've relabeled it clinical documentation, and again, we're going to have to struggle with what the definition is. So I guess what we've done is clinical as the modifier. Another possibility is to go back to licensed professional. Where do people think the floor is in a clear way?

Jim Figge – NY State DoH – Medical Director

I think it makes sense to go to licensed professional notes.

Neil Calman – Institute for Family Health – President & Cofounder

This is for inpatient, right?

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

Yes, that's correct.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Charlene?

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

Yes?

Neil Calman – Institute for Family Health – President & Cofounder

What's the current practice now? Are people still maintaining records in four separate places on the hospital floors in the places that you're doing where they have bedside records of vital signs and stuff, and INOs, medication records somewhere else, and progress notes in a notebook behind the desk, so that people making rounds have to go to four different locations to find out what's going on with their patients?

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

All that you just talked about is pretty organized and pretty documented and that's centralized. I think where you get the variation right now is around the physician documentation piece, which is just the piece that hasn't been echoed holistically at all. So there's a lot of different types of reports that you might want to include in the records. We've talked about discharge summary a lot, but there's other types of notes. That's the piece that is currently in most cases being dictated and transcribed in terms of the physician documentation piece. For ... or whatever, and a lot of times those get embedded into the record and they're added, but that's the piece that's not been automated yet.

Again, with the measurement piece, we're seeing the demand for physician documentation into the records starting to increase and necessary, but it's really not part of most of the systems and it's not part of practice yet. So that's the cusp that we're on. As a vendor, we're looking really hard at the physician documentation piece, but it's going to be a climb uphill to get there. So you get some of your advanced customers doing it, but the bulk of the market just says, okay, we're going to use the transcribing dictation. Again, you're starting to see voice and that type of thing start to come up and start to improve, so that could be potentially an option. That's kind of really more the development space right now. So the nursing piece is pretty solid. You can count on nursing documentation, progress notes, all that stuff being available and integrated and available.

Marty Fattig – Nemaha County Hospital – CEO

One of the things I'd just comment on is that anyone who will be achieving phase one meaningful use will have almost everything documented electronically in one place. As Charlene has said, the piece that is

yet to come is physician documentation. So I think we need to realize and keep in mind, those that are going to be achieving stage two, are those that have already achieved stage one, and they will have already had nursing documentation electronically, physical therapy, and all the different things will be in one place and will be electronic.

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

It's starting to sound like what we need to talk about now is the threshold, 30% and 90%. It sounds like we're also targeting the physicians and is it reasonable to go, is it a step function? Well, actually in a hospital for example, it could be different units. How do we think about 30% and 90%?

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

Wait, Paul, stage two is patient days, stage three is notes.

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

I just missed that, yes.

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

Then the other thing is, I agree on the physician, because yes, most of them already have nursing notes, we're not really adding anything, so what do I call it? It's not necessarily a physician, but it's a care provider of record, like I don't know what the name of that person is.

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

....

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

Attending physician?

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

Well, any physician would be okay, but in fact, is there other situations where they're may not be any

Jim Figge – NY State DoH – Medical Director

It could be a PA rounding for the physician.

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

Yes, yes, yes, I don't know, I don't know the answer to that.

Jim Figge – NY State DoH – Medical Director

It could be a nurse practitioner or PA that's rounding for the physician.

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

So use that eligible professional note.

Jim Figge – NY State DoH – Medical Director

Well, they may not be eligible professionals.

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

Yes, but in inpatient, we were talking about licensed healthcare professionals.

Jim Figge – NY State DoH – Medical Director

Yes.

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

Yes.

Jim Figge – NY State DoH – Medical Director

Licensed healthcare professionals.

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

No, but licensed healthcare professional might be the nurse and that note is already in there.

Jim Figge – NY State DoH – Medical Director

You should expand that to all licensed healthcare professional notes.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

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

Right.

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

Right.

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

No, but if in stage two it's 30% of licensed professional notes, you've already done nursing documentation, you need to add 0% doctor notes in stage two if we phrase it that way.

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

Well, correct.

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

The relationship in there, I mean like—

Neil Calman – Institute for Family Health – President & Cofounder

You could say like each licensed professional.

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

I don't know, I agree with the concept, but I don't think we can implement that.

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

Yes.

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

The billing provider has an incentive to get notes in there that's required for billing.

Neil Calman – Institute for Family Health – President & Cofounder

They could be in a paper chart.

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

Well, that's where this catches it. If it's all in paper charts, then it's not qualifying. Well actually, let's go back to I think it was Marty, so if we already have nurses, then really stage two and stage three might be capturing, you could call them billing provider or attending physician or whatever, that percent of those notes are recorded electronically. Is that what we're saying?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, if we're worried about PAs and whatever, why don't we just call that out specifically.

Jim Figge – NY State DoH – Medical Director

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

And say physicians, physician assistants, and advanced practice nurses, just call them out specifically.

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

Is billing provider, won't that catch them all?

Jim Figge – NY State DoH – Medical Director

It may not be the billing provider.

Neil Calman – Institute for Family Health – President & Cofounder

It's not really the PAs—

Jim Figge – NY State DoH – Medical Director

But the PA could always be rounding for the physician, they may not be the billing provider.

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

It's the hospitalists, and you've got the hospitalists in there, too, which work for the hospital.

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

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

Those are physicians or PAs, yes, we can just call out the categories.

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

Okay.

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

This one is what I think for stage two, because of where we're at and the timeframes of stage two, this is a tough one. So if there's any way that these new things can go on the menu, some will be able to get there that raise that bar. I think there would be a lot of push back because of the timeframe to do this is the challenge.

Jim Figge – NY State DoH – Medical Director

One question I have is whether voice recognition technology is good enough to get us to 90% by stage three?

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

Yes, that's a good question, we don't know that yet.

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

How is nursing in there already in stage one?

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

I don't think it's in the objectives, I think just a lot of hospitals have done it.

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

Yes.

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

Okay, that's what you meant, okay, fine.

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

Judy's not on the call, so she would probably make the case that we should probably have some nursing things in here, but the reality is we encourage the customers to put those systems in place in support of CPOE and clinical practice.

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

So right now I have 30% of eligible hospital patient days of at least one electronic note by a physician NP or PA.

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

Hospital day is one for each day.

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

But it's 30%?

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

Well actually, see that gets away from the, how do you know what the denominator is? So you know how many days are being billed and you've got to find one of these notes, that's a way, it sounds like, it's funny sounding, but it's going to get to the point.

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

Most of the time, I don't know if we can get there by stage two, because we don't have that software in yet in many cases.

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

Well, if we're going to do anything—so this is not that high a bar, I think we can find out on the public comment period if we've gone too far. Do you know what I'm saying?

Jim Figge – NY State DoH – Medical Director

Alright, if you don't have good voice recognition software or something like that, that's going to make this easy for physicians, this is going to be pushing it too fast.

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

Actually, you don't need voice recognition, the transcription goes in. It doesn't matter how it gets there, whether it's humanly transcribed or by voice recognition.

Jim Figge – NY State DoH – Medical Director

Okay, well, that's fine then, as long as that's made clear here in the comments.

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

Yes.

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

Before you wrote it in standard, we don't say structured, if you just write it in standard, that counted too.

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

Right.

Jim Figge – NY State DoH – Medical Director

Okay, as long as it's clear that all those count.

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

Okay, is there a reason why we're switching from patient days to notes written?

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

I don't think so.

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

I see how patient days work, because it's countable. The notes written, how are you going to catch that, what's the denominator?

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

Right, do you want to just change the threshold for, do you want to make it 60% or 80% for stage three?

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

Why would it go down?

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

Sixty percent or 80% instead of 30%. If we're 30%--

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

No, I mean, why would it go down from 90% once you change to days?

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

You're right, you're right, other than I just thought it was a hard thing to do.

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

It is a hard thing to do.

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

Very hard to do.

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

Well, let's move it down then for that reason. How does 80% or 70% work?

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

Comments, Charlene?

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

Again, I think this is in a space that we had the experience and to kind of know this as well. I think any number you're going to put there, you're going to get push back on. So I would put 80%, I would start with 80% then.

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

Okay, good, done.

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

Okay, good. We'll get comment on it.

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

And it is stage three, so we will have some time to evaluate that.

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

Yes. Okay, the next one is record family history.

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

Now we had said before, family history is likely an implicit requirement, but need to signal industry, that was in the comment field to the right.

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

Okay, sound goods.

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

There it is in the red column.

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

Could you just say that again, please?

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

Sure. There it is in the red column, family history is likely an implicit requirement, but need to signal industry, that's what we said last time.

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

I'm wondering whether this is a Christmas like issue, because it's a combination of what belongs in there, and if this statement is correct that essentially puts it anyway, why do we need to add to the reporting burden?

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

The comment was this data was necessary for care coordination in the feedback.

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

Right.

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

And again, we see a part of clinical documentation, but we've carved out, so where else can we gather it from?

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

I don't think it's so important for care coordination, I think it's important for screening.

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

Care, yes.

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

Okay.

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

Is this value worth the extra reporting burden, that's what we're applying to each of these new requirements that we want to add?

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

I think it probably is. It has a big impact on when you do both mammography and colonoscopy in particular. But I agree, it's on the margin.

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

Well, maybe that's what we meant by implicit, that in order to do those right, you have to have the family history, is that what we were saying? So therefore, they're going to do with it.

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

Correct.

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

The evidence is that they don't do it. Actually, when you look and see what's in the electronic record in most electronic records, what's in the family history is trash. It's really pretty

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

Well, unfortunately, you're going to have to add it to the up-to-date bucket to fix that kind of thing.

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

Yes.

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

The other thing would have to be structured. The way we have it, we would probably phrase it, it depends on what you're looking for. Do you mean the kind of unstructured broad family history or do you mean specifically do you need to check on these two risk factors?

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

No, it has to be structured.

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

Yes.

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

There's some other things, too, I'm over simplifying things, but those are the ones that has the biggest impact for. We're doing several trials around this right now and it makes a moderate difference in terms of who you end up screening.

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

Can David Lansky make the quality measure phrase so that it implies that the same should be taken that into account? In other words, put it in the outcome measures or the process measure.

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

Probably, too, like—

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

The patient might have a risk here.

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

Yes, like in colonoscopy or mammography, they probably do have that built in.

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

So that you can't do it unless you have a family history, that particular family history item.

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

Correct.

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

Could we make this a certification issue so that the system has the capability of incorporating a structured family history and then use the quality metrics to get at the other aspects?

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

I mean, I can just ... that most systems have it today.

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

Structured family history?

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

Yes.

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

Yes.

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

Yes.

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

What it was one of the absolute structured part. I thought it was, because this goes all the way to your secretary level clipboard argument seven years ago that there should be, just having a standardized family history would reduce all kinds of patient burden.

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

Yes, I'm wondering whether we really have a structured family history in all the systems.

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

So I've got a call with the vendors like next Monday, so I'll ask them that question and just see where they're at and their thoughts on that.

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

So in a sense, it could arise out of the quality measure, because probably there'll be some preventive things on the HHS priorities. As long as the measures are defined and include the risk factors, which I think they are, that's what we mean by simplicity. Then Charlene can provide some current status kind of a thing. So for now I think what we're saying is, leave this off the requirements list, because it's in honor of parsimony and reducing the overall burden or not increasing the overall burden to comply with this program.

Should we move onto the next row, let's see we have six minutes left? The next row is patient specific care plans.

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

I'm confused as to why this is here and not in care coordination later.

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

Yes.

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

I think it's just, well that's why I think it's there, so we should move to the next row.

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

Okay.

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

Just before you go on, the five year was, this was remember we were talking, this is ... where we didn't put a lot of the capabilities to support nursing practice in meaningful use. So we didn't put the support for clinical documentation, care planning, assessments, all those kinds of things that nurses do. So that's kind of a gap and we got a lot of feedback. So in the context of that, a gap in that process is the ability to be able to plan care.

I think the reason you might want to consider it is that if you start the care planning process in the hospital, then what happens there has to be a continuum of care regardless of whether it's in the hospital or as part of a shared care plan. So that was kind of the thought process. To some extent, I don't want to take it off, because I think it's such a critical piece that they're thinking in terms of outcomes and the interventions to get them to outcomes. And it's a whole transformation to really think differently when you practice. You're not just documenting what you do, you've got to plan what you do, so it's a step.

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

So you know what, since this is going to be a little bit more of a discussion point, I think we've done a great job with this category, we're almost finished. I want to make sure we still have time for public comment, so could we just add these three items to our discussion on December 3rd?

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

Yes.

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

Okay. Thank you, Christine, for sending around some teed up material for patient and family engagement. I'm sorry we didn't get to it today, but this will be a good start for December 3rd.

Christine Bechtel – National Partnership for Women & Families – VP

Great, well, thank you, George and Charlene and Deven and Neil, who were really integral.

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

Great, thank you. Yes, I didn't mean to—any other final comments before we open it up to public comment?

Marty Fattig – Nemaha County Hospital – CEO

Yes, I would like to see the comment period once this is put out to be 60 days instead of 90. I think we don't have enough information back on how people are reacting to stage one to make a good response to stage two in only a 30-day comment period.

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

We could probably talk about that at our face-to-face as well. Some of the issues are the 30 days is that people do it whenever in the last part of whatever the measurement period is.

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

Yes.

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

So we can time it appropriately, but I'm not sure if 60 days gets you anything. But if you're saying it's a long time, we can look at that.

Marty Fattig – Nemaha County Hospital – CEO

I appreciate that thought, thank you.

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

Great. Okay, can we open to public comment, please?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, operator, could you please invite the public to make comment?

Katelyn

We already have one public commenter, operator, if you could introduce them.

Moderator

Our first comment is from Carol Bickford with American Nurses Association.

Carol Bickford – American Nurses Association

This is Carol Bickford at the American Nurses Association. I had a question in relation to item 28 on the spreadsheet related to progress note. When does a patient be able to participate in the content documentation for the progress note? Is that identified later on in another metric?

Judy Sparrow – Office of the National Coordinator – Executive Director

Paul, do you know?

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

Well, we are going to talk about patients and families next, so it certainly could be something we could consider there.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Carol. Any other comment?

Moderator

Our next comment is from Michelle Blake with CDC.

Judy Sparrow – Office of the National Coordinator – Executive Director

Michelle?

Michelle Blake – CDC

Hello, I'm wondering on the spreadsheet, can you again go back to the comment on the smoking cessation, what was determined on, was it several years that was the final comment that you had made, was that session D, the requirement D for every year that the providers we ask you the question?

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

So it sounds like she's talking on a cell phone, so I didn't catch the whole question, somebody else?

Michelle Blake – CDC

I'm sorry, are providers to be required to ask the question every year to the patient or is it at every encounter?

Judy Sparrow – Office of the National Coordinator – Executive Director

She's asking about inquiring about the smoking cessation, whether you ask annually or every encounter?

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

The measure was every year, yes.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Ms. Blake. Any other comment?

Moderator

Our next comment is from Morris Rang with Selecting Health Systems.

Morris Rang – Selecting Health Systems

Good morning, everyone. I'd just like to make a comment on a couple of items, first of all on the drug formulary, possible making that an EP only measure instead of a hospital. Then on your most recent discussion in terms of clinical documentation and progress notes, I think it's not a good idea to assume that the nursing documentation is making it into the EHR, so you may want some clarity on that. Then you just started on the patient specific care plans, and I think that's a very important thing to have in the system. Thank you.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Mr. Rang. Just a reminder to the public that there will be a formal comment period. Paul?

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

Okay, well thank you, and those are helpful public comments. I thank the workgroup, and we will see you all, a Happy Thanksgiving, and we'll see you all in December.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Paul, Happy Thanksgiving.

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

Thank you, Paul.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Thank you.

Public Comment Received During the Meeting

1. Regarding drug-formulary: Remove as a hospital measure; use only on EP side.
2. Regarding the line 14 being discussed, two items are present, 1. calculate the quality numbers and 2. submit electronically.