

**HIT Policy Committee Meaningful Use  
Specialist Subgroup  
Draft Transcript  
November 28, 2011**

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

I'll start by taking the roll call. This is Mary Jo Deering in the Office of the National Coordinator for Health Information Technology and this is an open meeting of the Meaningful Use Workgroup's Specialists Subgroup. It is a public meeting and there will be an opportunity for public comments at the end. Let me start with the roll. Paul Tang?

**Paul Tang – Palo Alto Medical Foundation**

Here.

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

George Hripcsak?

**George Hripcsak – Columbia University NYC**

Here.

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

Eva Powell?

**Eva Powell – National Partnership for Women & Families**

Here.

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

Michael Barr?

**Michael Barr – American College of Physicians**

Here.

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

Charlene Underwood?

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

Here.

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

Okay and then we also have Allen Traylor?

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

Yes.

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

Anyone else on the phone from ONC? Okay I'll turn it over to you George.

**George Hripcsak – Columbia University NYC**

Thank you. Okay let me first thank you guys for coming and joining us this day after Thanksgiving weekend. Let's go over the agenda. First I'd like to just touch on the various materials that we've sent around before the meeting. These are for the most part previously public materials that I think in form what we'll be doing and then let's talk about our options for accommodating specialists, what do we need to do basically to not end this call without coming up with what really will be our strategy and I think we already have a direction based on feedback from the Policy Committee I think we have a good idea but let's solidify that. And then do a little bit of work on it, if the answer is coming up with common infrastructure and functionality for specialists start working in that direction. And then just talk a little bit about whether it's time to do anything in the direction, what is feasible in the way of imaging. Does that sound good as an agenda?

**Paul Tang – Palo Alto Medical Foundation**

Yes.

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

It's Neil I just joined.

**George Hripcsak – Columbia University NYC**

Oh, great Neil. Wonderful. Thank you. That's Neil Calman?

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

Yes.

**George Hripcsak – Columbia University NYC**

Okay. So first let's go over the materials a bit. First of all this is the specialist subgroup of the Meaningful Use Workgroup and the group had met previously and supplied minutes from that meeting and gave some brief notes on ideas like getting registry based reporting, focusing on laboratory information systems, contracting to develop measures to be electronically specified and how to broaden Meaningful Use measures and criteria. Now previous to this we had had a, let's see May 13<sup>th</sup> we had a public hearing of which the first three panels were on specialists. I can't go over all that comes out of that, but that was a very rich hearing in fact and I re-read it over the weekend, and I got a lot more out of it on this reading then I did sitting in the hearing because now I understand the issues better and in fact it covers many of the aspects extensively. So, again I can't review everything that's in there, but I think that should inform us as we make our decision going forward.

Next, the AMA has supplied us with a number of resources including a spreadsheet of how specialists fit in with the existing and planned Stage 1 and Stage 2 measures and I'd like to look at that briefly maybe, and then in addition supply the PDS document that is a little bit more of a narrative with it. If people have that available I welcome you to look at it, but I'll just describe it. There's a matrix that you can have various specialties for example anesthesia, cataract and refractive, chest physicians, dermatologist, family physicians, gastroenterologist, geriatrician, home care, infectious disease, internal medicine, neurology, neurosurgery, OB/GYN, ophthalmology, orthopedic surgery, otolaryngology, pathologist, psychiatry, radiation oncology, radiology and surgeons. Across the top of specialties is detailing with a color coding green, yellow and red on how they fit in with the Meaningful Use Program.

If you look at the spreadsheet quickly what you'll find is, and not unexpected, that for example pathologists are listed as having the most difficulty with the program followed by radiologist. Actually in looking at it, when I was looking at it over the weekend, if you go one step further the next group that seems to have the most difficulty is the geriatricians, which kind of surprised me because I would have thought that many of the family physician measures would have applied to geriatricians and perhaps more so than some of the other subspecialties.

Also, what you can do is look horizontally across the spreadsheet and pick each objective and say which objectives really have a lot of difficulty across all subspecialties and some of them are as expected, for

example the quality measures has a lot of red right across the row because we don't have a lot of existing quality measures for subspecialties. And vital signs would be the next one that pops up, but the next one that pops up is decision support and that's one of the areas where we thought that subspecialties could participate, perhaps there's not enough decision support already existing, but as a concept it's something that we would think would apply across specialties. So, I don't think we can use this right now, but I think as a tool we can use this to double check what we've done and what we've planned to do and see which areas are more broadly difficult for specialist.

And let me take the opportunity here to say that I think our mission, because we only have limited bandwidth, is to try to address specialists as broadly as possible, that we can't focus on one specialty group or another, but we have to say look across this broad range that the AMA has supplied us and see what can we do as a subcommittee to address it that way. And then there may need to be exceptions and that may be more the purview of CMS.

Next reference was I had sent around an e-mail where I summarized the results of the HIT Policy Committee meeting and my review was that we needed to review the past materials, we needed to assess whether we would have tracks as the Meaningful Use objective level, the recommendation from that Policy Committee meeting was that although there may be tracks in the quality measures and the functional objectives that may not be wise, but it's clear that doing some things for the specialists would be very important, I think that echoes through many of the presenters, many of the committee members of the Policy Committee.

And then we looked a little bit at what might be common among all doctors and the list that I came up with in that e-mail was reviewing data, sending data, local decision support, local quality improvement, care team and plan, and sharing with patients are things that we would hope would cover a large percentage of physicians. And then again, I mentioned imaging. Now, let's see, did I miss any, I think that covers our material. Comments from the subgroup?

#### **Michael Barr – American College of Physicians**

This is Michael Barr. I think you did a great job summarizing, putting together all the documents. I would say one thing that came across in some of the testimony I reviewed from some of the subspecialists was registries and how that could play into the Meaningful Use or give them credit for what they're doing there and the other one was, of course and it's referred to tangentially I think, was the care coordination, the information flow that came up on our pre-small group Workgroup a few weeks ago.

#### **George Hripcsak – Columbia University NYC**

Excellent. Agreed. Other points?

#### **Eva Powell – National Partnership for Women & Families**

Well this is Eva and this is a slightly subtle point and I think you actually kind of capture what I would imagine the elements would be in your e-mail under the number 3 what is common, but I agree that we need to take an across the board approach that we can't parcel out various specialists, we will make ourselves crazy and never come up with anything if we try, and so maybe a better a way to think about this is not what do we need to do for specialist, but what do we need specialists to be doing for patients, and I think you've captured that in the review data, send data, local decision support, and those kinds of things. So, I mean, like I said it's a subtle point, but I worry that if we kind of keep going down the track of what can we do for specialists that we'll get off on that tangent of trying to create criteria to the exceptions as opposed to what do all specialists need to be doing for patients and that should be a fairly limited set of concrete things that I think we've got a good start on.

#### **Michael Barr – American College of Physicians**

This is Michael. I agree with what Eva said, but I would say we also want to make sure what we've put forward is actually connecting specialists and subspecialists to the primary care hub.

#### **Eva Powell – National Partnership for Women & Families**

Oh, yeah, definitely.

**Michael Barr – American College of Physicians**

Posturing this and that could be done in a variety of different ways and I think George's outline gets us there and I agree, I mean we have to be as general as possible while fostering the kinds of objectives we just talked about.

**Eva Powell – National Partnership for Women & Families**

Right. Right and I think that would fit into the category of what do we need specialists to do for patients; we need them to coordinate with primary care.

**Michael Barr – American College of Physicians**

Absolutely.

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

Yeah, this is Neil, I just want to make the point that, you know, this has been sort of a dialog between the people who think that what we should do is create a measure for something that's relevant to every specialty versus trying to find, you know, something that's broad, that reaches across all specialties, and for me I think that's a tougher question to answer than it might appear because I think, you know, if you think about Meaningful Use what we're trying to do is get people to capture and use data practices so that they can become meaningful users of the technology that they're implementing, and for that I think it has to be extremely relevant to what they already do, in other words not using electronic health records to transform their practice.

On the other hand we know that there are major gaps in the way people communicate and stuff like that. So there's other pieces where we're using the technology to actually transform what we want specialists to do or at least to facilitate what we think that they should do, and I think that we sort of get into this kind of, you know, struggle between those two sides. So, I would suggest we kind of need to do a tiny bit of both, you know, that we need to do something that sort of stretches across, so maybe around communication back between primary care and specialty, which I think does cut across all areas. But, I think in the other area what we really need to do is to think about ways of creating a large enough menu so that people can begin to pick something that's relevant to their practice and be able to use that data to engage in an improvement activity.

**George Hripcsak – Columbia University NYC**

Okay. You know, in a sense, this is George, in a sense one way to look at our job is there may be objectives moving forward that we don't want to continue and there may be objectives that we need to add, and then there may be objectives that we need to modify, and so, in so far as we come up with a framework for what specialist need to provide and that's the review data, send data, etcetera, we can then go about our work by seeing which of these things we're already working on we just need to do it slightly differently, which things are totally new to what we've done, and which things do we think that need to be dropped off, or a different way to do it would be to say that this would be a reasonable thing to have an exception for specialist. So we have to have some method to go forward and actually get the work done.

**Eva Powell – National Partnership for Women & Families**

George this is Eva, sorry just a point of clarification, when you say things to be dropped off are you talking about eliminated from the Stage 1 criteria or from what's been proposed for Stage 2?

**George Hripcsak – Columbia University NYC**

What I mean is either provide, well either suggest an exemption.

**Eva Powell – National Partnership for Women & Families**

Yes.

**George Hripcsak – Columbia University NYC**

So dropped off someone's list or dropped off as we move forward into Stage 2 and 3.

**Eva Powell – National Partnership for Women & Families**

Okay.

**George Hripcsak – Columbia University NYC**

I don't think we should focus most of our time there though, I think most of our time should be seeing how we modify what we have to accommodate the vision you guys just espoused. Michael?

**Michael Barr – American College of Physicians**

Just one other thing while we're talking about exceptions, we still have to deal with the issue that for example pathologists don't use EHRs, at least by the testimony, they're using the LISs.

**George Hripcsak – Columbia University NYC**

And so now we're in the second part of our agenda which is options for accommodating specialist and LIS. So my question to you is does each specialty group have something like an LIS? Does a dentist have a dentistry system which is different from an EHR perhaps? Radiologist have the RIS. Ophthalmologist often have a very different feeling system than some of the others, so are we saying that there's a whole set of systems that different specialties and specialists use that might not be normally classified as an EHR?

**Michael Barr – American College of Physicians**

Yes.

**Eva Powell – National Partnership for Women & Families**

Yes.

**George Hripcsak – Columbia University NYC**

So, then what direction do you think we should go? Are we saying they should be treated as a module like an EHR? Are we saying they should be exempt from certification?

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

This is Charlene. On the certification topic, the Implementation Workgroup did make some recommendations which allowed there to be, if you will, more modular certification of those elements that pertain to the specialty, I think that's really important. Right now there's a concept that you have to possess the software that meets all the objectives and that's really problematic for instance for radiologist and pathologist who do not need to meet all the objectives. So, if it's sufficient to say here's the objectives that pertain to me, based on what Meaningful Use says, and it's okay that the vendors only certify those particular modules, if you will, then it will work, but the current certification process doesn't work and will have to be changed to accommodate this, and I think it can be.

**George Hripcsak – Columbia University NYC**

Can we come up with a pithy recommendation that lets all the specialist address their specialty specific systems? Is there some way to put down a recommendation about certification?

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

I think there's language in what the Implementation Workgroup provided and I can pull that out, that at least we can endorse perhaps.

**George Hripcsak – Columbia University NYC**

Okay.

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

So the legislation specifically allows pathologists and radiologists to access Meaningful Use dollars?

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

Yes.

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

It's a question.

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

Yes.

**George Hripcsak – Columbia University NYC**

Yeah, the original law actually used radiology and pathology I believe as examples of who would not be included, but the jobs bill then set specific criteria of whether you're in or out and the criteria are fairly strict on who, a small group of who was excluded and that's how they got included. So, in other words, if they do 10% more of their time billing for outpatient services they're included.

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

So, if they're included they need to be, I mean, there's to be a whole separate track for them. We're trying to pound the square peg in a round hole here.

**George Hripcsak – Columbia University NYC**

Well, I think that...

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

Their systems do completely different things.

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

Yes.

**George Hripcsak – Columbia University NYC**

So, I think in some ways this is more of a CMS problem than a Meaningful Use Workgroup problem.

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

I agree.

**George Hripcsak – Columbia University NYC**

In the sense that if we spend our time figuring out how to circumvent the law that kind of included the people who were explicitly excluded in the legislation we can spend a lot of time figuring out how to solve that when it's a fraction, I think that's something that perhaps CMS has to figure out how to address that, and that we need to spend our time more on the core which is improving care in the US and go more for the clinically oriented and perhaps we can make a statement about the other groups, but I don't want to spend all of our time addressing how to solve that issue.

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

I totally agree with that. This is Neil.

**Paul Tang – Palo Alto Medical Foundation**

This is Paul. I totally agree with that too.

**George Hripcsak – Columbia University NYC**

So the recommendation may be something as simple as, or it can be more meaty, but it could be as simple as the fact that ONC and CMS need to work together to come up with a solution for specialties who really do not see patients and do not use EHRs.

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

...some radiologists do see patients, but I just would say, you know, whose business practices depend upon information technology that does not have, and does not need to have the same capabilities of fully functional electronic health records.

**George Hripcsak – Columbia University NYC**

Well the interventional radiologists who see patients much the way a surgeon might you could argue would benefit from a lot of the features in Meaningful Use, whereas the ones who don't see patients as much aren't going to benefit as much from these objectives. So, I think there may be subsets of pathology and radiology for whom this makes sense.

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

You're talking about, you know, we're going to find little things like that for all specialists? I mean, you have, I would just not get into that level of detail. I think we have so much work to do with the other specialties.

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

Yes.

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

I think we should let CMS figure out what they want to do here.

**George Hripcsak – Columbia University NYC**

Okay. I'm in agreement largely because some of the issues are kind of on the fine details of, you know, kind of the legal, not just legal but the regulatory issues that, you know, it's hard for us, from our viewpoint to know how to phrase everything exactly so it all fits. You know, for example the jobs bill that brought them into the thing you had to read the fine details to figure out how broad that is. I don't think we have the skill set to do that. So, I agree that we need to focus on the center, which is the clinically oriented specialties, because if they don't fit in then we really have a problem.

**Paul Tang – Palo Alto Medical Foundation**

So maybe we ought to move onto them?

**George Hripcsak – Columbia University NYC**

Thank you, Paul. So, first of all let's just look at that list, review data, send data, local decision support, local quality improvement, care team and plan, and sharing with patients. Are we missing major categories that the specialists would benefit from that we need to focus on? I mean you could argue send data is really just a part of care plan. So maybe it's not a perfect list, but mainly I'm worried are we missing things.

**Paul Tang – Palo Alto Medical Foundation**

Is the mention of coordination in there? Is that part of care team and plan?

**George Hripcsak – Columbia University NYC**

Yeah, that's what was intended.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Well, I wonder...

**George Hripcsak – Columbia University NYC**

I should put explicitly.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, I think that may be one of the biggest. I really like the way Eva, I mean it's just a simple switching around the words, but I think it's a good orientation, that is what do specialists need to do for patients that use the EHR that use HIT.

**George Hripcsak – Columbia University NYC**

Okay, I'm just writing now. So, then I'll say care team plan, just for now I'll just add the word coordination just to make sure it's included and then share with patients. Okay, now do we feel, as a group, that where we're headed in Stage 2 and later Stage 3, where we did head with Stage 2 and where we're

headed in Stage 3 that we're missing something for specialists? How do we need to modify where we're headed on those items?

**Paul Tang – Palo Alto Medical Foundation**

I need to go back and check, but did we include the one that we considered in Stage 1 which is the round trip between specialists and primary care physicians?

**George Hripcsak – Columbia University NYC**

You know, we proposed, wait Paul is this correct? We proposed that it wasn't included in Stage 1 is that right? We never got...

**Paul Tang – Palo Alto Medical Foundation**

We put it in but it wasn't accepted and so I think we need to come back, I'm trying to look up our matrix, I'll find it.

**George Hripcsak – Columbia University NYC**

So, an example of something that may be missing is images. What we've heard, and if you look at the transcript, heard many times is that many of these specialties when they think about computers they think about images, because that's what they need to carry out their tasks, and they felt that that was a major thing that was missing from Meaningful Use, that's a big topic and lets hold off for a second, but that's an example of something that may be missing. In other words if they're going to be participating in sending and receiving data there would be a benefit from being able to share that image, so that for example there's less duplication of studies and so forth.

**Eva Powell – National Partnership for Women & Families**

Could not images be included in data as we define it?

**George Hripcsak – Columbia University NYC**

Yeah, but it's something that although we send and receive data in various forms in our current objectives we don't do images.

**Eva Powell – National Partnership for Women & Families**

Yes.

**George Hripcsak – Columbia University NYC**

Now whether that's an example of us trying to do something for specialists or the other way around I think if we do images it would help the process of care and the question is whether it's feasible at this point in time not so much whether it would be useful if it were feasible.

**Eva Powell – National Partnership for Women & Families**

All right and by feasible you mean technologically possible?

**George Hripcsak – Columbia University NYC**

More than that, I think that if we put in such an objective could it be reached whether the problem is technological or other societal factors I don't know. So, that's the discussion.

**Eva Powell – National Partnership for Women & Families**

Yeah.

**George Hripcsak – Columbia University NYC**

So let me not go too far in images yet, because I've put that aside on the agenda.

**Paul Tang – Palo Alto Medical Foundation**

So, George, I'm looking at our improved care coordination and the new kinds of things we've proposed, this is where we've got into care plan goals and patient instructions and the team members and

transmitting a summary of care but we didn't talk specifically about timely feedback from the specialists in a referral.

**George Hripcsak – Columbia University NYC**

Okay. So I agree with that. So, referrals would be one thing that's missing from our current push in Stage 3.

**Paul Tang – Palo Alto Medical Foundation**

I think we've definitely heard about that from PCPs and I believe we also had an agreement from the specialists in their panel.

**George Hripcsak – Columbia University NYC**

So, looking at our list, so review data we're trying not to say what screen you should have for reviewing data, it's a matter of getting the data and sending it, so we'll talk about images later. I'm not sure that there's any new objectives that need to be put there. Local decision support we left purposefully generic. So, I realize, I mean, I think the questions that arise if it's a generic system that gets delivered to a specialist, are they to get Meaningful Use supposed to write a reminder or is the specialty society going to supply reminders? How do they get engaged? I think it's obvious that having some kind of decision support could potentially be useful and some of it is generic across providers, for example drug interactions and we we're working on that separately, but there may be specialty specific reminders so I don't know if there's a recommendation at the society. Oh, I'm sorry, Michael you mentioned it already, but registries is something also on our list.

**Eva Powell – National Partnership for Women & Families**

Yes.

**George Hripcsak – Columbia University NYC**

Of missing.

**Eva Powell – National Partnership for Women & Families**

Yeah and I think the registry thing is a really important point to figure out how to do and do well and that was even, I don't know if you guys got a chance to read the letter from Kelsey Kurth who was I think from the ophthalmologist, and I don't know that we need to go with ophthalmology specific stuff but they mentioned registries in there as a...so that would seem to apply across most specialties.

**Michael Barr – American College of Physicians**

You could even say that registries should, we could ask the specialists, but for radiology and pathology it might be another way to get them in.

**Eva Powell – National Partnership for Women & Families**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

So, we actually had one, if not two panels specifically on registries in the two separate hearings, and some of the things that were left as outstanding issues and let's see whether we can deal with them now, the one was that to our knowledge no registry, certainly the big registries had it in a basic EHRs at the time so people were either entering in through paper and then transcribed or going through a web based interface to a registry. Second, that we didn't have standards that covered many of the, probably most of the data elements in those registries. Third, that most of those data elements didn't come from an EHR they were additional details that weren't generally entered in an EHR.

A fourth issue that came up was that a lot of these were actually expensive so to participate in them required some money so in a sense that would become another mandate that incurred additional costs. And then we also heard about some contractual restrictions with some registries that caused you not to be able to share that data with other parties if you were engaged in reporting in one registry. So, we had

some of these issues come up when I think we had our first panel on registry and that made us think twice about how to overcome those challenges.

**George Hripcsak – Columbia University NYC**

Paul, do you think that given that Stage 3 is 3-4 years off that there would be time to address some of those issues on registries?

**Paul Tang – Palo Alto Medical Foundation**

I think there's time, the question is, is that even in our scope of responsibility? So, for example, NQF requires that if you're going to propose a measure that it be open source, in other words there not be additional charges. I don't know that we have that capability, maybe we make a recommendation for CMS and ONC to deal with this issue, but I don't know that we have within Meaningful Use the ability to overcome some of those.

**George Hripcsak – Columbia University NYC**

Is there anything that we're asking providers to do for whom we could offer registry as an alternative that does not make it mandatory but say "well you have to do this, oh but if you're doing a registry that counts."

**Paul Tang – Palo Alto Medical Foundation**

Perhaps it's in the quality measure area? So, is it possible they could get credit for, so we already have, at least the Quality Measure Workgroup set up this core plus menu from each of the six categories, maybe there's some way that when you participate in a registry it counts as one of your menu options in one or more categories, I mean that's possible. In a sense it's consistent with this reporting theme and use in both quality improvement and public reporting.

**George Hripcsak – Columbia University NYC**

So maybe we make a recommendation to the Quality Measures Workgroup or Tiger Team to consider registries.

**Paul Tang – Palo Alto Medical Foundation**

As part of their strategy?

**George Hripcsak – Columbia University NYC**

Yeah, because if you're trying to come up with appropriate measures for each specialty and having trouble doing that this would be the thing that the registries would offset it and say "well if you're participating in a registry you're doing a similar exercise."

**Paul Tang – Palo Alto Medical Foundation**

So maybe the registries could potentially get certified as covering x-domains in the quality measure, that circle they have.

**George Hripcsak – Columbia University NYC**

Exactly.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, yeah, then that could be, yeah.

**Eva Powell – National Partnership for Women & Families**

Yeah, well that would seem like a good way to deal with some of those barriers is to treat it as we talked about the LIS and some of the other technologies people are using.

**Neil Calman – The Institute for Family Health – President and Co-founder**

This is Neil; I have a question in relationship to the functionality for this. So is there a standard language in which people communicate with these registries, I would imagine not.

**Paul Tang – Palo Alto Medical Foundation**

Unfortunately, no that was one of the problems we had.

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

So, how would a vendor program the capability, I mean how would this be included in certification requirements so that providers actually would have the functionality to communicate with these registries?

**George Hripcsak – Columbia University NYC**

So, Neil this is George, I think you're right and I think that's where the 3-4 year lead time gives us the advantage that we could adopt, you know, CCD or whatever it is would be the appropriate standards, that there is ample time to shift towards that.

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

Yeah, but we don't run the registries, so.

**George Hripcsak – Columbia University NYC**

No but if they want to qualify as registries that allow you to get Meaningful Use they'll have to do it that way. So they'll be an incentive to registries to fit in with the national standards because doctors are going to want to use registries that get them Meaningful Use.

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

So we let the market kind of run this through? Okay.

**George Hripcsak – Columbia University NYC**

Well we'll set the standard and then if you want to have doctors who want to qualify for Meaningful Use then you'll have a strong incentive to use those standards.

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

Well I don't know enough about standards, but I would imagine that these registries look very, very different from one another in terms of what they capture and how they capture it and whatever, but I assume that we could create some sort of standard format for that.

**Michael Barr – American College of Physicians**

This is Mike. I think we may be talking about two separate things if I'm understanding the conversation, one is if they're using registries to do clinical quality measurement and reporting on those measures than that would qualify for that part of Meaningful Use. I don't think that obtaining the registries is the way they're going to communicate in care coordinate all those other things, correct me if I'm wrong.

**George Hripcsak – Columbia University NYC**

No, I think that's correct.

**Paul Tang – Palo Alto Medical Foundation**

I think that's correct. And so maybe, so again we're talking about a voluntary, so let's say a registry can produce the following quality measures in this set that pertain to a particular specialty, so it uses a very small number of the total data elements that are submitted to the registry, but from the registry, if you submit to this registry you could report on the following measures that are relevant to your specialty, that would be an example where it's almost harmonization. If they, for their own reasons, participate in registry A and you can produce some of the quality measures that are required in Meaningful Use then you're participation does qualify you for those measures in the QM, you know, menu sets. Does that make sense? So it's totally voluntary but if you're doing this already for other reasons, it's not a mandate from Meaningful Use, then you would get credit for those particular measures.

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

So, this basically sort of covers the other issue that we've talked about, which is whether or not you have to use a certified EHR to produce...

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

It covers that issue basically.

**Paul Tang – Palo Alto Medical Foundation**

It also covers that issue. So we're dealing with the harmonization, we're dealing with sort of the menu approach for different specialties, we're not making it mandatory for everybody, and we're sort of allowing a third party, as you said, Neil, to produce the measures if it is "certified" and I don't know how we could get there, but, so a voluntary participation in this registry qualifies you to take credit in the following quality measures.

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

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

But, you know, it does meet some of those criteria, there's harmonization, you're not doing double work, and so on and so forth.

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

Paul, this is Charlene, just again from the vendor perspective here, when you speak harmonization again, I mean, even if you look at, you know, from the cardiology measure, there's, you know, three different kinds of measures for the same concept, if you will, so when you speak harmonization are you speaking to harmonization of the measures too? Because I think that's important in this process.

**Paul Tang – Palo Alto Medical Foundation**

I think it's really important. We're trying to, we sort of generally, collectively trying to get the harmonization process to happen both at the NQF stage so that we don't have 5 measures NQF endorsed for the same concept and at the people who pick these measures to report, i.e., the CMS and the payer stage. So, I think we don't have the authority to do the complete harmonization, but we're supporting it through things like this.

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

Okay. I just think we need to be clear on that, I know it's not the current state. And then the second point too is today the way, and again certification works is you're certified for the bulk of the measures and it's not broken down independently, so this, which I think is a smart approach, I'm not disagreeing with the approach, is that again you can certify to a subset of measures with a system so that they count. So it's going to be a lot more complex, but I think that's the real world, clinical report, clinical measures. So, you know, if you have to report 10 you might not all report them from the same, if you will, data warehouse.

**Paul Tang – Palo Alto Medical Foundation**

So, one of the things we wanted to try to approach and we don't have a good way of doing this, but we sort of delegated to the QM Workgroup which is how to move toward having a platform for our reporting measures rather than hard wiring each and every thing every time and I would guess the vendors would like that too, but if we could move towards somehow a platform where you actually had plug ins and it was up to the measure developer community to specify the standard plug ins I think that would make things easier for everybody.

**George Hripcsak – Columbia University NYC**

So it's gratuitous that tomorrow is the eCQM Workgroup so Paul you could bring the suggestion there and see what the in's and out's are.

**Paul Tang – Palo Alto Medical Foundation**

Correct. So that was going to be, and I think it's still on its way to Quality Measure Workgroup, but again it's something that has to be done collectively with the Meaningful Use Policy, with CMS and private payer program, and with the endorsement process and measure development process.

**George Hripcsak – Columbia University NYC**

I mean, I think that, you know, one of the challenges there's this balance between we want standard common measures across the country, but there's a zillion to develop and it's not necessarily true that a central committee is the best at developing it and that societies may be better so there needs to be some flexibility, and so working out how to, you know, walk that line between those two is part of the challenge. I think registries may be part of the answer to that. Okay, so that's registries. On care coordination, what would be needed to address care coordination is it just adding the referral as a new objective? Is it adding a referral to the care coordination objective?

**Paul Tang – Palo Alto Medical Foundation**

Making sure that all the people, all the stakeholders have information. So it's a combination of the compliment to our summary of care and our clinical summary. So it's important information as a result of this referral back to the referee, which is the primary care physician most of the time, and the patient.

**George Hripcsak – Columbia University NYC**

So, would we take that objective, the sharing the summary of care document that goes to providers and making it bidirectional, is that the intervention we need to make or is it adding another objective?

**Paul Tang – Palo Alto Medical Foundation**

Bidirectional would be more.

**George Hripcsak – Columbia University NYC**

I think so.

**Paul Tang – Palo Alto Medical Foundation**

More efficient and parsimonious.

**Michael Barr – American College of Physicians**

This is Michael, I would agree with that.

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

Yes.

**Paul Tang – Palo Alto Medical Foundation**

So the other thing that we include is the timeliness, just like we have timeliness with respect to patients, we should have timeliness back to the referees.

**George Hripcsak – Columbia University NYC**

Okay, let me think are we missing anything on, I want to pull out getting to patient separately, but as far as communication between providers are we missing anything or does that cover it?

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

Well if there's another aspect of care coordination and maybe that falls into a different category, but, you know, when we talked about the registries, registries are also a care coordination tool, and I'm wondering if we should call out here...just like we talked about with some of the measures that fresh data needs to be available and accessible to the providers in their systems, that there's some bidirectionality of the registry as well, you know, that they're not just...registry develops the measures and sends them off to CMS, but sends, you know, makes sure that the functionality is bidirectional so that people have registries of patients follow-up and help coordinate the care.

**Paul Tang – Palo Alto Medical Foundation**

That's an excellent idea and I think that could help the people who contribute to registries because I think part of their issues, what you said, which is they submit data in and they pay money, and do they get enough information back out both for public reporting as well as to improve their care. So, maybe some kind of bidirectionality is part of do you qualify by using this registry.

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

I think it's got to be, otherwise, you know, we're just creating a way for people to meet a burden but we're not giving them a useful tool to help, you know, deal with quality issues with this group of patients.

**Paul Tang – Palo Alto Medical Foundation**

And also that addresses one of our crossing over to CQM small group is the notion that it applies not only to public reporting but also to quality improvement.

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

Exactly.

**George Hripcsak – Columbia University NYC**

And Neil, I mean this is not care coordination, this is quality improvement, right? The bidirectional with the registry is not going to help you coordinate care; it helps you improve your care process.

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

Well, no actually, I mean, it depends on what information is captured in the registry. So, if the registry is capturing information, you know, that's reportable back to the providers in terms of which patients need to be sent to care managers, you know, which patients need to be referred for, you know, based upon their outcomes which patients need to be referred, then it does help with care coordination. Our diabetes registry is sort of the main link around how we coordinate care about our patients with diabetes, you know, we look at people whose A1c's are out of control, they go to a diabetes care manager, but we also look at people, you know, who haven't had ophthalmology visits and that helps us coordinate care, folks that come in and do our vision screening program. So it can be a powerful care coordination tool.

**George Hripcsak – Columbia University NYC**

Okay, so you're saying the registry can tell you that someone needs coordination. I'm not sure the registry can actually do the coordination, in other words I don't think it can match patients within the registry across providers. It can't serve as the coordination tool, you're saying that it tells you that here's what needs to be done on these patients.

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

Right, but only if I can get that information back that I fed into the registry.

**George Hripcsak – Columbia University NYC**

Okay, so maybe at the very least it should be bidirectional from a quality improvement and perhaps from a recommendation point of view, probably not yet for actually coordinating the care between two providers.

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

That's fine if you want to say it that way.

**George Hripcsak – Columbia University NYC**

Okay. Other things on care coordination for now? Okay, so then what about with interaction with patients, you'll notice that if you look at, here let me pull up my spreadsheet. I'm looking at the AMA spreadsheet, hold on one second, well actually provide patients with electronic access maybe was one that was a little more red than the others, but otherwise the spreadsheet doesn't show a preponderance of red across the rows on the patient engagement objective. Timely access and clinical summary, some of those are red. If you don't see patients then your denominator would be zero. Eva, what do we think we need to do in terms of sharing with patients and specialists?

**Eva Powell – National Partnership for Women & Families**

Well, I tend to think about this in terms of lab and test results, thinking about specifically what specialist do and the notion of closing the loop on the referral with the primary care. I think if a patient has been referred to a specialist I want to know, you know, what's the deal? What came of all of that in addition to having my primary care know about that? So I'm not sure that there needs to be any difference between what's already there and we just might need to think about specifically how it applies to specialist. The one thing that always comes to mind in this though are some of the arguments offered by those who don't typically have direct patient contact, which again, kind of getting to the notion of what do we need specialist to do for patients, I think in those instances rather than trying to make a square peg fit in a round hole, and trying to get a person that a patient has never seen themselves provide them information, perhaps that then loops back to closing the gap with the primary care and that becomes part of enabling the patient access to that information through the primary care by providing the information to the primary care, if that all makes sense.

**George Hripcsak – Columbia University NYC**

So it might not be the link to the primary care it could be another specialist who is the link to the patient.

**Eva Powell – National Partnership for Women & Families**

Well yes, true, true, true.

**George Hripcsak – Columbia University NYC**

Whoever sees the patient, I mean it's basically the referring provider whoever that is.

**Eva Powell – National Partnership for Women & Families**

Right. Right.

**George Hripcsak – Columbia University NYC**

So, is there something we need to, I'm just thinking, is there an objective? Is there something we need to change in order to accomplish that? For example, we added an objective in Stage 2 talking about hospitals serving as labs.

**Eva Powell – National Partnership for Women & Families**

Right.

**George Hripcsak – Columbia University NYC**

Is there a specialty, is there an analog for specialists that they need to send data to the referring doctor, that it's not just a summary. The one thing is to send back the referral letter, another is do you need to send back the tests? Of course the tests may have been done by an outside lab, depending on the specialist we're talking about, if it's you know, radiology and pathology would be different than say an endocrinologist as the specialist, an outside lab may be doing the tests, so whose job is it to get those results to the referring provider? Of course in that case the endocrinologist would actually be in contact with the patient so they would be the one to share it with the patient probably.

**Eva Powell – National Partnership for Women & Families**

Well how does that work, like if I were a specialist and ordered something done through an outside lab would I not want to get that result myself?

**George Hripcsak – Columbia University NYC**

Right. So, I think if its and endocrinologist you're going to see the patient, it's like a primary care, you're going to see the patient, order the test, follow-up, show them the test results and if they're following Meaningful Use there will be some way via the EHR for patients to get access to those results.

**Eva Powell – National Partnership for Women & Families**

Exactly, yeah.

**George Hripcsak – Columbia University NYC**

So that one just fits, it's really the ones that don't see patients that are a little different.

**Eva Powell – National Partnership for Women & Families**

Yeah. But I guess I'm still thinking that if I'm a pathologist and I send something off to an outside lab for analysis, I still am the steward of the information because I am the specialist that's gotten the referral and so would I not still want to get those results even though I never have any actual contact with the patient? Otherwise why am I involved?

**George Hripcsak – Columbia University NYC**

Well in that case you are the generator of the results.

**Eva Powell – National Partnership for Women & Families**

Right.

**George Hripcsak – Columbia University NYC**

So you have the results and the question is now what? Are you obligated under Meaningful Use to hand not only a summary of what happened but the actual data.

**Eva Powell – National Partnership for Women & Families**

Right.

**George Hripcsak – Columbia University NYC**

To the referring doctor under Meaningful Use, is that a requirement, so that it can then get to the patient.

**Eva Powell – National Partnership for Women & Families**

Right, yeah, and I guess I am having a hard time thinking of an example where that would not be appropriate, like to hold specialists accountable for the information getting back to the primary care even if they send off to an outside lab for something it's still their responsibility to make sure that the result was received and passed along.

**George Hripcsak – Columbia University NYC**

I mean, generally there's a report so it's like doing a blood test and the result is the report.

**Eva Powell – National Partnership for Women & Families**

Right.

**George Hripcsak – Columbia University NYC**

Which can be structured or not structured depending on the type of examination that the specialist did and I think right now the way I'd look at it the burden is on the referring doctor, say the primary care provider or someone else, to make sure that that result comes in and gets shared with the patient.

**Michael Barr – American College of Physicians**

This is Michael, it sounds like it's the responsibility of both the specialist and the primary care.

**Eva Powell – National Partnership for Women & Families**

Right, yeah.

**Michael Barr – American College of Physicians**

...having that same responsibility.

**Eva Powell – National Partnership for Women & Families**

Yeah, to me that strengthens it, it actually, you've got double the accountability for making sure that the result is received and created somehow.

**Michael Barr – American College of Physicians**

This is Michael, from the primary care perspective they might not actually be planning for when that's going to come in whereas the specialist would know it was sent and know to expect it and know to communicate with the patient, and then the primary care doctor.

**George Hripcsak – Columbia University NYC**

So for the most part do the specialists share the data with the patient?

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

Yeah if they ordered it.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, if they order it.

**Michael Barr – American College of Physicians**

They should.

**George Hripcsak – Columbia University NYC**

Are there examples besides radiology and pathology where the specialist is actually the one who does the thing but they also see the patient?

**Michael Barr – American College of Physicians**

Cardiology.

**George Hripcsak – Columbia University NYC**

What's that?

**Michael Barr – American College of Physicians**

Cardiology fits the bill as an example or GI or any other specialists they do something and then they see the patient.

**M**

Yeah, yeah.

**George Hripcsak – Columbia University NYC**

So you do your catheterization.

**Michael Barr – American College of Physicians**

Right and they share the results with the patient that's part of what we're talking about and then of course they have to give it to the referring physician, who may or may not be a primary care physician, let's be clear it could be another specialist.

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

Right.

**George Hripcsak – Columbia University NYC**

So, in that case we're not asking...

**Paul Tang – Palo Alto Medical Foundation**

You know professionally and legally the ordering provider is always responsible and accountable I think for both getting it back to the patient and for acting on it as appropriate.

**George Hripcsak – Columbia University NYC**

That's the specialist in this example?

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

Yeah and I wouldn't want to do anything to change that I think.

**George Hripcsak – Columbia University NYC**

Okay and that's already under Meaningful Use the way we've written the objective. If you're a member of Meaningful Use, if you participate in Meaningful Use there is an objective that says you have to share data with the patient, the kinds of things that we wrote in the list that have to be shared with the patient, I guess we do have procedures listed don't we under the summary? So, the only thing I can think of that would change is we would look at what gets shared with patients and make sure it includes the kind of things that specialists review with the patient. Now a different question is whether the radiologist or pathologist need to, you know, be the ones to share with the patient and again we don't want to go too far in that direction, I would think it would be the ordering physician who did it because they have the relationship with the patient and can give them the ID and password to get onto the portal. So when is it a referral? When is it an order?

**Eva Powell – National Partnership for Women & Families**

And is there a way to somehow work, instead of making an exception for say radiologist and pathologist just alter the requirements somehow by saying if you don't typically have contact with the patient then your obligation is to provide the results back to the referring physician.

**George Hripcsak – Columbia University NYC**

So, in our short concise, general statement for CMS to address this we can add that portion that it's our understanding that you probably don't have, unless you have a relationship with the patient, you won't be able to get them to a portal.

**Eva Powell – National Partnership for Women & Families**

Right. Well, but I think we would need to be clear that the criteria, we wouldn't want to let everyone off the hook, in other words give everyone a choice of whether or not to send the results to the patient or the referring physician, but that for those who do not have direct patient contact that the obligation is to get the information back to the referring physician.

**George Hripcsak – Columbia University NYC**

Okay. So perhaps we need to add to the list on view and download things that would be more, that we weren't thinking of because we were thinking primary care, that would be in that list. So, for example whatever procedure, I think procedure is already in there, so it may already be covered, so we need to recheck the list and see if the kind of thing that the ophthalmologist, the cardiologist, and so forth, cardiac surgeon do are in that list.

**Eva Powell – National Partnership for Women & Families**

And this is the list for the care summary or for the...

**George Hripcsak – Columbia University NYC**

View and download, maybe more view and download.

**Eva Powell – National Partnership for Women & Families**

View and download, okay, sorry. View and download, okay. I'm looking at an old list unfortunately, but we say referral at one point, so we'll look back and see.

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

This is Charlene. One of the areas that we get feedback on from the vendor community is, especially when it comes to the sharing information, if these specialist are part of an integrated network then by definition they're using the same system. So, some of these measures then don't apply in those situations because the data is available. So is that accounted for in our thinking? When they're outside of a network would they need to be able to exchange information, but if the data is there because they are part of the same system then the data is there.

**George Hripcsak – Columbia University NYC**

So they meet the objective of the patient being able to view and download, but you're pointing out that how we measure, how CMS measures that needs to account for that so it gets counted.

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

Yes that's all.

**George Hripcsak – Columbia University NYC**

They get credit for it.

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

It's been a problem, yes.

**George Hripcsak – Columbia University NYC**

Okay.

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

And also I think that relates back to the referral one we were talking to earlier.

**George Hripcsak – Columbia University NYC**

Okay. So in effect we've covered the first, you know, of our framework of five areas, we've kind of done quality and safety, and we've done patient engagement and we've done care coordination. Is there anything specific to public health, I think those are only relevant if they're relevant to that specialty, because they're very specific things like immunizations. So pediatrics would apply to pediatrics but perhaps not to others and then the 5<sup>th</sup> category is privacy which would apply to everybody.

**Michael Barr – American College of Physicians**

This is Michael, before we go there I apologize, I want to just react to what Charlene just said.

**George Hripcsak – Columbia University NYC**

Oh sure, please do.

**Michael Barr – American College of Physicians**

I agree with her accept that I'd be really hesitant to leave it to a pull thing, in other words if I'm in the same system and I do a procedure or a test, sure it's in the system, but I still think that there should be something in there that says that that was pushed to the referring provider and if that's not part of the current system that they're in than that should be something that is called for and that might not be within our Meaningful Use Group, but perhaps in the certification side. I just hate to have information hanging out there to say "oh well I did it let's wait for the referring physician to go look for it."

**Paul Tang – Palo Alto Medical Foundation**

Yeah and actually so that turns into an EHR certification criteria, in other words on completion of a referral there should be some kind of notification.

**Michael Barr – American College of Physicians**

Right, that's exactly what I was getting at Paul. I'm not sure if it was in the scope of our group or we should push that up to the certification.

**Paul Tang – Palo Alto Medical Foundation**

Well we have to write the policy objective that gets turned into a certification requirement.

**Michael Barr – American College of Physicians**

Very good then. Thank you.

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

Yeah, so my only comment was sometimes, I don't have a problem with the requirement, but it needs to be considered in the context of an integrated system as well as an external system.

**Paul Tang – Palo Alto Medical Foundation**

Well both, right?

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

Yes.

**Paul Tang – Palo Alto Medical Foundation**

Somehow the specialist would like to have the facility that if I have a referral that will get to me electronically the act of my completing that referral creates this notification distribution.

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

Yes.

**Michael Barr – American College of Physicians**

That's exactly it, Paul, thank you.

**George Hripcsak – Columbia University NYC**

Well before I move on, anything else on sharing data with patients?

**Eva Powell – National Partnership for Women & Families**

I just took a quick look at the spreadsheet that we had put together for care coordination and we've got on their diagnostic test results and labs, and I think procedures, so do we need to clarify by putting referral results? I mean, what if it's like a consultation kind of thing and there's not a test or procedure?

**Paul Tang – Palo Alto Medical Foundation**

I think that clarification would be helpful because it's not clear if I do a procedure, so I think referral is different from procedure.

**George Hripcsak – Columbia University NYC**

Okay, so we're clarifying that we want referrals included in the, well are we asking for the referrals or the data that come back from referral or what in that case?

**Eva Powell – National Partnership for Women & Families**

I would think it'd be the data that comes back, maybe consultation results or something, I mean, I don't know the best way to make that clear, but, well, actually referral sending and receiving might be good, I mean, because sometimes, if this is going to the patient it would be nice for them to know, it's not always easy to remember, you know, I referring you to thus and so doctor for this purpose.

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

Well a consultation report is often a long narrative, you know, it's not necessarily like data.

**Eva Powell – National Partnership for Women & Families**

Yeah.

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

You know, it can be a long narrative that says, you know, if this happens do that, if, you know, you should consider doing this or doing that, I'm mean it's, heck it's narrative text.

**Eva Powell – National Partnership for Women & Families**

Yeah. So, what's the best way, because, you know, I don't know that patients need the entire narrative text that the referring physician would want, but kind of a summary of that?

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

I'm sorry I'm having trouble with my voice this morning. When you say need, I mean the question is they have access to all of this stuff if they want it, right?

**Eva Powell – National Partnership for Women & Families**

Right. Right.

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

So whether they, you know, to say what they need I think depends upon, you know, what they're doing. If they're going off to another provider and they're trying to put together their medical record so that they can go off and get a second opinion.

**Eva Powell – National Partnership for Women & Families**

Yeah.

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

Then they need a copy of the first consultation report maybe to take with them.

**Paul Tang – Palo Alto Medical Foundation**

It's interesting Neil so this is a test report, it's basically a progress note, and so we don't require that patients can get access to a progress note from let's say a primary care visit, what they are entitled to are for example the encounter diagnosis, medications prescribed, etcetera, so would we have that equivalent for the specialists, i.e., they clearly need the encounter diagnosis of what the specialist diagnoses as a result of that, any medications, treatment plan, update, that kind of thing, but not necessarily the "consult note" which is equivalent to a progress note for the primary care provider.

**George Hripcsak – Columbia University NYC**

Okay. Other comments on that?

**Eva Powell – National Partnership for Women & Families**

Yeah, I'm just wondering, I'm trying to think of how to make this simple, and what Paul just said makes me wonder if we could make this more relevant to specialists not by adding additional details to put in the view and download, but just clarify the reason for visit, encounters, hospitalizations maybe add to that referral and then updated problem list would include, you know, summary of results, referral or however is best to say that.

**Paul Tang – Palo Alto Medical Foundation**

It may be the same thing as "clinical summary."

**Eva Powell – National Partnership for Women & Families**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

Yeah. So, we just want to make sure that, and I think it's assumed, that the specialists have the same obligation of returning a clinical summary to patients within Stage 2 in 24 hours that anybody else has. So, I think that's actually an example of being parsimonious.

**Eva Powell – National Partnership for Women & Families**

Yes.

**George Hripcsak – Columbia University NYC**

Yeah, I think, if what we're saying is maybe we need to add referral to the other list, but other than that we cover it, I agree with that.

**Eva Powell – National Partnership for Women & Families**

Yeah. I do think we need to be explicit in terms of making sure people understand that when we say reason for visit, encounter, hospitalization it's not just for primary care and hospitals it's also for specialists, and then the same for updated problem list, but I don't know that we need to add to what we've already got in terms of elements.

**George Hripcsak – Columbia University NYC**

Okay. Does anyone have any comments about public health, other than the need to perhaps have exceptions, which I think are in there?

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

Are we moving forward at all with syndromic surveillance in either Stage 2 or 3?

**George Hripcsak – Columbia University NYC**

Syndromic surveillance is one of the three and we changed it from has to do it if it's possible.

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

So, wouldn't that be something that we would want everybody to participate in? You're a pulmonologist or something and you're seeing people with pneumonia secondary to flu or whatever, I mean these are things that, you know, you'd want data to come for all parts of the system I would think, and if the systems have the capability of communicating, it's really no additional burden on the provider to have them communicate.

**Paul Tang – Palo Alto Medical Foundation**

So, they're not excluded from this list and maybe we actually make the positive statement that all of the core measures apply to specialists as well in the name of clarification, so like the clinical summary, even the summary of care, the problem list, the medications, and the public health submissions.

**George Hripcsak – Columbia University NYC**

Yeah, well either we clarify or we don't, but I agree that's already covered, it's not excluded, so they're supposed to be doing it. They're only excluded if they don't see that kind of patient. Their denominator will be zero. And then privacy is straight forward, that applies just like all the others. So we've kind of covered what to add, what to modify. Is there anything particular anyone wants to bring up related to deleting or creating exceptions that you have in your mind right now?

**Eva Powell – National Partnership for Women & Families**

Well this is Eva, it's just a general statement, and I feel like we covered most everything in a way that makes what we've already intended relevant to specialists, but as we go through and have discussion my hope would be that we could steer clear of flat out exceptions and when something is clearly not relevant in the way that we talked about it to a specialist that we provide an alternative that I guess is kind of along the lines of care coordination, that kind of gets at the concept that we've intended in a way that makes sense for specialists. I don't know if what I just said makes sense to you, but I don't know, I worry about planning for exceptions because I feel like we've done a good job of keeping to what's absolutely necessary and if we need to alter some things in terms of our interpretation so that they are relevant to specialists then we can do that, but just to give them a bi, I really am uncomfortable with that.

**David R. Hunt, MD, FACS – Medical Director – Office of the Provider Adoption & Support Office of the National Coordinator for Health Information Technology**

This is David Hunt and I agree because if you start down the exception road and thinking of, you know, every, you know, neuro-endocrine consult or anything like that, the list of exceptions may continue to grow and what I've heard so far it sounds like a very common sense approach that will cover most people, most specialists.

**Paul Tang – Palo Alto Medical Foundation**

And as I look through the AMA spreadsheet there are a lot of "reds" and "Ns" N means that they can't do it, which I guess I don't understand, for example provide patients with an electronic copy Stage 1, ability to meet under anesthesiologist is "N" no, don't know if I understand that, same thing for geriatricians, yes they do have an older age group but it doesn't mean that they can't "provide the patients with an electronic copy" that means make it accessible as we discussed last time in the Meaningful Use Workgroup.

**George Hripcsak – Columbia University NYC**

Well a classic example is vital signs and for some providers it's not in their workflow, the dentist, the chiropractors, most dermatologists are not vital signs unless it's relevant to the diagnosis. So how is that handled now Allen?

**Paul Tang – Palo Alto Medical Foundation**

Right, how did they get a bi if they say that none of those apply to them?

**George Hripcsak – Columbia University NYC**

Right.

**M**

Okay, well that's it.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

**George Hripcsak – Columbia University NYC**

It should be green in that category because in fact if it doesn't apply they can meet the measure by saying it doesn't apply, so to say it's red is, you know, the red in some cases may mean that the main measure doesn't apply so I have to use an exception, which really means that the thing, as coded is green, because they can appropriately opt out.

**Michael Barr – American College of Physicians**

In some places, this is Michael, they do have Needs E or need exemption, so it's part of their code, but it wasn't used universally, so.

**George Hripcsak – Columbia University NYC**

Right.

**Michael Barr – American College of Physicians**

...applies and so some of the red, yellow and green gets a little confusing.

**Paul Tang – Palo Alto Medical Foundation**

Yeah, so the E says that they meet the exception and so for dermatology for example they acknowledge that although it's hard for them they meet the exception if it doesn't apply.

**George Hripcsak – Columbia University NYC**

So, I agree certainly this group of 4 people or 7 people are not going to come up with all the exceptions for a matrix of every specialty by area objective and what the exceptions are would not be possible. And if there is a mechanism that appears to be working according to Allen on things like vital signs then that seems to be the best answer. And then as Paul pointed out there may be some that are being seen as can't be done that we're not sure why, for example, you know, CPOE wouldn't apply to geriatrics.

**Eva Powell – National Partnership for Women & Families**

Yeah. This is Eva. I'm wondering if at some point, probably not our next step, but at some point in this process if we kind of come up with a very concrete plan for how we're going to make this all relevant to specialists and then pull together. At the Policy Committee meeting I've been pulled aside by a couple of different people who represent specialists and all volunteering to help with this process, which isn't surprising, but I'm wondering if there's value and somehow once we've got some really concrete ideas or recommendations really, to pull together more of a working group, I'm not thinking of a hearing, but just a working group to elicit their feedback on those things and then we can get clarity on some of these questions that we have in terms of what the spreadsheet says.

**Paul Tang – Palo Alto Medical Foundation**

You know, as I read through a lot of these things are, the red comments for example, would it be possible Allen if the department went through this and annotate it, many of these things actually are probably a misunderstanding of the requirement.

**Eva Powell – National Partnership for Women & Families**

Yes.

**Paul Tang – Palo Alto Medical Foundation**

So for otolaryngology it says, you know, otolaryngologist believe the threshold for requirement is too high, this is vital signs, this requires vital signs being recorded for every visit regardless of patient diagnosis. I believe that is not correct is that right Allen?

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

So you're asking, we should go through the list entirely and provide comments for each of those?

**Paul Tang – Palo Alto Medical Foundation**

Correct. I think that would be very useful.

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

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

And I think they've color coded so red is the thing you pay most attention to. And I'll bet you a lot of these things you could provide comments and many of the comments will be duplicative, in other words, for example, exception applies here and/or they may not have interpreted, and it's very easy to misinterpret the requirement, and that may straighten up a lot of this stuff, both for specialists and primary care.

**George Hripcsak – Columbia University NYC**

Well, that's very good. I mean, I think that we're begging for feedback and we've gotten feedback and we should take it seriously and if ONC can get through and comment on each thing and see, as you said, which ones are misunderstanding, and are there any there that really need to be substantively changed, we could do that. I think, similarly to the way the request for comments first gets aggregated by the ONC staff, similarly this is such a volume that it may need to be aggregated by ONC staff also.

**Paul Tang – Palo Alto Medical Foundation**

So may I, this is something we talked about last time and maybe I can ask Allen what's a follow up or how do we expect to see the follow up, this notion of, this is under engaged patients, it's the whole provides clinical summary and our intent, and I believe you agreed with this, Allen, that the intent from the Workgroup and the Policy Committee was that if you made electronic copies available, for example through a patient portal, you didn't have to meet the 50% threshold of people being enrolled and logging in, but you had to offer it, I mean it's available for them to take advantage of the electronic copy of their clinical summary, it would be available to more than 50%. First of all did I get that interpretation correct?

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

I think so. It's the idea that if you make it available it's there if they want it.

**Paul Tang – Palo Alto Medical Foundation**

Correct. It's not forced. As the panelists actually were concerned about, it's not forcing it down people's throat. And so I see this same kind of comment for example under cataract and refractory surgery, saying the senior may not want to take advantage of this. So, I think we're going to find more than 50%, the majority, and probably a lot more than 50% of these comments are addressable exist through clarifying the criteria.

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

I think that's good. So I can take that as an action item and get it back to you by the end of the week.

**Paul Tang – Palo Alto Medical Foundation**

Great. And then maybe part of it is not just for the small group but, if FAQs would help maybe we have a plan for writing those FAQs and getting it distributed, so that this group and the Policy Committee, and ONC can make that available, you know, make that available to the broad community.

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

Okay.

**Paul Tang – Palo Alto Medical Foundation**

I think that's going to cover the majority of these comments.

**George Hripcsak – Columbia University NYC**

So, can we take a little bit of time and just see what people feel about imaging before we run out? What's the general sense of the group on imaging?

**Paul Tang – Palo Alto Medical Foundation**

So are we restrictive to images, the actual digital rendition of the images or reports about imaging?

**George Hripcsak – Columbia University NYC**

Well reports about imaging should be, I mean it may not be adequately covered, but it ought to be adequately covered it's analogous to a lab test coming back, but I'm actually talking about the images. And then for the specialists in the hearing set, if you're going to do something for us, which would also help the nation, it would be having these records address imaging. Now, of course the problem we've had in the past is well what are we going to do, we can't put in an objective that says you need to merge PAC systems with EHRs that have different kinds of databases, different kinds of requirements, how do you transfer these gigabyte images across town and so forth, but there was clearly a request for the actual study itself.

**Paul Tang – Palo Alto Medical Foundation**

So, one of the ways we could help that is, as you say, not require everybody to buy a PAC, because that's very expensive, but to ask EHR vendors to have one quick access. So, for example if you get a radiology report back or nuclear scan or whatever, then there will be a hyperlink, you click on that and you go to that patient's individual report, that's enormously helpful without requiring that everybody have a digital system for all ancillary departments.

**George Hripcsak – Columbia University NYC**

But it seems as though the report should be handled, the report seems as though it would be different from what I hear as far as the image.

**Paul Tang – Palo Alto Medical Foundation**

Correct and we think those are covered in our test results.

**George Hripcsak – Columbia University NYC**

Right, okay. Our intention was that reports were covered in the test results whether it got translated forward or not, actually sitting here right now I am not actually 100% sure, but the intent was a radiology report, a pathology result would be covered under the existing data sharing like view and download. So, what is it that specialists need? I mean, if they're just asking something about transporting images and if so, people are using a CD to carry to the next doctor is there then something about standards for images? Is there something we could do there where we show up with a CD, normally the CD has it's own browser, these browsers are normally proprietary or not necessarily proprietary from a financial point of view, I mean there all different and so is there, even though there's DICOM apparently it's difficult because each product does it slightly differently, so there is no common browser. If you wanted to load these images onto your local system it's apparently, I am told, difficult to do. So is there some move it towards, despite the presence of DICOM, additional standardization?

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

This is Mary Jo; could I just add an observation? The Standards Committee is tentatively, and I say very tentatively planning a panel on imaging at its February 16<sup>th</sup> meeting. I know that they haven't really framed the purpose of that and exactly what they want to get out of it so, you do have a great opportunity to perhaps provide some guidance to them in terms of what would be valuable for them to hear. They're going to call into three or four imaging people to look at the standard side of it.

**Paul Tang – Palo Alto Medical Foundation**

This is the HIT Standards Committee, which Workgroup?

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

Well it's actually Doug Fridsma's team. John Halamka is asking him to look at several topics over the next few months and imaging is one of those topics. I'm not clear on exactly how specific the guidance has been on what Doug is supposed to prepare.

**Paul Tang – Palo Alto Medical Foundation**

So it's interesting the radiologist and others dealing with imaging have told us that DICOM is in wide use. I think it's not just DICOM that is required in order to have this kind of, sort of one click link to the actual image, you know, that has to be an understanding about the test identifier and the patient identifier, etcetera. So there's more to it, probably than just DICOM but that's probably presumably what ONC and Doug are actually looking into, correct?

**George Hripcsak – Columbia University NYC**

Paul, a question. When you say one click access, what are you accessing? If you're the radiologist then you have your system.

**Paul Tang – Palo Alto Medical Foundation**

Correct.

**George Hripcsak – Columbia University NYC**

But if you're a primary care physician what am I clicking to?

**Paul Tang – Palo Alto Medical Foundation**

Okay, so, and it's not just primary care in fact it's mostly specialty care where you have the report from whoever performed the test and you'd want to see the image yourself. So the orthopedic surgeon or the neurosurgeon etcetera, and you would click this link that would open up the actual image in the radiology system, the PAC system for example, that kind of integration rather than separately logging into the PAC system is what would be really helpful to folks.

**George Hripcsak – Columbia University NYC**

So if you're an integrated delivery network where the PAC system and you are the same organization I guess network, but if you're out there the field how to get your image?

**Paul Tang – Palo Alto Medical Foundation**

Good point. And that's certainly a lot bigger challenge because then you really do have a patient identifier problem again in spades.

**David R. Hunt, MD, FACS – Medical Director – Office of the Provider Adoption & Support Office of the National Coordinator for Health Information Technology**

Yeah, I think that's a bigger issue, much bigger.

**Paul Tang – Palo Alto Medical Foundation**

Allen is it your sense that, what's the main ask from folks interested in images?

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

Well there have been a lot, but I think the radiology group has identified a standard already out there so they've asked ONC to recognize that standard for transitioning and viewing of the images and getting them built into electronic health records. So, from the ONCs perspective, I mean that's something we've heard is that it has to be included in the standard and that it could be then just used today because they do have a standard image, but.

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

I can read the two sentences that Doug's team put together as they were reaching out to people to speak. The topic as they have preliminarily outlined it is, standardizing DICOM image objects for image sharing and investigating other possible approaches. Review of image transfer standards, image viewing standards, and image reporting standards. I just saw this today, so I don't really have anything more that I can share with you, but I did ask them to flesh that out a little bit and specifically break out what they would like from each of the three or four people that they might bring in.

**George Hripcsak – Columbia University NYC**

That's exactly, this is George, this is exactly what I was thinking of, so that's wonderful to hear. I don't know what else we could do in terms of actually getting images from one place to another I would hope that, as Paul said, if it's an integrated delivery system then in fact you should be able to just get to your PAC, but outside of that I think for a few years we're still going to have patients showing up with CDs and DVDs and it would be nice, now do we want that thing to be, I mean I don't think you normally, they don't have the storage capacity for the primary care provider to copy, or even the time to copy a DVD into your EHR, right it's 5 gigabytes, that would be your whole visit would be sitting there to bring it in. So it's more about viewing the image then actually collecting them in a local database.

I mean and we can't really forward these. There's the idea of a nationwide server of health images, but that, you know, is neither feasible nor necessarily acceptable from a policy point of view, but it's kind of that you have the URL could you federate a database for each institution that produces images, has a URL that you click on that URL and you get to the image, that's where we get into the non-feasible.

**Paul Tang – Palo Alto Medical Foundation**

Well also, and I don't know that the browser, the viewer for those images is standard, in other words you'd have to use the individual vendors viewer to view their images.

**George Hripcsak – Columbia University NYC**

Well that's the thing, so given 3.5 years, that's the thing that we might be able to achieve technologically in time, that they have a common standard for the data so that even if they have different browsers you can use any browser with any image. So they may want to, you know, have their product stand out as having a better browser, but the browsers would be working on the same underlying data standard.

**Paul Tang – Palo Alto Medical Foundation**

Charlene do you have any additional knowledge about this in terms of the ability to view images recorded by different manufacturers?

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

Again, the standard enables you to share data among different PAC systems, right, so you've got different PACs so that's good right?

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

So, you're right, Paul, I think the viewers are proprietary right now and typically, again, if you can use your browser to go in and look at the PAC system, there are some questions about the degree of resolution that you can see and again, there's questions about if you're looking directly on the PAC it's diagnostic

quality and again if it's through your browser it's not diagnostic quality, you know what I'm saying on that point?

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

So that has to be understood.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

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

And then there's capability again to use the CD to transmit the full resolution but there's also capability to provide a content, I don't know the right word for this, but you can have a condensed version that you can share potentially.

**Paul Tang – Palo Alto Medical Foundation**

Right.

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

So, again it's what's the use. So, if you want to look at the broken leg and just see what the image is but not necessarily do diagnosis with it, maybe that's sufficient, that's actually what we've heard for instance in primary care settings. So, again that's the piece that has to be, what is the need, the degree of resolution required and that in that context how do you want to share that data?

**Paul Tang – Palo Alto Medical Foundation**

So it's really good that John Halamka's working with ONC to figure out what is possible to meet the need, the clinical need.

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

Yes.

**Paul Tang – Palo Alto Medical Foundation**

And if we can't meet the extreme need of saying we can get image, you know.

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

The diagnostic quality.

**Paul Tang – Palo Alto Medical Foundation**

Diagnostic quality images from any system anywhere, we're not there yet.

**David R. Hunt, MD, FACS – Medical Director – Office of the Provider Adoption & Support Office of the National Coordinator for Health Information Technology**

And to be cynical, I really question how many primary care are really pulling up images or really have a need given the time constraints. I know that it's not necessarily a good thing to say, but I don't think folks are...

**Paul Tang – Palo Alto Medical Foundation**

So who is speaking? I don't recognize the voice.

**David R. Hunt, MD, FACS – Medical Director – Office of the Provider Adoption & Support Office of the National Coordinator for Health Information Technology**

I'm sorry?

**Paul Tang – Palo Alto Medical Foundation**

Who is speaking?

**David R. Hunt, MD, FACS – Medical Director – Office of the Provider Adoption & Support Office of the National Coordinator for Health Information Technology**

Oh, I'm sorry. This is David Hunt and admittedly I'm in a rarified area because I'm a general surgeon, I look at my own mammograms, but beyond that.

**Paul Tang – Palo Alto Medical Foundation**

Okay. Thank you.

**George Hripcsak – Columbia University NYC**

David, this is George, I agree with you about the primary care, but we're also trying to get the specialists to be like regular providers and for them this would be more useful than for the primary care.

**David R. Hunt, MD, FACS – Medical Director – Office of the Provider Adoption & Support Office of the National Coordinator for Health Information Technology**

Absolutely. So the orthopedists, me in general surgery for mammograms, they are the same areas, but I'm wondering if we would be able to, you know, that's such a big chunk and that seems like a really, really hard problem.

**George Hripcsak – Columbia University NYC**

So we would need, I mean it would be nice if during that hearing there could be, oh by the way Larry Schwartz is Chair of Radiology at New York Presbyterian and Columbia and he actually was working on this problem Mary Jo so that maybe someone that John Halamka wants to pull into the hearing.

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

I'm sorry; would you repeat the name please?

**George Hripcsak – Columbia University NYC**

Larry Schwartz.

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

Larry Schwartz.

**George Hripcsak – Columbia University NYC**

And he was working on exactly this problem of the multiple browser CD. If you come up with a CD and the browser don't talk and how do we address that.

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

Yeah, okay.

**George Hripcsak – Columbia University NYC**

The, well, it would be nice if during that hearing we could come up with some proposals of what would be the next step to do. I mean, that's what I don't have the skill set to figure out. So, one thing that's obvious to me is well sure standardization will always be good and will work, but is there another step you could do that would make it easier for the cardiologist to pull up the study she or he needs. And so the one click access is one thing but it only works on integrated delivery system. So I don't know if there's another step that can be done that we're missing right here that's short of a nationwide image server, but more than just a standard. So that's the feedback I'd want from the Standards Committee.

**Paul Tang – Palo Alto Medical Foundation**

When did you say the hearing or the presentation was Mary Jo?

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

Well it tentatively for the February 16th meeting of the Standards Committee.

**Paul Tang – Palo Alto Medical Foundation**

So can we sign up for a summary of that maybe?

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

Of course, absolutely, for your March meeting they could bring that forward.

**Paul Tang – Palo Alto Medical Foundation**

Great. Thank you. It's probably worth it for the whole committee since it gets asked in the whole committee.

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

But just to summarize, one of the things that this group would like to convey to Doug's team who are planning it, is that one of the key outputs would be, you know, what is a reasonable next step. I heard you say, you know, less than a nationwide image server, but more than just a standard.

**George Hripcsak – Columbia University NYC**

Right.

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

Yeah it does look like they were particularly focusing purely on what to do about DICOM and I think suggesting that they think through what more they could do would be really helpful, so I'll pass that along.

**Paul Tang – Palo Alto Medical Foundation**

Well it's not just what more they can do, so to achieve the functional outcome that we described, i.e., across vendor, across organizational, so access to images across organizational boundaries and across vendor platforms, that's really challenging and so what is available, what would it take, and I guess part of our bottom line is would that be even reasonable to expect by 2015?

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

I've got it, thank you.

**George Hripcsak – Columbia University NYC**

I mean the clinical goal is that providers and patients can see the images that they feel are relevant and that should be as seamless as possible.

**Paul Tang – Palo Alto Medical Foundation**

Yeah.

**George Hripcsak – Columbia University NYC**

So that's what we're trying to head to and so what's the next step on the way there? Okay, so I'm going to summarize in a minute but first are there other items that the group feels we should bring up? Okay, let me summarize and then see if there are other images the group feels I should bring up. So, first of all we made a general statement that this subgroup needs to focus mainly on the issues that cross all specialties and that's what we need to focus on. We picked a couple of areas of things that we can do and we made the statement that it's not just what we can do to help the specialist but also what specialist, we need to focus on what the specialists need to do for patients, how do we all fit together in this quest for quality care, and we came up with several items, number one is the registry as a possible alternative for how to produce quality measures. We said that we may need standards for how data are sent to

registries. We said that it should be voluntary, that this is an alternative to something else to the more central generation of the quality measures that have then become required. And we talked about it being bidirectional so that there is also quality improvement and perhaps even suggestions on care management coming back from the registry. So that was one.

Two, on care coordination we need to make the clinical summary of care that gets shared between providers bidirectional and timely so the referral comes back to the person who did the referral. Third, on patient sharing we talked about, so we think that much of what we wrote already covers the sharing of data from specialists with patients, although we saw that perhaps we need to add the referral or the "consultation results" with the patient adding that to the list. Number four, on images, we talked mainly about standardization of images, so it's one next step, maybe not the last next step, but that is going to be largely carried out through this hearing of the HIT Standards Committee. We also mentioned one click access, but that only works if you're in an integrated delivery system.

We shied away from creating a large list of exceptions, specialty specific, objective specific exceptions, and I think the idea of the next step there is for ONC to go through the materials provided by AMA and comment on each of them, which we can then review.

**Eva Powell – National Partnership for Women & Families**

Yes.

**George Hripcsak – Columbia University NYC**

Let's see if there's anything else. Did I miss anything?

**Paul Tang – Palo Alto Medical Foundation**

No that sounds...great summary.

**George Hripcsak – Columbia University NYC**

Okay, so now our next up, I am not sure, Paul, that we need another meeting of this group exactly based on that. I mean, I think we need to wordsmith what we've decided when generate Stage 3 measures, but do you think we need to meet again as this group or does it just become part of the Meaningful Use Workgroup.

**Paul Tang – Palo Alto Medical Foundation**

No, I think we return the summary to the next Workgroup call.

**George Hripcsak – Columbia University NYC**

Yeah.

**Paul Tang – Palo Alto Medical Foundation**

So you have reaffirmed some of our principles, like...crosscutting and avoid specialty specific exceptions, etcetera, and some specific concrete recommendations like what we dealt with in registries, and clarification around care coordination. So, I think that does it and I think it addresses the issues. How do other people feel?

**Michael Barr – American College of Physicians**

This is Michael, I think we've covered a lot of ground and I really appreciate the effort George and Paul, so hopefully we can move it to the larger committee and move forward from there.

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

Yeah this is Neil. I agree I think we're in good shape.

**Eva Powell – National Partnership for Women & Families**

Yeah, same here, this is Eva.

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

I'm sure we'll get a lot more comments.

**Eva Powell – National Partnership for Women & Families**

Yeah.

**George Hripcsak – Columbia University NYC**

That's the other thing, that's a very good point, this is George, that if we work too hard, too far in the direction among the five of us, you know, we'll be further and further away from the masses potentially. So we want to link this back in with the group quickly.

**Paul Tang – Palo Alto Medical Foundation**

I think one of the things that would help a lot is the ONC annotation of the AMA matrix.

**George Hripcsak – Columbia University NYC**

Yep.

**Paul Tang – Palo Alto Medical Foundation**

Because I think we will learn that most of it is a misinterpretation of the existing criteria and that as we've gone through in this call, it turns out that most of the things do apply across all providers.

**George Hripcsak – Columbia University NYC**

Okay, very good. So, we look forward to that call. Mary Jo, I guess it's time to open up for public comment. Thank you guys for all the time in this.

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

Your next full Meaningful Use Workgroup is on 15<sup>th</sup> of December. And just to let you know that that's the Meaningful Use Workgroup, I believe, if I understand you correctly you would be bringing it back to the Policy Committee meeting, which is on December 7<sup>th</sup> or did you want to wait and have the Meaningful Use Workgroup discuss it?

**Paul Tang – Palo Alto Medical Foundation**

I think would bring it back to Meaningful Use Workgroup.

**George Hripcsak – Columbia University NYC**

Yes.

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

In which case then it might come onto the January Policy Committee Agenda.

**Paul Tang – Palo Alto Medical Foundation**

Correct. I don't actually think Meaningful Use is reporting out in December.

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

That's what you had said, this just sounded so constructed and productive I wanted to be sure. Good. Okay. Operator, would you open up the lines for public comment?

**Caitlin Collins – Altarum Institute**

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

**Carol Bickford – New York Nurses Association**

This is Carol Bickford from the American Nurses Association. As you've gone forward focusing on the specialists needs, I would caution that you don't become too prescriptive because there are many other folks in the community who are relying on these activities to support us, for example the physical therapist, the occupational therapist, the registered nurses recognizing we're not the primary target that it is physicians, but don't close out the shop for the rest of us.

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

Thank you, Carol. Operator are there any other comments? Okay, then I think if there are no other comments, George and Paul.

**Operator**

We have a comment Mari, please proceed with your question.

**Mari Savickis – American Medical Association**

Hi, thanks very much. This is Mari with the AMA. I really appreciate you taking the time to look at the documents that we submitted. They're very helpful...the conversation and I had a few comments. It sounds like from the conversation this morning that this is focused on Stage 3 and not Stage 2, so I'm just wondering how physicians are going to be able to, the specialists are going to be able tackle Stage 2 given the concerns and the questions that we have around applicability and the exemption process.

And then with respect to the exemptions, I would strongly urge you to allow us sufficient flexibility for physicians and specialists to determine whether or not they feel that there is applicability to the measure or not and not make it so prescriptive that it's just those doctors who only have face-to-face patient visits. If you look at the matrix, while there may have been some confusion, we tried to make it responsive and the color coding as standard as possible, you'll see in the detailed document, which you indicated you're going to have ONC review closely, that there are a lot of comments about applicability. So, I would just urge you to take a close look at those and why some of the specialists felt that they were not applicable because I think if you build in that flexibility you're going to find a larger uptake.

And then lastly, it may be worthwhile having a reactor panel given that most of the eligible professionals are physicians. We would be more than happy to organize a one-person per specialty, you know, reactor panel if you wanted to get reactions and clear up confusion. I would be happy to work with you to coordinate something like that if you think that would be helpful. Thank you.

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

Thank you.

**George Hripcsak – Columbia University NYC**

Let me just a thank you for the hard work on this, very much. I very much appreciate it and although this group is focused on Stage 3 because we've already given our Stage 2 recommendations of course, CMS and ONC, ONC being the one doing the summary, are still focused on Stage 2 and there is the public comment period to come after the NPRM is published, so I believe there is still opportunity for input on Stage 2.

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

Paul and George, this is Mary Jo. I have a couple of just clarifying questions. The first is you mentioned Larry Schwartz and just for the record I don't know who he is and what organization he's with.

**George Hripcsak – Columbia University NYC**

I'll send that on e-mail separately.

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

That would be good. Okay. And then secondly, I think it was Mari from AMA, would you for the record give your complete name? She may have gone already.

**Mari Savickis – American Medical Association**

Are you there?

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

Mari are you there? Yes, would you give your complete name for the record?

**Mari Savickis – American Medical Association**

Yes, can you hear me?

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

Yes.

**Mari Savickis – American Medical Association**

Okay, great sure. M-A-R-I. Last name S as in Sam, A as in apple, V as in Victor, I-C-K-I-S as in Sam.

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

Thanks very much. Okay. I have nothing else Paul and George.

**George Hripcsak – Columbia University NYC**

Okay thank you very much everybody.

**Paul Tang – Palo Alto Medical Foundation**

Thank you, George.

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

Thanks. Good work.

**Eva Powell – National Partnership for Women & Families**

Thanks.

**George Hripcsak – Columbia University NYC**

Okay, bye-bye.

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

Bye.

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

1. There are many pathology/laboratory quality tools but no registry per se.
2. The list was completed before HHS issued the NPRM on patient access to laboratory results so some of the responses on patient access may be out-dated.