

Meaningful Use Workgroup
Draft Transcript
December 10, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good afternoon, everybody and welcome to the Meaningful Use Workgroup. This is a Federal Advisory Committee and there will be opportunity at the end of the call for the public to make comments.

Let me do a quick roll call. Paul Tang?

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

Here.

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Bates? Christine Bechtel? Neil Calman? Art Davidson?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Joe Francis? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Latanya Sweeney? I'll just check on these. Michael Barr? Jim Figge? David Lansky? Judy Murphy and Charlene Underwood, they were not going to be able to make the call.

Christine Bechtel – National Partnership for Women & Families – VP

Judy, it's Christine Bechtel. I was able to join.

Judy Sparrow – Office of the National Coordinator – Executive Director

Oh, good. Thank you.

Christine Bechtel – National Partnership for Women & Families – VP

Actually, could you re-send the document because the one I have doesn't work. Sorry.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, I will. I'll turn it over to Dr. Tang.

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

Wonderful, thank you very much. Thanks for participating in this call. Our in-person meeting is going to be happening on Monday, just a few days away. Just to review the agenda for today, we're going to finish up finally, Art, with the population and public health. I believe Art sent around a document, and I haven't had a chance to look at it either, earlier today. George, do you have access to that as well? I think one of his suggestions was to move over to his document during that part of the discussion. Then we'll pick up— Deven, I didn't know whether you had anything—?

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

I was on mute. The answer was yes.

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

Okay. Deven, whether you have anything to propose for 2013 at least for privacy and security?

Deven McGraw – Center for Democracy & Technology – Director

No, but we could talk about what you and I e-mailed about. I just wanted to move up our proposal, rather than pushing it out to 2015 to 2013. I think it's just worth it if we have time at the end for a discussion about how it's kind of too early given all of the uncertainties about what's going to come out of the Governance Workgroup. What is going to be the impact of the ... Report on the technology approach in this area for us to be able to propose specific criteria at this point?

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

Okay, so we'll just discuss that.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

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

Then, I have a few clean up, as we were putting the slides together for Monday there's some clean up questions there. One is on CDS. ONC hosted a two day meeting just this week. One of the outcomes I think I'd like to vet with this group because I think it might be one of the ways that we handle the whole clinical decision support topic. If we have time talk a little bit about shared care plans, which we did cover at our face-to-face, but we didn't really define shared care plans, so look at that.

Without further ado, any comments on the agenda? Then let's go to Art with public health and population health.

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

Thank you, Paul. George, are you in control of the screen or will you be able to put up the document I sent?

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

Yes, I forgot that we were starting with yours. Let me get it.

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

Okay. Maybe as George is doing that I can describe how I got to this point. You'll see this worksheet coming up here. Following the same format we have been working with up to now, I tried to flesh out a little more about these public health items that we had collected during testimony. And additional contact with the public health community—the Joint Public Health Information Taskforce (JPHIT) and the CDC—which has now been very organized around meaningful use objectives ... time working on this.

This document now is a compilation of what we heard in testimony, what the public health community has suggested as items, including state and local and federal partners. So in this document— And, George, you may need to get that a little bigger. I don't know. I can't really see too well now. Let's see.

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

Can you see anything?

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

Yes, I see some of it. Is there a way to get this a little bigger on my screen?

M

You can hit the Full Screen button at the bottom of the slide. Do you see the button that says “Full Screen?”

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

I’m not seeing that right now.

M

Right below the slide window.

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

Oh, maybe that’s it. Oh yes, okay, thank you.

M

You’re welcome.

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

This document, and I’m just going to pull up my own as well here, so if we’re on row 63 the same three items that we’ve been talking about up to now in stage one are still represented here. Let’s start with the immunization data.

For this stage two, you can see that everything that I’ve done is primarily in green. For eligible hospitals and eligible providers, we would continue to have mandatory testing of the ability to submit immunization data. We’re now pushing up the expectation, and I’m just trying to lay out some straw person here for all of us to discuss to accelerate the conversation since we have so little time, so I’m suggesting that by stage two, 2013, 90% of all immunizations are submitted to immunization information systems if accepted and/or required by law.

Then underneath that, to make sure that people are using the immunization data, that 50% of patients have an electronic review, so there’s a query of what is going on up at the immunization information system records during their well child or adult visit, so someone could look up there and see what’s the status of this patient. As we progress to stage three, the same thing holds for submission that first point of 90, but down at the bottom now the review is no longer just—you could just do that manually. But now there is a request, a query of the immunization information system and a return with a recommendation about what is suggested with regard to immunizations for the patient for which there is a query. So maybe I’ll just stop there and see if anybody even understands what I’m talking about. Comments?

M

Art, on stage two they’re looking at their own immunization records, or they’re pulling data down? They’re not pulling data down. They’re logging on to the health department?

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

They’re logging into the health department, that’s correct, on the second bullet. The EHR, on the first, the 90%, would automatically be sending the immunization record to an IIS.

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

My comment, Art, is it seems like this combination is really a tall leap between a test and once it works, and I think submission seems reasonable, I don’t know whether 90% is a good number for stage two. But the ... of reviewing requires, I think, new functionality and new workflow and a lot of things that would make it challenging. Remember the timing, the final rule comes out in the middle of 2012 and for this to jump to this kind of new functionality in 2013 might be rather challenging.

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

I'll accept any recommendations or modifications. I just wanted us to start with something to comment on.

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

Yes. One stake in the ground might be to actually shift that to stage three. That would definitely give people enough time, both the vendors and the providers enough time to recognize that well, it really did mean bidirectional and you picked on something where it has a big, big win in all age groups, etc. So that's another amendment to consider.

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

Maybe you're saying that we would drop the second bullet in stage two—

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

... and move it over.

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

It is in there. In stage two, you could do that manually. It's just saying there's the opportunity to query the IIS. It doesn't say that it's automated. In stage three it is an automated electronic review.

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

I don't understand what you mean by manually?

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

Paul, in one case you're just logging in to the health department system, but not linked to your EHR for the backflow, but in stage three, you're connecting your EHR to the health department with a bidirectional flow.

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

I'm not sure logging into another application is part of the spirit of the EHR adoption incentive program. Would you consider moving access to stage three but keeping the automated, in other words, keeping the integration or interfacing point? So in a sense it's just giving more warning to do what you really intended to do in phase three anyway, that might be another way to say it. So without losing your goal by 2015 of having an automated query of public health records having to do with immunization, it would be just not having this intermediary that seems like a pretty tall leap.

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

I think that's reasonable, but I think it is important for us to get to this bidirectional—

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

Yes.

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

So we basically could drop the second bullet then, George.

M

Okay, do you see that? Then what percentage do you want? Is 90% reasonable after a test, or is it 20% or 50%, or something else? Percent of immunizations? What you have to think about is what is the denominator to know how to answer this.

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

In this case, it was just the well child or well adult visits, so that would be the denominator. So to make it less burdensome, because obviously you have different counties and I don't know how in different states it's done, but once you have this thing in place and you're moving things, there's no reason people, once they have an interface up and running, that they would stop something from flowing, right? So maybe the actual exchange versus just a test is what you're shooting for?

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

Right.

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

Is that correct? Then if we don't have the actual percent then we don't have to worry about the denominator if it's all in the counties that accept it. Then if you have an ongoing, maybe the phrase is ongoing exchange, ongoing submissions, automated submissions to public health agencies where they can accept it. How does that sound?

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

I have immunizations are submitted to immunization information system if accepted and/or required by law. Actually we've got to get rid of and/or, which one do you want, —ad" or -er"? Accepted and required by law?

M

Yes.

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

Okay. Then this ... thing is submitted, what did you say, Paul, in real time, not in real time but something that implied that.

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

The concept is to have in place ongoing automated submission of immunizations where accepted and required by law.

M

All right, how's this? Immunizations are submitted on an ongoing basis, immunization information systems accepted and required by law.

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

I think the fact that you can do this is where we're headed. Do you need to do it to cover all counties or states where your patients come from? That could certainly be one question. I'm not sure we intend to cover every state, because you would have to know a whole lot about every place, and that's—

M

We're required by law.

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

Well, so if you get a visit from somebody in Nevada and—

M

....

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

Art, how do you feel about that?

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

I don't know that it's our role here to deal with multi-jurisdictional issues.

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

Right. We want to start people doing this, and over time it will become required. It's like CMS would start requiring electronic submissions, etc.

M

It means they should submit on an ongoing basis the immunization information system accepted and required by law (for your home county) or public jurisdictions.

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

Couldn't you just say that you have one of these things up and going? People will decide what's most efficient.

M

We don't need the parenthetical expression because we're not putting a percentage.

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

Correct.

M

Okay. ... back here.

Marty Fattig – Nemaha County Hospital – CEO

My thought was just put that we have to have it in place and submit as required by law, and that should take care of the percentage.

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

I think where it might be left open, so people worry about the corner cases, so let's say you're on a state border, well, no matter what you may see patients from various states, some of which you may accept these things and may be required, but would you want them to have electronic interface to all 50 states?

M

Well, if we get the ... in place, that's the goal anyway.

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

I know, but we're talking stage two, that's by 2013. I think what we're trying to emphasize is, all right, we said have an EHR with this capability and test it. What we're saying is, gosh, if you have public health departments that can't accept this electronically then go ahead and use it, prove that you go ahead and use it. That's what we're asking for in stage two without necessarily dealing with the denominator problem.

Marty Fattig – Nemaha County Hospital – CEO

I think that's what I was saying using different language.

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

So are we good with that stage two as it is now? I think Marty's right; if it's required by law it's effectively going to be 100% or whatever.

M

But they can send a piece of paper to another state if—

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

Right.

M

Paul's just saying that you say at least some immunizations are submitted on an ongoing basis.

M

Yes. So you have an active interface basically and you've got an automated process to do that. Then it's in your best interest and everybody's best interest when you have departments that can accept this you want to do this, whether it's high prevalence. If you only get a rare one then you do that by paper until the

whole NHIN is up and running. Nobody wants to hold back once they have this capability and they know how to use it.

M

Then what about stage three?

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

This first bullet there is the same as stage two, but now the second piece here is about this automated recommendation for what that patient should get in the way of an immunization.

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

Can we talk about it in stages? So one is this automated query that's done electronically through your EHR, so that seems like a good thing and a natural next step and by making it phase three we've given everybody a chance to put it in place.

Then your second piece is to say recommendations. Now, can you really have recommendations coming out of a public health department, we don't necessarily have the NHIN going yet, and they may not know whether they've had it at Walgreens, for example.

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

That happens today on paper still. If it's not entered in the registry, there's a gap and that kid may get an extra shot. That's why we want to get everything into the registry so that we can have clinical decision support running on complete data.

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

But what we do now is in our own system of course we can talk to the patient or parent and recognize that they've gotten it and then we manually annotate that. Those are things that we keep in our local records.

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

Well, no, that local record would also be pushing historic data to the state from the EHR. Something that was not given at that practice but now bring in the immunization card, that gets entered into the EHR and that should be pushed to the state registry as well. And where's the source of truth? If they got it at Walgreens, Walgreens should push it out eventually, and I don't know that you want to try to reconcile with all these manual entries.

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

That's the way the registries work right now. They accept historic data. I have lots of kids who got shots in Mexico and come up here with their cards. We accept that card as a source of truth.

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

So let's take it in stages, how do other people feel about the automated query of the IAS to the EHR?

M

Well, there might be pushback from the ... the IIS' of the world.

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

The IIS has to develop this skill as well, and service and it's where applicable. But I know that there is an HL7 standard for immunizations to provide this sort of information back on a query. So this is not entirely unknown or not currently happening.

Neil Calman – Institute for Family Health – President & Cofounder

Hi, it's Neil, and I apologize for being late.

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

Thanks, Neil. We're on stage three for immunization at this point, immunization queries rather than submission. We took care of submission in stage two. The two components is one, to have that capability and be using that capability to automatically query IAS' from your EHR through your EHR, is phase one of this.

Neil Calman – Institute for Family Health – President & Cofounder

The question on the table is what? I'm sorry.

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

Is in stage three should there be use of automated queries of IIS' through your EHR, and then I'll ask about the threshold. Art, how does that sit with you for that particular component of your –

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

Well, I think there should be automated query, but the real thing is this gets back to clinical decision support, will each EHR need to develop its own clinical decision rules about immunizations, or can we leverage one site as the source for clinical decision support around immunization required for particular patients at a point in time? It's not easy to maintain these rules, so we're asking the IIS to provide that service, and that needs to be developed.

M

True. The only problem is we're asking the doctors to ask the IIS to develop the service, because it's the doctors' incentive we're adjusting here. This is also stage two. Remember that we're now through one-third of our time together.

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

Yes. So can we try to break this up into components then? So the first component is automated queries of IIS where available through EHR.

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

That should happen. How are we going to get to the point of bidirectionality if we can't even make a query?

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

Well, I'm just asking it. So you obviously vote yes, George.

M

Does the query mean that my health record queries the IIS and gives me the immunization data?

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

Correct.

M

For stage three, I mean I might be early but from right now's point of view open for public comment, I guess I'm okay.

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

Okay. Other folks on the call?

Neil Calman – Institute for Family Health – President & Cofounder

I agree.

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

Okay. Deven or Christine?

Deven McGraw – Center for Democracy & Technology – Director

... me.

Marty Fattig – Nemaha County Hospital – CEO

I think it's a bit aggressive, but per chance, we can get it there by stage three. But an RMA query, I think a requested query is vital but I'm not sure about the automated query, whether that's going to work well or not yet.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I think for public comment it seems like it's okay.

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

Okay, so let me introduce now the next phase, which is thresholds. Art has suggested 90%. I think given Marty's comments one might back off considerably, or resort to what we did before, which is you do this so that means you, one, have the capability; and two, you're using it and then the market will drive as these things roll out. How do people feel about just doing this versus what percent of patients?

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

I think doing it, because once it's automated it's going to happen on some automated basis.

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

Yes.

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

I think we should just leave it.

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

Okay.

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

You can't say all of it, so what do you want to say?

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

Automated, I think is enough, then the criteria for that gets developed.

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

So immunizations are submitted to IIS—

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

Yes, that's correct. It's basically the same as stage two, but for the second bullet, George, then instead of 90% we're saying— I can't read any more. We're getting rid of the 90%, the providers' EHR perform an automated query of IAS' where available.

M

That almost sounds more like a certification requirement than a provider requirement when you say it that way.

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

Yes, okay, sure. So we'll try to get away from the ... but the notion is that providers have this tool available and use it.

M

Exactly.

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

So let me go to the third component of Art's suggestion, which is that the IIS service provides recommendations on immunization for this individual. I think it's a bit far.

M

Yes, I would say so too. My main concern about this is that you'll have a proliferation of people trying to maintain clinical decision support on immunization practices that change almost annually. That's my main concern. Maybe the main thing here is that the EHR has a place to go for that service.

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

Why don't we highlight that to ONC, that that's something that needs to be stimulated somehow in this process? But I think having that be something that the providers are accountable for doesn't make sense.

M

Okay.

M

Yes.

M

But I think we should call it out in our report, that ONC should do something to help facilitate that as an important component of what we're recommending.

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

I agree but I'm trying to write something down. Hold on one sec. I agree with Neil but I'm trying to put it in here actually anyway, during well adult ... providers review IIS records and any supplied recommendations.

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

I think what we're saying, and Art did agree that we're not going to have the supplied recommendations.

M

I just think if they have them supplied— Okay.

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

Yes, but you're not going to know whether they looked at them. I would agree. I think we're getting too nuts here. We should call out that it's important to have access to them and that ONC should help stimulate the production of that. By the way, that would be national, right?

M

Yes, it should be.

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

Except don't forget city health departments and state health departments build their own recommendations sometimes on top of that.

M

All that needs to be harmonized at some point or there could be variation, but at least it's not each practice having to do this.

M

I totally agree.

M

Yes.

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

George, you can fix that later, I think. Let's move on to the submit reportable lab data.

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

In this one here, what I've tried to do is—basically it's the same for the eligible hospital but one of the things that came up was that this reportable lab data requires sufficient demographics for public health to act. So something that we may want to go back to look at in the demographics section is that there is address information and contact information. Currently lab specimens submitted by a provider to a hospital or to a commercial lab do not require that sort of identification, making it much more difficult for public health to follow up on reportable diseases.

Neil Calman – Institute for Family Health – President & Cofounder

Can I make a suggestion here? I think it should say for this piece —submit or otherwise ensure that it's submitted.” Because I think it's a reasonable solution to work through laboratories to basically, in some cases to require them to report stuff, and that if we can work out a process to submit the required demographic data for contact to the laboratory and they can report directly, that takes two loops out of this process. It makes it more timely. It makes it more assured. It doesn't depend upon 300 EHRs to be doing it. In our situation the labs report directly to the health department on a lot of stuff. Now, whether they have all the demographic data they need is another question, I bet that they do, and it might make more sense to just say that the provider needs to make sure that it's submitted either directly from their EHR or otherwise directly from the laboratory.

M

That's precisely the problem today. It's optional. The lab processes whatever it gets.

Neil Calman – Institute for Family Health – President & Cofounder

I'm saying that the provider needs to be responsible for making sure that it happens, but without calling out the pathway, in other words, without saying that it needs to be directly from the EHR. Does that make sense? It might not make any sense to you, but does it make sense? Let me ask.

M

I think it's an interesting approach and it creates a market force, so the providers want this to happen. There is a logical alternative. I think it's an interesting approach, Neil.

Marty Fattig – Nemaha County Hospital – CEO

Neil, it makes sense because that's the way it happens in the real world right now.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, and if there's missing data then we should work with the laboratory to supply whatever that required health department data is rather than insert ourselves in that loop.

M

The lab gets it from the provider. How would the lab get the information about a patient?

Neil Calman – Institute for Family Health – President & Cofounder

Because we're requiring it. We're requiring the provider to make sure that either their lab submits directly or they do and we'll obviously at some point have to specify what the data set is that needs to be submitted along with the lab result. Assuming that we assure that that data is submitted, the provider doesn't meet the criteria if they don't assure that they're providing the data to the lab and the lab's submitting it.

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

So how would we word this, Neil?

Neil Calman – Institute for Family Health – President & Cofounder

Without wordsmithing to basically say the provider shall either provide directly through their EHR or cause to be submitted through their contracted laboratories all of the data required to make a report to the health department. Then I guess somebody's going to have to sit and figure out what those data requirements are, if they're not already outlined, which they probably are somewhere.

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

So in stage two it doesn't deal with the providers, it deals with the hospital still because this was one of those menu items that were just for hospitals in stage one.

Neil Calman – Institute for Family Health – President & Cofounder

Well, it definitely should be a menu item in stage two for providers, I would think.

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

Okay. Have you got that, George?

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

Do we want to add ... to stage two now, but make it optional if they make sure that their lab is sending it? I'm not—

M

Exactly.

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

So that's our intent, so I agree with that. Do we need to make that an objective? How are we going to make sure that they made sure that all the labs that they draw from are sending it? Is it an attestation?

Neil Calman – Institute for Family Health – President & Cofounder

I think the health departments will become a powerful force here once they know that their providers are supposed to be doing this. But I don't think we need to—

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

Well, we're presenting this on Monday so we've got to get it right.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

So let's see, submit and—

Neil Calman – Institute for Family Health – President & Cofounder

Submit directly through their EHR or assure that their contract laboratories are submitting the full—

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

Maybe the objective is to ensure that reportable labs are submitted electronically as required by law. This may be accomplished either by the provider through the provider's EHR or their whatever, the lab—

Neil Calman – Institute for Family Health – President & Cofounder

Or by the provider submitting appropriate demographic data to the laboratories so that the laboratories can report directly.

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

I don't have all that.

M

All right.

M

For EPs ensure that—

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

Ensure that reportable lab results are submitted to public health agencies, I think he said as submitted, results are submitted to public health agencies, either directly through their EHR or through their associated lab. Maybe performing is the right one, performing lab, or by the performing lab. Is that what you intended, Art?

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

I think that's generally in the right category. Now, if you take a look off to this, for the third stage there are a lot of tests now that are being developed at the point of care and they may not be labs that are processing tests. So I guess that you now encompass that in the new wording for stage two. I was suggesting in stage three that this point of care testing probably will grow and that we want to be sure that new procedures for diagnosing reportable diseases allow EHRs to directly report. So I think Neil's already accelerated that into stage two by what—

Neil Calman – Institute for Family Health – President & Cofounder

We've covered it, yes.

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

Okay. So we're accelerating something from stage three into stage two and I think that's covered it, Paul.

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

Is that reasonable by 2013?

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

I think in stage one, we said it's just the hospitals, but there are reportable conditions that don't have a lab test that are of interest to public health partners. So we want to make sure that those reportable conditions are reported electronically. I think it's reasonable, but I was giving it a little bit more time.

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

Well, here what we're saying is reportable lab test results, which is a bit more tractable and so in stage three it can be reportable conditions. I guess I'm a little nervous that by 2013 it could be out in front of both the functionality of the products and the receiving capabilities of these public health agencies. You just don't want to get out so far that not many people can—

Marty Fattig – Nemaha County Hospital – CEO

I agree. I think that's pretty The other thing I think that's going to have to happen is some sort of standardization of the reporting of these test results, and that's going to take some time to develop that.

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

Again, we shouldn't get into the standards discussion since the standards committee could probably respond to that. I know that there are groups around the country working on it, CSTE, the Council of State and Territorial Epidemiologists is working on this and standardizing and unifying with the CDC. So there are people working on this. I hear what you're saying; we shouldn't get out in front. We could restrict this to laboratory reporting in stage two and then in stage three add other reportable conditions.

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

Well, I think Marty and I were saying that in itself is pretty far out.

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

I don't think that's that far out. I think that there are hospitals that do this already, there are EHRs capable of doing this already; my hospital does this. It's a challenge. It would be a challenge to get this to work, but we do want to have hospitals reporting. That was in stage one.

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

Perhaps we're talking about also EPs. I think just because this exists some few places isn't necessarily saying that we should make something that really applies to all providers and all hospitals by 2013.

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

Okay.

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

That's, I guess, where we're having a bit of a—

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

This could be the public health alert or report button. We're thinking it's going to wait until 2015.

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

I would think so.

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

Okay, if that's where we think we're at.

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

Remember this is a floor. It's got to be a floor for everybody, that's the issue.

Marty Fattig – Nemaha County Hospital – CEO

The reason I brought up the standards issue is because I think that's going to slow us down.

Neil Calman – Institute for Family Health – President & Cofounder

Do you really want to depend upon a report button as the sole means of reporting this?

M

No.

Neil Calman – Institute for Family Health – President & Cofounder

To me that would be a tragic waste of being able to not use the intelligence in a computer system. If you can make an automated report of a laboratory test, I think the report button makes sense for non-lab data but it doesn't make sense for lab data.

M

I agree.

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

Okay. So, George, I think we're agreeing to put this into stage three. Did I capture that correctly?

Neil Calman – Institute for Family Health – President & Cofounder

Is there a part of this that we can call out as part of a ramp up into stage three so it doesn't just appear suddenly in stage three that people are reporting with a button and automated labs. We should do something to stimulate the development of the standards and the capability from the vendors now.

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

The thought, Neil, is one of the reasons we're doing this stage three and then stepping stone stage two is to give that signal, thinking that the six month lead we have currently is not anywhere near enough time to develop new functionality. So by sticking it into stage three what we're asking is that's the trajectory, that's the destination. By that time, people hopefully would have less to—there would be less of an issue when they've had this kind of warning.

Neil Calman – Institute for Family Health – President & Cofounder

Okay.

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

I think, George, that's copying stage two into stage three.

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

What are we putting in stage two?

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

I think we can ask that question next, is what can we put? Right now, it's in menu. We certainly can make that a core. That's one of our strategies we've had before is to do a test where someone can receive it. What do people think about that?

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

Didn't we just add eligible providers as well as hospitals in this?

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

That's true, and we can make that a test. So for hospitals we've made it for menu to core. For providers, do you want to just add it as a menu, that's your first stage for step?

Heidi

Pardon me, this is Heidi. Mira had asked me to call in and help you get going with your work conference.

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

It seems to be going okay, thank you.

Heidi

Okay, thank you.

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

I think making a menu for the eligible providers would be appropriate.

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

Yes.

M

In stage two.

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

Right, because we've got to give the 500,000 providers some kind of a heads up.

M

Then in stage three, are we saying that it then becomes core?

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

That would be the transition for EPs, correct, and a lot of that has to do with the vendors having this amount of time to put it in their systems and for the standards ... to get the standards in place and implemented. I think it's actually a fair amount of reach here, but we can decide that later. How are people doing with these two now, stage two and three here? Remember, this is just going out for comment. There are two more big steps here.

M

I'm okay.

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

Let's go to the next one, which is syndromic surveillance.

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

That really doesn't change much from where we are today. I think the public health community would like to see this become core at some point, so we might accelerate or move that over from a menu to a core item.

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

It looks like that's what at least somebody put in blue here, mandatory testing, so that becomes core.

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

Right. I think we had done that before.

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

Is that hospital?

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

No, that's both, so that the EHR would be reporting this as well.

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

This is a pretty big step too. But fortunately at least it's been on the menu, and actually there was already a strong signal so we can argue that that's the lead time because there's a strong signal that CMS was intending to make the menu core. How do people feel about this?

M

It's good.

M

... is that what we're aiming for?

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

Yes.

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

Right.

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

Is there anything more, Art?

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

Yes. We have heard testimony and heard from others in the public health community that these three items are not sufficient and we're trying to address what we heard in the testimony and from that public health committee. So I want to go down to the next several lines. You will get comment, I know, from the public health committee about these other areas, the three areas we worked on for stage one are insufficient. So the first one we heard during testimony was, as we discussed a little while ago, about the send to public health button. We also heard about bidirectional surveillance data, something coming back to the EHR, alerts.

The next item down here and some of these may not stay in the meaningful use area, they may go over to clinical quality measures, so let me run through the rest of them. The health care acquired infection, HAIs and the National Health Care Safety Network, a reporting system for hospitals, many of which already participate and have shown improvement in and reduction in health care associated or acquired infections, so there's a suggestion about that. There's a suggestion as well from the public health community about reporting to cancer registries. There's been a major effort by HRSA and by CDC on the two next areas respectively, newborn metabolic screening and then the next one is newborn hearing screening, both of which have implementation guides for how those would play out.

So when we started this, I don't know how long ago, we focused on three areas, but the public health community is saying these are not all we do. So I'm trying to raise those to our group. We heard testimony occupational industry coding is not ready for primetime, but the CDC came up with some other areas about pregnancy status, sexual activity, and environmental tobacco smoke, which I think we discussed early on during MU and what core measure around smoking we were going to use. So I just

want us to be aware, even though we may not have enough time today, because I knew we were going to get to this point, that there just isn't enough time to discuss these all, but we're going to hear a lot of comments about these from the public health community.

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

Art, I think you alluded to this in your introductory comments, these certainly feel like quality measure requirements to me and quality measures is covering each category, including public and population health. So it seems like it's going through that vetting process. In fact, they have a request for comment open right now. Does that seem—?

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

I didn't know what the relationship was and whether we pass this off to them, that we thought this was important and it's something worthy of their review, or whether we just say our work stops at these top three and then start the whole process again with I have to go present to that group.

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

Are you not part of the public health part?

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

Well, I have not been participating there. There are just so many workgroups you can be a part of.

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

I'm guessing that there's healthy representation on the public health quality measures but I don't know offhand who's there, and I don't have at my fingertips what's out for public comment. But each area, each of these categories, does have some new measures being proposed. My guess is some of these, like HAI and newborn screening, I'm guessing it's in there.

Marty Fattig – Nemaha County Hospital – CEO

Paul, I think these things all have valid reasons for them wanting this information, but I think this is beyond the scope of meaningful use. Not everything that is required for an outstanding health system needs to flow through meaningful use.

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

Yes. I think what's going on in the quality measure group, they're vetting it against presumably eventually it will be vetted against the national quality strategy. We've always said that we don't set the country's health priorities, the secretary order is being asked to do that, and so the quality measures will probably track against what she ends up coming up with.

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

Then the area where I'm reporting to cancer registries—is that a quality measure or is that a meaningful use measure? Since the others may have already been dealt with by quality measures or are about to be dealt with and I can go back to them. That reporting to cancer, I mean, we have reporting to electronic disease registries typically for communicable diseases, was a request that similarly be looked at for cancer registries.

Marty Fattig – Nemaha County Hospital – CEO

When I testified before the HIT Policy Committee a year ago the registries were there testifying and it appears that there are registries for about any disease process known to man and where do we draw the line.

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

These are different than the registries that were being discussed by the societies. These are state mandated reporting requirements for cancer. This is not the American Heart Association tracking on cardiovascular or implantable cardioversion devices. This is a different category.

Marty Fattig – Nemaha County Hospital – CEO

I see your point. I still think that we've got to draw the line some place and not try and run everything through meaningful use.

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

Yes, that is something we need to be concerned about. I think most of this is going to happen in the Quality Measures Workgroup and I've been struggling right now to find this on the Web site, but there's a request for comment from the Quality Measures group going on right now.

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

I will follow up with David.

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

Yes. David Lansky and David Blumenthal co-chair that, and somewhere on the Web there should be one that goes by category. If you could both see who's on that group and what they're proposing right now in terms of measurement ... concept level at this point and I would guess things like HAI and newborn screening are on there.

M

The request for comment is out on the Federal Advisory committee's log, which is healthit.hhs.gov/log/faca.

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

Okay, I think we need to move on. Does that do it then, Art?

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

Yes, thank you, Paul, and thanks, George.

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

Thank you for spending the time and collecting all that useful information. Deven, I think we heard from you. Do you want to summarize? I think you were talking about some areas that we were considering for 2015, and it seems a little premature given the current state of not only where we are from a governance point of view in governance and where the community, the country is in terms of some of these things.

Deven McGraw – Center for Democracy & Technology – Director

I think the challenge here is that we've got it as a category of meaningful use and CMS having affirmed that they believe it's an important category to have, but at the same time, they certainly were not comfortable with an approach that's focused on compliance with current law.

Then we're looking to what other sorts of policy requirements do we want to place on meaningful users that wouldn't necessarily be applicable to the general population of entities who handle health data. The Governance Workgroup, which we saw their recommendations for the first time, those of us who were not in the workgroup at the last Policy Committee meeting, they're clearly focusing on a set of conditions of interoperability and trust. We're creating another acronym here, COTIs, that are going to be a set of policies that are going to be required for participation in the Nationwide Health Information Network. While it's not clear what those conditions will be, it is clear that they think privacy and security should be a category of those conditions. That they should be required in order for you to be participating in the Nationwide Health Information Network, and whether those COTIs get enforced at law or through this governance accountability process that they're trying to establish is still really uncertain.

So I think there's the potential to look to that process, depending on how it turns out and whether there is a consensus agreement on the approach to tying that in to meaningful use in some way. But it's a little early to be spelling that out for our public comment period because that set of recommendations hasn't really wound its way through the Policy Committee yet, much less I think do people on the Policy Committee necessarily fully understand.

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

One of the nice things about wrapping it into governance is that has persistence. Meaningful use has a time limit effect.

Deven McGraw – Center for Democracy & Technology – Director

That's right, although you could essentially be doubling back, that's not the right term, but reinforcing it, so through the persistence governance process depending on, again, how well that shakes out. It is voluntary, versus using the meaningful use policy lever to get at least those people who are getting financial incentives to be on board with the program.

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

Yes.

Deven McGraw – Center for Democracy & Technology – Director

One thing we could do to avoid leaving the category totally blank is to just put a reference in there to the COTIs possible link to COTIs developed through governance and say to be discussed or to be filled out at some later date. I'm not sure what else to do. I really hate leaving this category open, but I want to be able to address this in a way that links up several efforts that are ongoing that are much further behind than where this workgroup has gone with the other categories.

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

I think it's fair to link it NHIN governance, and to the extent that we can give it an additional boost at the proper time. Right now, we would be getting ahead. Then that makes sense as well. I think that's a good note.

Deven McGraw – Center for Democracy & Technology – Director

Yes, it's definitely signaling to both the Policy Committee and the public that it's not our intent to leave this as a blank category, but we want to be able to harmonize and be in synergy with a bunch of ongoing efforts here.

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

George, I just referenced ... COTI, that's the conditions of transparency and interoperability.

Deven McGraw – Center for Democracy & Technology – Director

Trust and interoperability.

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

Trust.

Deven McGraw – Center for Democracy & Technology – Director

But transparency would be in there.

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

Good, thank you.

Deven McGraw – Center for Democracy & Technology – Director

Sure. No, thanks.

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

Now there's a little bit of work we have to do to clean up where we've been before. As I say, I've been putting together slides for the presentation on Monday and I found some of these open questions. One of them, and I think it was a healthy approach that we took, was in the realm of clinical decision support. As I mentioned in the opening, I went to a two day workshop about this. I'd like to review with you one of the main outputs that we could leverage, which is remember our idea was instead of saying oh, gosh, we're going to have to enumerate here are six ways you can have clinical decision support. You need to choose one from here and one from there, and that just seemed, one, very limiting, unnecessary, and

clearly stifling of innovation when clearly clinical decision support has its own value proposition. It's one of the ... of EHRs.

So one approach is instead of coming up with an all-encompassing and then having to tear apart the definition of clinical decision support, is to enumerate attributes of decision support. So that then becomes the floor that you have to meet these attributes to be the floor, yet without stifling innovation. I'd like to read off these seven items to you. George, I just sent you an e-mail, if you can flip over that's great, otherwise it's pretty short. The attributes, the first one is that whatever you're going to get showing up on your screen, however it's displayed, it should be authenticated, and that's just simply you know where it comes from, and that's pretty basic.

Second, that it be credible and evidence based. In other words, a discussion about what's evidence based and does everybody who just calls himself evidence based equal that. Another alternative is to call it evidence rated, and that means then you are going to use the rating system to say here's the evidence level, it could be consensus, which I think ..., but you just want to know that it has some evidence, anywhere from consensus ... opinion up through a randomized control trial. So that's another attribute.

The third attribute is patient context sensitive. Now, that's the same thing we used in the patient information, we said we didn't want you to Xerox something that appears on every discharge summary, it needs to pertain to this patient, or people with this kind of condition. The same thing here, that's what the computer's there for to make this decision support relevant to this patient.

The fourth is that it invokes relevant knowledge. So it means that you're applying knowledge, so that's where the value comes in to this specific patient, and come up with some kind of thing that it should inform decisions made on that patient.

Fifth is that it's timely. That's why we have CPOE, is because at the point you're making this decision about a particular order you're getting this informed decision support.

Sixth that it be an efficient workflow for use, and that's just basically if it's way too hard it's not going to be of use anyway. Finally, that it be integrated with the EHR. The reason that's in there is that what makes it part of meaningful use rather than any decision support tool.

So I'll read them off again. One it's authenticated; that it's credible and at least evidence rated, if not evidence based; three, that it's patient context sensitive; four, that it invokes relevant clinical knowledge; fifth, it's timely; sixth, it's sufficient workflow for use; and seventh, that it's integrated in an EHR.

Neil Calman – Institute for Family Health – President & Cofounder

Is this subject to editing or adding?

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

Yes, it depends on how detailed we want to get there.

Neil Calman – Institute for Family Health – President & Cofounder

The thing that I would add to it is that it's presented to the appropriate party that can take action on it. I think that's very important and it's come up in a lot of our discussions.

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

Yes, exactly, with CPOE, for example. Okay, how do other people feel about the list with Neil's addition? The purpose of this list it would be used by the standards committee in theory and they could write the certification that basically says this. So if you come up with innovative ways that would fulfill these now eight criteria then that would qualify as decision support that you're using.

Neil Calman – Institute for Family Health – President & Cofounder

The other question is I'm wondering whether or not because of the potential blooming of a plethora of decision supports whether or not there shouldn't be something in there that talks about, I don't know how to say this, its relative importance sort of at a population—

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

What we had, Neil, was we used CDS to improve performance on high priority health conditions.

Neil Calman – Institute for Family Health – President & Cofounder

Okay, that's good. That's perfect.

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

We were smart. We just forgot how smart we were. That's where the importance comes in.

Neil Calman – Institute for Family Health – President & Cofounder

High priority health conditions, good.

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

By the way, while we're at it I think George and I, or no, it was David Bates and I thought that the number four actually we couldn't remember where the number four came from. So you'd want to use CDS to improve performance on high priority health conditions and is the number four an important piece of that.

Neil Calman – Institute for Family Health – President & Cofounder

Do you want at least one or four or more than one? Do you know what I'm saying?

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

If you're going to apply it to, by definition without even putting it it's set up by the one, right?

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

Do you want to go to four in stage three, for any reason, or just leave it –

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

I don't know.

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

... number.

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

Yes, it goes to a floor. We're all imagining that performance measures are going to play a bigger role in our life and even in payment, so there's plenty of reasons why people would want to use this tool.

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

... to improve public health, how is that defined?

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

I don't remember that either, so I don't know if other people have a recall of why these are there. Is Art still on?

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

This gets back to this immunization scenario that I described earlier. I had suggested that we could use that as a clinical decision support for what should be given in the way of immunizations.

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

Certainly, that's important. Is there any reason not to let the organization decide where they have the biggest gap, so for example what if they're doing really well in immunizations?

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

The problem is if we drop four then to say to include anything doesn't make as much sense. When you have four then one of them should be public health. If you have one and one of them has to be public health, then I guess it's public health.

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

That goes back to our principles of this, remember we had the parsimony, we used floor as one of the principles.

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

That would be

M

I guess in light of this discussion I'd like to bring forth Michael Barr's letter that he gave and under 4C he discusses clinical decision support and I'd like to introduce that at this time.

M

Are you going to read it?

M

-Using clinical decision support to improve performance is unrealistic based on the evidence to date. It has only been proven in a few carefully controlled study settings. Evidence supporting the general notion that the use of CDS produces measurable performance in general clinical settings is very sparse. Therefore, any expectation implied by the metric as written that the use of CDS will improve quality is inappropriate and should lead to EP and EH requirements that are not based on available evidence."

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

That's where I would disagree, that there's a lot of evidence to say that when you put in this clinical decision support regarding immunizations you improve immunization rates and you protect the population, there's evidence of that.

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

I think that's true, and also if you have one and for some reason because there have been ... on this and you turn it off, the rates go back to normal. So it's not something that persists. It's truly a reminder function. Do other people want to weigh in?

M

Backing it up to ... instead of four at least goes in the direction of being a little less certain, so it's actually more in line with the comments than it was. But it's being less prescriptive, both in the use of attributes instead of here are the six types that work and in the getting rid of the number four. So we've leaned in that direction without getting rid of it all together.

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

How do people feel with the way it is now, which is to use the attributes as the definition for the floor and then the meaningful use requirement is you use CDS that have these attributes to improve your performance on high priority health conditions.

M

I like it.

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

Is everybody else okay?

M

I think it makes more sense than being prescriptive about certain

Deven McGraw – Center for Democracy & Technology – Director

Yes, agreed.

M

It does do more of an outcome base. I like it.

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

Yes, so wait leave this? I'm sorry.

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

Yes. With more experience under our belt we can certainly revisit 2015 stage three, but right now I think it's getting closer, as Marty said, and it's more outcomes oriented. It's a neat opportunity to do like we said we wanted to.

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

Very good.

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

The other one, and I don't know that we can decide here, when we did cover care coordination we talked about this thing called a Shared Care plan, we didn't have at our fingertips what that was defined at. Well, there was some question whether it is defined in the rule. I don't think so. There are things called Definition for Care summaries, but there is not one for Shared Care. Did I get that correct, Josh?

Josh Seidman – ONC

Right.

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

So when we put in our – are you looking for that?

Josh Seidman – ONC

Yes, so in stage one there was a definition and a summary care record and a definition of a clinical summary after visit, but there was no Shared Care plan or integrated care summary.

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

Okay. I thought we had it. Oh, there it is. Yes, even worse now there's a longitudinal care plan. I don't know that we have a definition for it. People are obviously going to ask us for one.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, that was something that I thought we had some testimony on from the care coordination hearing. I'd have to go back and look, or maybe David Bates could help. But, you're right, it's not defined and we would have to say, much as ONC did with the clinical summary, what the core elements of this are. I'm not prepared to do it on the call, but I think there are some things worth following up.

Deven McGraw – Center for Democracy & Technology – Director

We could ask for comment on it.

Christine Bechtel – National Partnership for Women & Families – VP

True, although we should probably give at least a basic

Deven McGraw – Center for Democracy & Technology – Director

Yes, I know. Well, I tried.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, nice try.

Deven McGraw – Center for Democracy & Technology – Director

Let's ask the people.

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

We can ask somebody else to do this work. Okay, so—

M

I think we have to say something in the comments, what the first cut of this is right now.

Deven McGraw – Center for Democracy & Technology – Director

We know it needs to include the list of care team members.

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

That wasn't above, though. We have that covered separately.

M

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

I thought that was part of it.

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

No, we actually even called it out as a separate one right in the row above it, Christine, list of care team members for—

Christine Bechtel – National Partnership for Women & Families – VP

I see it. It just looks like it's part of the row to me. Okay.

M

What is in the Shared Care plan? The care team members

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

Diagnoses, meds, allergies.

M

We're missing the essential element which is a plan, but I don't know what that is. I mean, maybe goals.

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

Correct.

Deven McGraw – Center for Democracy & Technology – Director

Yes, that's what we had talked about

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

Yes, nurses are actually better at this because they have something called a care plan. Doctors aren't used to doing this in the same way.

Deven McGraw – Center for Democracy & Technology – Director

Somebody ... defined it I think it's better for us to do a little bit of off line work, maybe Josh or David Bates or somebody could do some fleshing out.

Josh Seidman – ONC

Yes, we'll do that. One of the things that comes to mind is the Shared Care plan that was developed is part of the RWJ Pursuing Perfection project by

Deven McGraw – Center for Democracy & Technology – Director

Yes.

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

If you can grab some of the key elements from that, that would be a starter set for us to

Josh Seidman – ONC

Okay.

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

Great, thank you. Okay, anything else that people think of as loose ends before we— Again, this is just the beginning of it. We're going to present this to the full committee, get some of their reactions, incorporate that, and go out in January for public comment, take that in and revise things during February, re-present it in March to the full committee. Then we will weigh the information that's coming in from surveys, from the RACs and from the initial submitters before we come up with our final recommendations in the summer time frame.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Paul, this is Micky Tripathi.

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

Hi, Micky. Yes, I was just going to ask you.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Great. Thanks, George. So I had a specific question that George and I and a few others have been e-mailing about, and I think that also raises a general question about HIEs in general, so the specific one is related to entity level provider directory recommendations that we're going to be making on Monday. There were two levels of recommendations related to having as a meaningful use requirement an initial registration, a one-time registration with a national entity level registry, and then the other having to do with various flavors of how do you have a requirement that says it ought to be used once or tested once or something like that.

The conversation that we were having with George was really related to this question of wanting to move away on stage two, stage three from process type of measures that say test this piece of infrastructure, test that piece of infrastructure, to something that's more about clinical outcomes and clinical processes that would rely on those things and having that be more of the focus. It's certainly been elevated, the question to well, what about the other HIE infrastructure components and how do we think about those as well and what's the appropriate place for the Information Exchange Workgroup to weigh in on those. Anyway, so the question is I think that second question maybe more is a general process question that we can discuss among the workgroups and we would love your perspective on that. But on the specific one, on Monday I'm trying to finalize our recommendations and wanted to get the workers' perspective on that as well.

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

It seems like having somebody enroll in the provider directory doesn't feel like a "meaningful use" requirement from a targeting clinical outcome point of view, as you mentioned. I wonder if this belongs in, it's almost a COTI thing, so NHIN governance decides a number of policy standards and practices and technical standards, so one of the things that can be part of that is the provider directories. And if you want to be, whatever it's called, certified by NHIN then you would obviously have to participate in the provider directory. Is that logical?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes.

M

You'd probably have to do that to meet any of the meaningful use requirements that require exchange of information.

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

If you are going to do it through an HIE organization that participates in NHIN, that kind of thing. But hopefully everybody will

M

But even through direct, right?

Deven McGraw – Center for Democracy & Technology – Director

Even through direct.

M

So it's really through any mechanism.

M

Right.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

M

So that's why I say I think it's pretty well covered because there are requirements that we're calling out in other parts of meaningful use that require you to exchange information and that exchange will require this authentication process and I think it's covered. You can't be a meaningful user without doing it.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I guess the one small part that isn't covered is that you have the one-time registration in this directory, and in direct assumes that the directory exists without specifying how that would work. We also are recommending the governance side of this, Paul, as part of the recommendations.

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

So I guess the question still is, doesn't this belong as part of the infrastructure whether it's through NHIN governance. Or like Neil says, any of this has to have this exchange and to the extent that NHIN related things, NHIN direct, NHIN organization kind of things, wouldn't it be incorporated in that, and really the standards committee makes it so.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right, so that's also a part of the recommendations is the standards committee certifies the systems according to a set of standards about interoperating with these directories, so it seems to me that there are two questions. I guess the first one about having that initial registration, that felt to me like it was appropriate from a meaningful use perspective just to the extent that you want to be able to make sure that everyone is in the electronic phone book, as it were. Have this be the opportunity to make sure that you're part of the electronic phone book, which will then facilitate all other exchange. I would certainly grant that that feels like one specific infrastructure type process certification, but I guess I would suggest that maybe that's one small exception that we can make now.

I can see for the second one how having it be a one-time test or something like that maybe that's something we ought to work on and not require that. So that's one thing that I guess I would just love to get peoples' feedback on. Or I guess from a process perspective what we could do is just recommend that the meaningful use workgroup consider this as part of deliberations and then we take it up. But at least that allows us to formalize the sentiment of the Information Exchange Workgroup, that this has that level of importance.

The other thing I just wanted to ask about as well is that at the last HIT Policy Committee meeting the committee approved the Privacy and Security Tiger Team's requirement that participants in exchange have a digital certificate. But nowhere in the recommendations did they say that that's a meaningful use requirement. Is there a gap there? Deven, I don't know if you're still on the phone.

Deven McGraw – Center for Democracy & Technology – Director

I am.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Was there a discussion at the committee, I mean, was that strongly implied or was there a discussion? Was that a gap or was that specifically left out that you're thinking about it as being part of the governance requirement rather than being a meaningful use requirement?

Deven McGraw – Center for Democracy & Technology – Director

Yes. We have some specific recommendations with respect to systems certification, but that's obviously not the full complement of how the authentication piece can get done. I think we defer to governance as an accountability mechanism.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. Okay, so that was a deliberate decision not to make it a meaningful use requirement.

Deven McGraw – Center for Democracy & Technology – Director

To be honest, I don't even think it came up on the calls as the right policy lever, but I see what you mean and I'm thinking through. Arguably, the only category of meaningful use with any sort of overarching infrastructure implications is the privacy and security category.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right, absolutely.

Deven McGraw – Center for Democracy & Technology – Director

I don't know if you were on for the comment that I made earlier, we're putting a placeholder in that category for now to see where some of the work on governance spins out.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes, because I don't know if you were on the last Information Exchange Workgroup call, but Paul—who I don't think Paul Egerman is on this call, but—he was pushing hard to make the certificate a part of our meaningful use recommendation. Which now strikes me as being beyond what the Tiger Team had recommended to the Policy Committee at the last meeting.

Deven McGraw – Center for Democracy & Technology – Director

Oh, right, that you have a certificate to be a meaningful user.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

That you register with the entity level provider directory and that that would mean that you have to have a certificate because—

Deven McGraw – Center for Democracy & Technology – Director

Right, because it's a precursor.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Yes.

Deven McGraw – Center for Democracy & Technology – Director

Yes. I can go back and pull the recommendations, but I think—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

I've pulled the—

Deven McGraw – Center for Democracy & Technology – Director

You did that already. Yes, I think that must have been a subsequent thought on his part.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right.

Neil Calman – Institute for Family Health – President & Cofounder

I think it's covered, but listening to the discussion again and thinking through what providers are in our read and how tied everybody is into meaningful use and understanding the criteria and everything, it might be useful to throw these requirements into meaningful use only from the perspective to make sure that it's clear to everybody that this is a requirement and people begin to understand what it means. Because if you're a provider out there in the community and you've been focused on meaningful use I'm not sure what other document people are going to be reading that's going to now describe authentication and whatever. It might make sense to wrap it in only for that reason, although—

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

It's just not the only lever that CMS has. They can require this eventually—

Neil Calman – Institute for Family Health – President & Cofounder

Right.

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

There are lots of places where this kind of enrollment function happens. I'm not sure it's a meaningful use of technology and proved outcomes kind of function, other than that it's required to do the other.

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

But anyway, since you're going to have this as part of your recommendation that we present on Monday, that's an opportunity for it to come up, especially from the full committee. Does that make sense, Micky?

Micky Tripathi – Massachusetts eHealth Collaborative – President & CEO

Right. Okay. Then maybe we can talk off line about how we get the— Because I certainly appreciate, as George I think very clearly said in his e-mails, there are a number of HIE infrastructure pieces here that we want to make sure are instantiated in some way but not as process kind of measures. We're happy to have that broad conversation with you and assist in whatever way possible to figure out how to tie those two to clinical processes and outcomes.

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

Judy, I think we need to have an opportunity for public comment and then finish up.

Operator

We have a public comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Please identify your name and your organization.

Mark Segal – GE Healthcare – Director Government & Industry Affairs

This is Mark Segal from GE Healthcare. Just a couple of quick comments. First, I'd really like to thank Dr. Tang and the whole workgroup, as you've been working over the past several meetings, for your focus on the regulatory timing issues and evaluating new meaningful use items and particularly those that would involve new functionality.

Secondly, as you put together the request for comments and there's been a lot of discussion about signals to the market, just to emphasize that the more that it's a super set of items that maybe haven't been fully vetted, it's obviously a bit less powerful as a signal to the market, which I think is still important. Also just ask that as this is put out for comment, that the status of the specific items is emphasized.

Finally, one quick substantive suggestion, where you're looking at refining and expanding the one test of HIE, I think this was your intent but if it is I'd ask that you clarify that for stage two this would include importing the CCD, CCR data, structured data into the EHR and not just for display. Because I think for

stage one as framed it's really just testing sending the information, so I think that would be a very powerful move forward for HIE and also consistent with some of the directions that ... had recommended the other day. Thank you very much.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, Mr. Segal. Any other comments?

Operator

You do have another comment. Ms. Bickford, your line is live.

Carol Bickford – Nurses Association

This is Carol Bickford. I work in Nurses Association. In relation to the discussion about the plan of care please ensure that we have clinicians who are not just physicians participating in that conversation. For example, OT/PT, nursing, and some of our complementary ... alternative medicine folks so that we're all contributing to that discussion.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you. Any other comments?

Operator

I do not have any more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Thank you, operator. Thank you, Dr. Tang.

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

Good. Thank you to all the members, to the workgroup, and we will see you—

Deven McGraw – Center for Democracy & Technology – Director

... on Monday.

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

Yes, we will see you on Monday.

M

Nice job, Paul.

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

All right, take care.

W

Bye.

M

Bye, Paul.

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

Bye.