

Meaningful Use Workgroup
Draft Transcript
May 26, 2011

Presentation

Caitlin Collins – Altarum Institute – Meetings Coordinator

Good morning and thank you for joining us with the Meaningful Use Workgroup. Judy Sparrow is not available this morning so we're going to do a quick roll call. Paul Tang?

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

Here.

Caitlin Collins

George Hripcsak? David Bates? Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP

I'm here.

Caitlin Collins

Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder

Here.

Caitlin Collins

Art Davidson? Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO

Here.

Caitlin Collins

Joe Francis? David Lansky?

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

Here.

Caitlin Collins

Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Caitlin Collins

Judy Murphy? Latanya Sweeney? Linda Fischetti? Tony Trenkle? Charlene Underwood?

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

Here.

Caitlin Collins

Micky Tripathi? Michael Barr?

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

Here, and I'll be able to stay for an hour.

Caitlin Collins

James Figge? Is there anyone else on the phone I've missed?

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

Hi, George Hripcsak. Sorry for the delay.

Caitlin Collins

Okay, great.

James Daniels – Medical College of Wisconsin – Associate Director

James Daniels.

Caitlin Collins

Okay. Paul, over to you.

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

Wonderful, and thank you, everyone, for joining as we continue this ... on towards stage two meaningful use. I think we have an important task before us today and we really want to, having heard now back from the HIT Policy Committee, some of our workgroup, and some additional feedback from the HIT Standards Committee, "you need to put together this package." They call it a package because it's a combination of the criteria we have for meaningful use stage two and our recommendations to ONC and CMS and the timing recommendations, which everyone on this call recognizes is really an integrated package because one affects the other. For that reason, I wanted to switch our order around and talk about the timing first because I think that will influence the way we approach the objectives and criteria for stage two, at least for our recommendations.

I want to review our context. It's always been the case when HITECH was passed that this program, meaningful use, of EHR systems and HIT, is part of a larger initiative and was certainly felt to be a necessary but not sufficient part of healthcare reform. But our role is an enabler, and so we're working on these systems and we know how powerful this enabling tool can be towards providing data that helps provider systems improve. But unlike in 2009, when this law was passed we didn't have the benefit of the 2010 ACA (the Affordable Care Act) and that of course we all recognize puts forward a lot of initiatives that can help move the ball forward in terms of healthcare reform. That relieves the pressure on this program, not that we ever had the responsibility to do health reform, but we have to recognize that this is a part of a larger initiative. There are so many more levers that were put in the hands of HHS that weren't there when we started in 2009 and came up with our stage one. So while it's never been up to us to execute or implement health reform, we have this important role of putting in place the tools that we think are necessary and the tools that are not being developed by the market already that are needed for health reform.

I think what we want to do is focus on the critical functionality we think that needs to be in these EHRs and particularly the ones that are not there now that are required for reform. In David Lansky's workgroup, the Quality Measures Workgroup, I think they have an additional opportunity to put in front of people goals. Again, some of which were not in front of folks currently because of either lack of measures that are even in existence or the ability for EHR systems to provide the data and the measures to put in front of the providers as they see patients. I think that's a broader context. I know we all know this but I just wanted to remind ourselves of our role and the broader context. That's clearly something that Tony Trenkle has talked about, that Farzad has talked about, and even the secretary, so that's the framework and the context under which we're doing our work.

So with that in mind, we've talked a lot about the timing. I think where we last left off we had three, and still open to others, that people might have thought about in the course of just thinking about this or other conversations, but the ones we had were, one, leaving everything here status quo, the same timing for every cell and the same one year reporting period for stage two.

The second option we had discussed was to tweak that latter part, which is the reporting period, reducing it from 12 months to 90 days. That was to help where we'd at least ... on the patient side to give providers an additional nine months to safely implement, particularly new functionality.

The third option that we had was to delay that one cell. To remind us, that one cell was for 2011 entrants into the meaningful use program stage one. They would find themselves in a bit of a bind where for hospitals when the final rule comes out in the middle of 2012 they could start their reporting period, under the current rule, in as early as October of that same year, and providers would soon follow in January of 2013. That became one of our issues, but George and Farzad point out that really it's only that cell when we say shift it back from 2013 and 2014, it's really affecting the early entrants.

Now one of the things that I think we're all aware of is that the industry is almost, even though there are providers and hospitals that are ready to attest now, some of them have been getting the advice to avoid attesting in 2011 because of this glitch. So ironically, that alone could be pushing back the engagement of a lot of folks. So you can flip that, if we shift to the timing for that one cell it would almost not only remove the "penalty" but almost encourage people to apply in 2011 because you start getting your incentives earlier and actually your criteria, the threshold, the floor for 2013 in the case of that group, would not advance to stage two.

Now, another principle that we've been talking about here is that it's not as if by not changing the floor you're going to stop forward progress. People rapidly learn that hybrid situations, getting anything less than 100% puts you in a painful place where you have to operate on both paper and electronic systems, so people are wanting to, once they start using functionality, are going to want to use it in all the places in which they deliver care or ... patients. I don't think that by not changing a floor that you stop progress.

Let me pause there for any comments just about the overall context and then we'll start talking about the timing question per se.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I heard you talk about timing recommendations, but I thought we had agreed a couple of times now that what we would do would be to lay out the options and do an analysis in narrative form of the pros and cons of each. So my suggestion would be that we might recognize that the option that many people think probably fares best is extending stage one by one year, which would compress stage two and probably we'd have to address the length of the reporting period subsequently in stage two. But that if we recognize that that is the option that seems to fare best in our analysis, then that's the context through which we would make a second set of recommendations, which is what's next on our agenda, for how the criteria might change given the extra time that vendors will have to code the systems and the extra time that providers would have to plan workflow changes.

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

I think that's exactly right, Christine. So while we're presenting both some of the options we've thought about and our relative weightings, as we did that matrix before, it's probably unwieldy if we have, for three different timing options three different meaningful use criteria. So I think it's just as you described, it seems like, and I want to get feedback from this group after having people ... over it, it seems like option three fixes a number of problems and maybe actually works somewhat to our advantage in terms of our meeting the program's advantage in terms of encouraging people to apply earlier. With that in mind then, how would we look at the meaningful use criteria then, and I think that rather than having a matrix of all these possibilities that it only makes sense for us to try to go with what seems to be our favorite approach.

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

I'm sorry, Paul, so you're saying we—well, I was actually going to agree with you because although, as you know, I've been the options, options, options proponent, the other side is that if we don't favor one it's not helpful. Because otherwise by the time we hear that the option was selected, which is I guess

December, the next time the public gets feedback on how this is going is December, right, because really we're just going to hand whatever we write over to CMS—

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

Correct.

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

—and then we're not going to hear anything again.

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

That's correct.

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

And if we're going to favor one we have to favor it at this point or it just doesn't have much of an effect. But finding out in December that it is going to be option three, they've got to already have developed the software by then. But on the other hand, even if we favor one CMS can do whatever it chooses, we're just advisory, so they still have to strategize.

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

Right.

Christine Bechtel – National Partnership for Women & Families – VP

George, I don't think we're saying anything different. I'm saying that at this point in our transmittal letters that we would acknowledge that we consider these options, we should acknowledge that there may be more on the table that we didn't think of, but that the one that seemed to fare best was this option. So we're actually delivering two sets of criteria: one, as we've already discussed them, and then the other how those criteria might change given the extra timing and the implications of that. I'm saying signal that as its point, but stopping short of saying that this is what we think you should do. It's simply this is what we think fares best, but there might be other stuff out there that they cook up too.

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

Okay, so in some sense everything we offer is optional for the government.

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

Paul, just a quick comment. I like the idea of the option three, but I do want to comment and caution that if the perception is that by offering option three that it automatically means—and ... that. That it will raise the bar further that any perception of wiggle room or space or trying to get people up and running in the right way kind of disappears if we signal we're going to raise the bar even further without. Just concern that it won't be as positively received if there's also attached to it that we're going to raise the bar even higher because of this extra year. I know that we have to have that conversation, but I don't think we should be recommending it with the assumption that that bar is going to be raised further without the discussion.

Neil Calman – Institute for Family Health – President & Cofounder

I agree, but I think we need to take a pass now. If we're really going to recommend the one-year delay I think we need to take a quick pass through all of our recommendations and just make sure that there's nothing that we put off because we said well, we can't really do it on this timeline. I think specifically the things that I think about in that realm related to health reform are the things about patient experience, because I think that it's such a critical piece of the health reform agenda and it's a piece we've struggled with the hardest because we didn't think we could get it done in a year. But I think that's a piece that I think is worth taking a second look at, and I think that there's probably a few others, so I don't think we should call out, well, if we picked option three there's going to be some unknown set of things that are going to get escalated. But I do think we should take a pass through that stuff today and see if there's anything that falls into that category.

Christine Bechtel – National Partnership for Women & Families – VP

I agree, and also the Policy Committee agreed on that when we last met. So I think just to try to put some boundaries around it, the things that we discussed were really in particular those things where system capabilities could be vastly improved and would be the largest driver of change rather than wholesale brand new criteria that we've never talked about before. I don't think that's what we're considering here. It's simply, well, gee, if there's more time to create the function and the technology, then the threshold might be higher or we might actually add this thing that we talked about in stage three and those kinds of things. We've done some analysis to try to be helpful, and we can certainly share that, but I think that that's right. It's not wholesale de novo stuff we've never heard of before.

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

Paul, can I add here? I understand the signaling issue Michael's raising. I guess I want to also respect the vendors' argument that each cycle of system enhancements takes quite a while to take through the entire pipeline. I'm wondering as we do the review that Neil suggested we also look at stage three directions and see where there are opportunities to say to the vendor community, especially now with this small amount of extra time make sure, in the coding you're doing this time around. Provide for the capabilities that we think will be needed for stage three so that we don't have the same argument a year and a half or so from now that the escalator is too steep, the timeline's too short to add the capabilities we think are important in stage three. If there's one cycle of reengineering to be done, let's put as much at least clarity into what we think is needed for that cycle as possible.

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

Thank you. I appreciate that. But also I'd say in addition to reengineering, which is part of that is actually testing, and we have no experience with some of the things that we're asking for, even while we don't know how it's going in stage one, so I'd just raise continually the caution about escalating too fast without knowing if we have any unintended consequences.

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

Something we might think about, Paul—Michael makes a really good point—is to encourage, starting now, whatever testing is necessary so that when we get to 2013 we aren't having to have a discussion about whether something's feasible by '15. But we've taken this extra time to put in place the testing regime with the vendors in partnership to make sure that these things are working well.

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

These are really helpful comments, and I think we also heard from the vendors about the stronger the signal the more precise and clear we can be, the better off we'll all be at the next cycle.

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

Paul, one more quick point. It's not just the vendors that have to be part of the testing, it's the clinical teams and the physicians and eligible professionals. So it's both sides, both developing and testing the technology and making sure it works in practice the way we are hoping it works in practice. Some of the space we're giving by this option three signal, I'm just concerned we're going to use it all up by moving things a little further than we ought to at this point.

M

Paul, before you move on can I just throw something in here? Just to park it or figure out where we're going to talk about this, in the part of our hearings, at the end where people were talking about their experience. We had the experience of people who had adopted and stuff. We had that last panel, and there was terrifying information that came from almost every single person on the panel at some point about the inability of the vendors to support the upgrades and to do the things that were going on. I don't know where to put that on our agenda, but it was our hearing and I think we need to figure out, as a policy recommendation I think we need to make some sort of statement about that and figure out whether that's something we send off to the certification folks or what. But it's clear that people had functions that we're going to be calling out, that had functions that were certified but that had nothing to do with whether or not they were implementable in reality and the practices of the people we were talking to. So these were all certified products that crashed, banged and collapsed when implemented in providers' offices. I just want

to make sure that that doesn't go on unheard ears, because I think it was a critical factor and we need to figure out how we're going to discuss that.

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

That's a really important point. I'm glad you brought it up. Let's make sure we keep that on the agenda. So it's a combination, I think you had a couple of issues there, but they're ... related. One is the certification criteria good enough. Then second, and if you pass them, how does that assess whether you can or can't, the ability of the vendor to support providers implementing that functionality. But it almost seems like one of the problems is certification criteria was not comprehensive enough or was not able to detect something that was usable.

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

Two things I want to clarify again. Certainly, I heard some of the messages around some of the challenges around implementation, but I think we also have to recognize that a key theme of all those testifiers was the timeline. The message was slow down. The message was people are running 100 miles an hour, there's risk when you try and run 100 miles an hour and implement complex systems. So while I'm certain there are issues out there with the implementation process from the vendors and everyone, I think there's a strong message around be sensitive to the fact that we're implementing pretty complex things and trying to do it very fast.

I think the other thing this group needs to be aware of is on the certification process as it's designed today it's not a customer assurance program. That's not its intent. Its intent is to ensure that a vendor can comply and achieve meaningful use with what it's certified with. That's not to say that this criteria cannot be perhaps clearer, but to date that's not what the process is designed for and is intended. So again, I would be very wary to say let's make certification do everything, because it is a very difficult process to implement as it is designed today. I raise a concern there. We can certainly talk about the issue and what needs to happen, but that's not the intent of that program as it's designed.

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

Charlene, just to respond, you explained it to me very well, I think, which is that these are just test scripts and if it takes 25 clicks to generate the report that's required, and as long as the system can generate that report it passes. I think what we heard from the people was because maybe the vendors are rushing, maybe they're just not supporting it right. We don't really know what the explanation is, and I don't think we should guess at it, but when the systems get put into use what we heard pretty much across the board was not just the slowdown message. It was that people are passing certification but it doesn't mean that the systems are usable and that the pieces that are being tested crash other pieces of the system. So I think we need to send a signal that we heard that message, and the certification process, I'm not saying it needs to be more difficult, but clearly our responsibility is to protect the people that are putting huge amounts of money into this both on the hospital and on the provider side. It's not our fault but somewhere that process is failing people if they're having these incredible crises when they're upgrading their systems, and that's what we heard.

Christine Bechtel – National Partnership for Women & Families – VP

I wonder if maybe one suggestion might be, there were a number of things I think we heard in those panels, and that was certainly one of them. There was just some basic stuff like, gee, does it count for a clinical visit summary if I upload it to the portal? Well, yes. So just things like that, and I thought the Massachusetts e-Health Institute did a really nice job of cataloguing some of the challenges and questions. I wonder if what we ought to do is say here's what we heard, here's the list of issues and challenges that we heard that maybe are harder to address through criteria change. That we transmit that to ONC and see what they can do in terms of solutions, because each of these issues that were raised require probably pretty different solutions, but there's a list of them.

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

I think that's a great idea. What I'd like to propose is that was a really rich panel.

Christine Bechtel – National Partnership for Women & Families – VP

It was very good.

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

It was really good. Why don't we spend our June 1st call time dealing with this set of issues, everything from what Neil introduced this topic, which is the certification. It's not just that it can be done with 20 clicks, it's got to have some kind of usability component in there, and then the rest of the "list" that Christine talked about. If we could put together some of our notes from that panel ahead of time we can march down the list, because I totally agree, some of it may not be meaningful use objectives per se, but it's important things that are part of our letter for ONC, some of which the HIT Standards Committee can take up. But I think we don't want to lose that. I totally agree with you.

Marty Fattig – Nemaha County Hospital – CEO

I just want to mention that as a user of IT technology for a number of years every time we do an upgrade we have certain processes that crash other processes because every install is different. So the fact that people are having crashes really doesn't surprise me. Even when people take a long time to develop these products, when they were under the gun to develop things as quickly as they had to for stage one this is going to happen, and I think that is probably one of the best reasons we can come up with for maybe slowing down the implementation.

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

Okay, I think there's quite a bit of consensus, because we talked about this earlier, around our favorite option. We'll present all the options, we'll present our matrix and say our favorite option, and the one that we assumed to go through our meaningful use objectives was option three. Can I just get re-confirmation of that sentiment and then we can move to looking at, with that as our favorite option, look at the meaningful use criteria that we have so far?

Christine Bechtel – National Partnership for Women & Families – VP

Paul, so you're saying stage one lasts an extra year, stage two is compressed into one year?

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

Right now, yes. I guess the way I've always said it is because it makes so much more sense to me is that really we're shifting that one cell in that grid. So for the early entrants they would still be under stage one in 2013 because of the—

Christine Bechtel – National Partnership for Women & Families – VP

Right, so I'm okay with that, but would like to suggest probably a slightly different course for the conversation. But I'm okay with the idea of having that option in mind of the most workable of what we considered.

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

Okay, that's what we're asking.

W

Paul, I just wanted to add one, for framing this discussion I actually did map to the timeline and I know there was a decision by the Policy Committee that there should be an 18-month window. What this gives us, given that the final rule comes out in July, is a 15-month time window, so it's still a little tight. So maybe we add 90 days. But I think for purposes of what we're doing it's not 18-24, we're still talking about a pretty tight timeline there, so just to frame the conversation. I think the message, again, that was from other vendors too at the Policy Committee meeting was, again, recognize if you can signal for stage three so we can get it on the development plan. I know it's hard but that would be really helpful.

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

Great. Hearing consensus around that favorite option, let's use that as our visor into how we frame our meaningful use stage two recommendations. Through the discussion, we can clearly indicate what would be stage three, and if there are things where we're on the fence on is it feasible in stage two, and that's

considering both the vendors and the whole ecosystem and the ability for providers to implement. We may want to shift it one way or another on the stage two, stage three kind of timeline.

Let's remind ourselves, the other handout was Josh putting together and the staff putting together the mapping between the National Quality Strategy and our stage two meaningful use requirements. If you look at that, one, gratifyingly, it's quite well aligned and you don't actually even know who ... because we adopted a modification of the National Quality Forum, the National Priorities Partnership, and it seemed to be carrying through in some of the work. They even cited it as well of some of the CMS initiatives that have come out of the ACA. So, any comments, it just seemed very well aligned and very much supporting the quality strategy as published.

Christine Bechtel – National Partnership for Women & Families – VP

I agree. I would have just maybe on the first page of the pyramid had something about patient engagement.

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

Let's see here.

Christine Bechtel – National Partnership for Women & Families – VP

I'll just throw that out there, but otherwise I'm fine with it.

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

Absolutely, yes. Of course, it's not our pyramid.

Christine Bechtel – National Partnership for Women & Families – VP

Yes—

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

But I totally agree.

Christine Bechtel – National Partnership for Women & Families – VP

—the comment wasn't really directed at you.

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

Okay, well let's dive into it. I think both Christine and Neil gave a good introduction, which is assuming that we do have this additional time. It's hard to say additional because it's something that was needed to do safe development and implementation anyway, but with this time what is the critical core functionality that's needed in order to support the providers in operating in a new reformed health ecosystem.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, clearly, I had a lot of coffee this morning, but I think this is important. I'm struggling with how to go through this part of the conversation. One way is certainly to go through it and look at, well, given that if that option of an extra year is adopted, what in here needs to change. But I think I have two things to say. One is, the way the ... are written there's still a lot missing and not consistent with the agreements that we've had, so the missing pieces are for a lot of things, whether they're core or menu and in some cases EP versus EH, things like that.

Then there are just differences in, at least it was my understanding, for things like advanced directives and patient view and download, where we made some nuanced clarifications at the Policy Committee meeting that I don't see reflected here. I would almost think about going through the slides as they are in the context of what we've already agreed to making sure that they're correct, but in terms of going through and seeing what might change as a result of the extra year, I think that it might, at least from me, require a little bit more thoughtful consideration. We have done a lot of that and have pulled together a document where we basically said, okay, for things like, I'll just use recording of demographics, it's really driven by a technical function. So we should think about our technical capability, whether there is the

change in that, that we might ask for before stage three given the extra year. But I think it's a more sophisticated list.

We also came up with a potential way to create some parsimony across some of the care coordination and patient engagement stuff by looking at care planning as a way to hook all the pieces together and not have them floating out across the board. But I think my sense is that it will be very difficult for people on this call to think on it on the fly. So one of the things that I was going to suggest is that we might all circulate some electronic versions of places where we see those criteria advancing given the extra time so that on our next call we can really have a thoughtful discussion where folks have looked at stuff ahead of time. I don't know what you think of that, but I'm a little bit worried about trying to do all of that on the fly given that we first need to get the criteria right in the current context as well as thinking about how they might evolve.

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

One, I think you're right that we can't do things on the fly. It's better to have some briefing materials up front. So if you want to send us your stuff, and I don't know whether others have the same kind of other tweaks to the framework kind of thing, but we need to coordinate that before the next call as well. I think in principle I agree with what you're saying.

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

Paul, it's really hard to know what we're reacting to. I mean the nuances of what we're saying, so let me give you an example, because I've walked a lot of this through with the vendor community. So just finite detail like to view and/or download, or is it view and download, because as you look at those capabilities and measure them, there's a lot of implications of some of those details. The intent is all the same, but the nuances of some of the stuff gets really complicated so we just need to make sure we have the most accurate, common set of stuff that we're responding to.

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

I totally agree. Maybe for today's call we want to make sure, we've heard from three different groups at least, we have the HIT Policy Committee. We've had some of our workgroup, like Adoption group and states give us feedback, we heard some from the Standards Committee. So I just want to make sure at least that the slides we're looking at, and we can tweak them as far as differences in interpretation, is accurate, and then talk about some of these other nuances and details that both Christine and Charlene raised in the next call. Is that fair?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I actually think we can talk about the nuances—I'm sorry?

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

Yes, some of it

Christine Bechtel – National Partnership for Women & Families – VP

Yes, absolutely like view and download, and then we should at least flag, okay, summary of care record, it doesn't say if it's menu or core. Now that might change depending on the timing option, but if we get the core set of criteria right in today's context I think we can do that today on the phone. I also think, though, that the other thing that would be very helpful before the next call is we have talked about having a transmittal letter that is really in narrative form. Because we lose so much nuance and context and explanation in the slide deck that if we could spend today ironing out the basics of this so that a letter can be drafted before the next call. Then those of us who have ideas about evolving criteria given the timing options can circulate those before the next call, and then the next one could focus on that and review of the letter, that would be, I think, a home run in my view.

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

Yes, a home run, but a lot to ask.

Christine Bechtel – National Partnership for Women & Families – VP

Well it is, but we've done this for a million meetings now. So it's no new information. It should be catalogued already.

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

Josh is not on, he's going to be on I think in about 15, 30 minutes, so we can re-raise that when Josh is on. How's that?

Christine Bechtel – National Partnership for Women & Families – VP

Is Allen on?

Allen Traylor – ONC – Meaningful Use Policy Analyst

Yes. Hi, Christine, I'm here.

Christine Bechtel – National Partnership for Women & Families – VP

Okay. So Allen's on, who's our other lead, right?

Allen Traylor – ONC – Meaningful Use Policy Analyst

Yes.

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

Do you think you can come up with a draft for us to review? I think that's a great suggestion.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Sure, I think so. Yes.

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

Okay, good. Great.

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

Paul, I just want to be careful that the reason we consider timing options is because we didn't think we would make it with what we proposed. I don't want to necessarily cast it as we're going to wait a year and therefore we can double the ask because we're waiting a year, because all we're doing is we're saying 10% of people or 20% of people who engage in the program have 12 months extra somewhere in the midst of their thing. Do you know what I'm saying? We're doing timing options so that we can do this successfully.

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

Right .

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

We're not doing—

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

That was—

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

—... more to it.

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

I'd like to just echo that because I think we are moving the timing so that we can do what we've described, and I think a number of folks on this call have said that in different ways. So I think we all understand that, but sometimes the way it's phrased is, well, let's do more because we have a year. I think George is exactly right. We're trying to make sure that people have a reasonable amount of time to do what we're proposing. So it's not as if we're trying to double this, just as a frame of discussion.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

So let's move through this. So this first pass is, one, making sure that we have the critical functionality described in here; and two, making sure that we've gotten the right interpretation of what we've heard as feedback. And also open up to some of the nuances that people have heard about, whether it's the view and/or download or some of the things that Christine mentioned. Let's try to do this category by category just so we can stay somewhat focused. So category one, which is big, in fact, why don't we do the screen full kind of thing, I think there weren't any changes suggested in the first page. So what George said is in red are edits based on feedback from the full Policy Committee.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, the thing that's missing, though, is summary of care record. It doesn't say if it's a menu or a core item.

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

Is this on page one?

Christine Bechtel – National Partnership for Women & Families – VP

Oh, I'm sorry. I'm looking at the wrong page. My bad.

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

Okay. I think there's nothing changed on page one, right?

M

That's correct. Christine had a good point that it's not actually always clear whether it's EP or EH in all of this, so we've got to just make sure that it goes in there.

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

Okay.

Christine Bechtel – National Partnership for Women & Families – VP

I think I don't see a menu or core for drug-drug and drug allergy interactions.

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

We have no menu. So far there's no menu.

Christine Bechtel – National Partnership for Women & Families – VP

So these are all core?

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

So it only says "menu" when it's menu, but otherwise you should assume core, because later it says core on some of them.

M

Judy, the change was that we moved it to core, but in the second column there are zero menus. The only two that we considered menu now say "CMS to consider" instead of calling them "menu."

Christine Bechtel – National Partnership for Women & Families – VP

I think we seem to be clear about that, certainly in the transmittal letter every single thing needs to be said: menu, core, EP, EH.

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

Okay, that's a fair clarification.

M

Why not?

Christine Bechtel – National Partnership for Women & Families – VP

Because we're not consistent at all, we have moved to core on some, but not on others where they should be moved. It's just not consistent.

M

That's just an error then.

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

Yes. That's one of our clean ups, and, Allen, maybe you can help us make sure we do that. Page two, we probably still have some work to do on the ... piece. Now, I don't know who was going to try to figure out and who can figure out what's the current state of practice. That was one of our questions. Let's move to inpatient first, because I think we were fairly clear there. We do have the patients there. They are in the hospital. There's something ... going on, and certainly something can happen and it's very important that we understand the patient's wishes. So that's why we had initially had a pretty nice threshold, 50% for folks where this is more likely to be an issue. Any changes to that?

Christine Bechtel – National Partnership for Women & Families – VP

I think what confused people was whether this is a requirement, and it may be a difference about a distinction in reality, but whether there's a requirement that you have to have a conversation about what the advanced directive is and you have to establish one. I believe, and I'd be delighted if I was wrong, but I don't think I am, that what we were trying to get at here is do you have one, yes or no, and if you do, that the contents are documented. In other words, what it is—

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

That is correct. That's my understanding.

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

Read that sentence. Why is the word "who" there?

Christine Bechtel – National Partnership for Women & Families – VP

It is 50% of patients who have recorded, right, it doesn't—

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

Christine's asking the question because this is ambiguous. So just read that sentence, Paul, and do you see what I mean? Like "who" shouldn't be in there unless they mean that. What it says now is if you happen to do one, if you've already done the discussion that's your denominator.

Christine Bechtel – National Partnership for Women & Families – VP

No.

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

That's how it reads with this word "who" there. So I think it's a misphrasing.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, but I also think that the reference to advanced directive discussion is throwing people. I think what it is, is 50% of patients over age 65, for 50% of them there is documented, whether or not it exists, which is the carryover from stage one and if it exists what it is.

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

That was my interpretation. You cannot expect people who might end up in the hospital to be able to, or should they be expected to process the complex issues in an advanced directive. So all we're asking is

have you had that discussion. And it can be no, and here's information about it, but if you have and you've made a decision then let's make sure that we have a record of it. That's what that's intended to do, I think.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, so what I would do is go back to the stage one language, which is not what's on the left. What's on the left is shorthand. So I would go back to the stage one language that describes document whether or not an advanced directive exists, and you don't use the word "discussion." If it exists document the directive itself, what it is.

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

That sounds reasonable, actually, because it's hard to—

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

Okay, so that means take out the word "who" and take out the word "discussion."

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

I have to go and look up—

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

Instead of wordsmithing it, I think we agree with what Christine just said. Do other people on the call agree with that?

Christine Bechtel – National Partnership for Women & Families – VP

No, Paul, let me make a correction. It's really 50% of patients over age 65. It's record whether or not ... exists. And then if it exists what the ... is.

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

I think that's exactly right. Do people on the call agree with that?

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

Yes, and the caveat that was unclear is that over 65 applies to both EP and EH?

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

We're not on EP yet, so let's talk about EH.

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

Sorry. Yes, keep it the same, totally aligned, don't change it if it's working.

M

Paul?

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

It says record advanced directive for patients 65 years or older is the objective.

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

The way Christine said it is record whether an advanced directive exists for half of the folks over 65 and if it does exist to put it in the record.

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

Paul, you were looking for some sort of benchmark as to what actually is happening out there, if I recall, earlier.

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

Yes, we're looking at the EPs, I think.

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

I was just ... because advanced directive is completed by patients who are either in the hospital or ambulatory. There's this one quick reference from the *American Journal of Medicine* 2006. They surveyed University of Buffalo. So this is one center, but 86.2% were unfamiliar, or 500 patients, with the term "advanced directives," but 93.5% thought they knew one or more specific kinds, and 43% said they had one, but of those only 25% thought their provider had a copy. That's one study, just to give you a—

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

Who did they survey, Michael?

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

Five hundred and eight patients, a prospective study of adult ambulatory patients at four academic internal medicine clinical sites—

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

Ambulatory?

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

Right. But they use the same function as a hospital, so at some point they have an advanced directive. It's one study obviously, but I just wanted to give a scale.

Christine Bechtel – National Partnership for Women & Families – VP

I think that supports, actually, what we're reframing this objective as.

M

Hospitals are required to record this anyway at the current time. It just may not be electronic.

Christine Bechtel – National Partnership for Women & Families – VP

Right, and that's the difference is if it does exist it needs to be reported electronically.

M

I totally agree.

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

They're required by which—is it JCAHO?

M

No, it's required by CMS. It's been a requirement for a number of years.

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

Then we're making really a small advance by moving it into—I mean we're not adding.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

M

Yes, just recording it electronically makes sense, so you can say yes or no and then scan it in.

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

Okay, so this is really an important accompaniment to what you just said.

M

It is. The big question of course is that physicians are real reluctant to make a decision based on an advanced directive wondering if it is the latest, that's the issue.

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

Correct. Yes, sir. So what we did add to this was that this was going to be date and time stamped to give people a fair chance of understanding it's

Christine Bechtel – National Partnership for Women & Families – VP

And that should be reflected in the letter, Allen.

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

Correct. It should be right into the criteria.

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

Yes.

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

So moving on to EP, which is new territory for us, and we all agree that this whole topic is something that should be occurring with someone you have a trusted relationship with over time so you can discuss, and who is familiar with your health and your life status, so clearly EP is an area. Now, we do have the specialists versus primary care, so now let's look at Michael's one study said that at least 43% actually had one. Was there an age limit on this, Michael?

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

I don't see it. I'm just looking at the ... obviously because it was just quick. But 43% claim to have completed one, but of those who said they had only 25% thought their provider had a copy. Then a significant correlation between having completed one and age, reading ability and educational level, so we have to understand there are going to be some pretty significant disparities based upon that statement.

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

Right, but this is part of the problem we're trying to solve.

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

Again, I'm not arguing on it. I'm just trying to get at least one

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

Right.

W

....

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

So let's try to restate where we were and see if that seems right. We said 10% of patients seen during the reporting period, so not your entire database, have this same thing. It's known in the record whether the patient does or does not have an advanced directive, and if they do it is in the record.

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

This is George here. One concern is what incentives we're creating. So I don't want to pick a specialty, but if you're a sub-specialist who wouldn't normally have done this what you want to do is get enough patients to say no so that you reach the 10%. So the ones who say yes you can say yes but not read it into the record because you don't really have the facility, or the patient would never be carrying it with him. The idea of how you'd organize to have your patient bring the advanced directive so that you could just scan it in, even if you wanted to, would be a challenge logistically. So what you want to do is get ... your patients to say no.

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

To deal with that problem, let's start talking about primary care first and then let's discuss specialists. For primary care do we agree that for patients, and is this over or equal to or greater than 65?

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

That was going to be my question, somebody raised it earlier, should we keep the same age?

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

We might as well. Most of the providers are applying under Medicare, so we might as well make it consistent. That's one technicality. For folks who are 65 or older we should have a record of whether they have ... or not, and if so record it and put it in the record for primary care. Does that seem like a fair requirement? Is that an important ... to move in this direction?

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

I would support that with the age cutoff. Just because it makes it a little more reliable that you can get it done.

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

Other comments or ... from that?

Christine Bechtel – National Partnership for Women & Families – VP

What kind of age cutoff?

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

The same as what we said for hospitals, 65 or over.

Christine Bechtel – National Partnership for Women & Families – VP

Oh. We had comments from about 30 consumer organizations that really didn't want any age limit and certainly thought that 65 and older was too high. I understand the need for an age cutoff, but I think I'd rather see a younger age, maybe 50+ or something.

Neil Calman – Institute for Family Health – President & Cofounder

I think we have to be careful about the burden on providers. I really do. I think that you want to go where the biggest bang for the buck here in terms of really trying to make sure that we have stuff on file, whether you want to use 65. I wouldn't go as low as 50.

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

My memory of this debate years ago is that it wasn't really about the age cutoff. It was really diagnostic based.

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

I know, but we ... really do that.

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

You can't do that, but I'm saying we should be careful what sort of policy precedent we set. I'm sympathetic to the burden issue. On the other hand, I don't know that setting an age threshold is a way to reduce burden and may misdirect the focus of attention to the wrong people.

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

Maybe we can call out two different age groups to get people focused on this in stage three, age 65, and then think about taking the next cohort of people in stage three or something.

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

The key here is, and I think we said this with the other metrics, is to get people talking about things and doing things. So I would expect that if they're able to do it with 65 and over, that those conversations will become easier to do with others. Roughly calculating, if you look at it, an average internist has about 2,000 patients and about 40% of them are Medicare, so there are 800 in theory within an internist's practice. So we're talking about 10% of that would be 80 advanced directives. If you're talking about 10% of the entire population of an internist, that's 200. So it's a pretty significant difference between

trying to get 80 documented versus 200. That may not sound like a lot, but it's a lot of work in the middle of everything else and these are not necessarily easy conversations to have.

Christine Bechtel – National Partnership for Women & Families – VP

Right, but we're asking them to ask do you have one. No, okay, next question. Then if the answer is yes, okay, what is it, or can you get me a copy so I can include it in my record. That's all we're trying to do. I get the provider burden side, but I also get the enormous burden on patients and families when they're advanced directives aren't followed.

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

Absolutely. I think we're all talking about getting to the same place. It's just a matter of where you set the threshold. We want everybody to have the appropriate conversations. But if you're going to judge a practice or an eligible professional for an incentive, this among all these other types of things they have to do, we have to look at the collective burden here. It's not that we don't want them to talk to every appropriate person about an advanced directive and record it. It's a matter of where do you set the threshold. The rest will come through education and trying to learn the system. That's what we're trying to do here. I applaud the objective in trying to make it reasonable for folks in terms of the scoring, even as we're going to try and educate folks to do it all.

Christine Bechtel – National Partnership for Women & Families – VP

Perhaps we can take Neil's approach of signaling that it's a broader cohort of people in stage three and definitely some work needs to be done to figure out, by stage three it may be that David's approach of condition base is much more feasible with more widespread implementation of health IT. So at least if we can signal a reduction in the ... stage three but think between now and then about how we might do it in a way that makes more sense. There's a huge community of people who can advise on this.

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

That's fair. Let me just restate it. For patients 65 and older in the hospitals what we're asking for is that 50% of patients have recorded the presence or absence of an AD, and if they do have one that it be in the chart and for EPs the same criteria except that we're requiring it only for 10% of patients seen during the reporting period. This is for primary care so far. Now we've got to talk about specialists.

Moving on to specialists, your argument is whether they have that same rapport. I don't think there's a question of whether they may have that same need to know because it can happen in anything, including ophthalmology or even derm, but where's the appropriate place to put this responsibility from a satisfying this criteria point of view.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, let me ask a broader question, because I think this is certainly, and we all agree, not the only criteria where this kind of an issue comes into play. This is our first conversation since we've had the specialty hearings, and I'm wondering how we're going to respond to that. I think there are some potential options for structuring the program in a way that might make more sense and be a little more customizable for specialists. But I think that's a whole big separate conversation. Are we planning on responding to what we heard in the hearings?

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

Paul, I apologize, but I have to sign off.

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

Paul, I will have to sign off shortly too.

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

Okay. So one of the questions raised was, it came at the tail end of some discussion is the whole menu option. Menu is not a bad approach to dealing with this kind of problem, it seems to me. What do people think about that? It's a combination of not all provider organizations are the same, whether you're an EP or a hospital, you could be a rural, you could be in a place where there's less broadband Internet, there's

lots of reasons. You could have different health literacy and you can be specialists in primary care. Menu options seem to be a way of dealing with that. What are people's thoughts on this?

Christine Bechtel – National Partnership for Women & Families – VP

Paul, I think that's right, but I think the problem is that as we constructed the program, it's on our recommendations, and it's pretty blunt. It doesn't currently have the ability to have separate tracks, which is what we're hearing a lot about from the specialists, so I think having a huge list of menu items that are optional for everybody doesn't make sense and is counter to what we already agreed on. However, for certain codes of specialties who are eligible for meaningful use it might make sense for them and them only to have—and we would have to define them—a very limited set of universally applicable criteria but then a large list of menu items. And a minimum number that they've got to do that will get them on par with what primary care and internal medicine and cardiologists and others who more easily fit into the current construct might do.

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

I was going to add that in the quality measures of our program where we are likely to end up with specialty specific menus, the easier place to put some of that. You can say oncologists, for example, have a different threshold for advanced directives than dermatologists do, or a quality measure about completing advanced directives might appear in the oncology menu. It doesn't even appear in the dermatology menu. So the functionality that you want to have enabled through these functional criteria may be universal but at a low threshold, whereas, the thresholds could be tweaked through the quality measure side of things for different groups of EPs.

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

That's an interesting approach.

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

The only issue at all as we're starting to go through these is today you've got to certify, you have to buy all the ... issues in certification where you've got to have these complete things. So that just has to be fixed so they can exclude, if it's appropriate. I don't think that should be the barrier to this approach. I like this approach where it's specified by ultimately the outcomes because that's where we want to go. There's just some infrastructure stuff we have to fix.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, and I agree, Charlene. I think that's one of the things that goes in the letter, Allen, not the transmittal narrative for the criteria, but the letter where we're flagging issues around vendor capacity. I think this certification issue, or having to buy the whole ... is another one that we heard loud and clear should be in there.

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

Could we put that on our list for June 1, whoever's keeping track of this? David, before you have to leave I want to give you an opportunity, particularly your perspective from the quality measurement point of view, on anything else that you wanted to raise before you leave.

Christine Bechtel – National Partnership for Women & Families – VP

David?

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

That was his parting words, his parting shot. Okay.

Christine Bechtel – National Partnership for Women & Families – VP

Could you just reiterate what you think you heard David's concept, because I'm not sure if it's the same as what I suggested or different.

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

I think, and this will come up again, we have been using MU objectives as a way to make sure that EHRs are certified to be able to do such things. Sometimes what we do is put a low threshold, but our purpose was to get a certification criteria. I heard, and I forgot what was the context, but ONC can cause certification criteria to be put in the program without a specific MU objective, and maybe Allen can confirm or not confirm that.

Christine Bechtel – National Partnership for Women & Families – VP

Oh, well that's new. Maybe they can but there's a lot in those rules.

M

Paul, say that again.

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

I forgot what the criteria was, but it caught my ear and I think it may have been at the Standards Committee that ONC can write a certification criteria because it is needed for certain things without necessarily having an MU objective as the driver. Is that correct?

M

Yes, that's correct.

Christine Bechtel – National Partnership for Women & Families – VP

That's what they did for privacy and security, Paul.

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

Yes.

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

That's true. You're right, exactly.

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

Here's where I think David was going, we really do believe an EHR, even a specialty EHR, needs to be able to handle AD, both the ... and the scanned in document when it exists. We don't necessarily have to specify who this applies to, let's say, in the EP world. They can, because they're already going to have menus or things to choose from in the quality measurement domain. This might be one of the ways that we handle this if not all EPs are the same. So we can require that the EHRs have this capability and then the Quality Measurement Workgroup can decide, well, what's the threshold for primary care versus specialty. That to me makes a lot more sense and it gets us out of the bind of the menu versus not menu objectives.

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

Paul, does that mean that we're now thinking about putting the AD not in this list but in the quality metrics only?

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

No, we're thinking of one requiring through our letter, let's say, that certification criteria exists so that all EHRs, including specialty EHRs, be able to accommodate the coded information that an AD exists or doesn't exist and where it exists has the ability to get it scanned and connected to that. That would be a functionality everybody has. Then we can go ahead and say for hospitals write this criteria as we've written it. But for EPs where we have the distinction of does it apply to every specialty of EPs, that can be executed, that menu approach can be executed through QM, quality measures.

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

So we leave the hospital on this list but move the EPs over to the other side?

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

Correct, and we may have a special way of writing this that maybe this is where we go ahead and say that EHRs be certified to do this and that the thresholds be set by the Quality Measures group.

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

Thank you.

Christine Bechtel – National Partnership for Women & Families – VP

Even for criteria that are really functional criteria?

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

So far this is the only one we've had. But we may use this approach because I think it's an interesting way and it's easier to understand, I think, for some of these others where it applies to some and not all.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, this might be solved under the same solution. So I've got an integrated system where I'm seeing the patient in my clinic as well in the hospital and I have one, right, the shared, would this apply then? The EP could still ask, right, but it would still be stored once?

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

Correct. So when they write the rule about the numerator and the denominator, they can say it exists in an accessible fashion. You may not be required to ask this when you're seeing the patient, dermatologist, but you have to be able to access this through your EHR.

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

Do we want to say that explicitly?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, because that's some of the feedback we're getting is if I've got a unified system –

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

George, you said "say that explicitly," that's why we're requiring it as part of the certification criteria for all EHRs.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

I'm just saying that right now in the directive itself it exists is one statement, this is a different statement, and are able to access it—

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

....

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

—is a different statement.

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

For sure, but I don't know why that's required. Surely, you'd want to access it.

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

No.

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

No, no, in other words, what I think Charlene's asking is the hospital has it and the patient says oh, my hospital has it, then you don't need to scan it.

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

Right.

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

Correct, correct.

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

So saying in the directive itself, if it exists, implies you need to scan it into your EHR, so that's—

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

Okay, well then—

M

I don't understand, how does that help society if it exists at their hospital but you're their primary care provider or whatever and you don't have it?

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

We are saying you must have access to it. If you—

M

How are you going to have access to it if the hospital has it?

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

Then you figure out how, either because you're connected to the hospital or because you go through an HIE organization, or because you have re-scanned it in.

M

We had brought up the issue of whether or not—back to the certification piece—whether or not we wanted the certification folks to deal with the issue of having a standardized way of capturing AD information so that it could be passed through an exchange in other than a scanned kind of version. Which I know for a lot of exchanges I don't even think they're doing scanned copies. If we really want the stuff to be accessible and moving, and we did talk about this, another piece to call out to the certification process would be a way of standardizing the information in advanced directives so that people could potentially capture it in a way that can be exchanged.

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

Right. So, Allen, we want to make sure we capture that as part of our recommendations, in this case of certification, so there's a list that we have for the

Allen Traylor – ONC – Meaningful Use Policy Analyst

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Paul, separate and apart or broader than this I think we still need to come back to how we're going to deal with the specialty issues, so anesthesiologists who don't prescribe, should they be doing electronic prescribing.

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

That's already covered, because there are 100 prescription thresholds.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Christine, I think on something like that the exclusion is not a bad mechanism because it's less common. Whereas, for the advanced directives I think it's more common and the exclusion doesn't work as well, and that's why David's suggesting a quality measures—

Christine Bechtel – National Partnership for Women & Families – VP

Do you understand my broader point? Maybe I'm picking on the wrong examples, but we hear repeatedly that specialists don't fit in the constructs that we have. So whether it's I don't see patients directly or whatever, there are some criteria that don't apply to them that I don't know would be appropriate for inclusion in an optional quality measure set and what do we need to do with that. I don't know that we can get into that conversation right now unless there's some short answer, but I'm not sure how to deal with what we heard from the hearing two weeks ago, or whatever it was.

M

I think there's a spectrum of categories here. There's the stuff like prescribing, where maybe one out of every 200 providers out there doesn't prescribe. Then there's the stuff that's just relevant to only primary care or something like that, where it doesn't affect a lot of the specialists. I think we need multiple strategies to deal with it. I think on the 1 in 200 piece exclusion is a reasonable way to move forward.

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

Good point. Okay, well, we can keep that in mind as we go through this review and see whether the menu quality measure or exclusion handles it. Then if there's something big we'll have to find another way that would push it from the direction of the menu MU objective.

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

Okay, the question, and did you answer it, this is Charlene, so the current criteria for enabling users to electronically record whether a patient has an advanced directive. But did you want to put in there, are we just assuming being able to view it? I think that's a given.

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

Yes, we have to be able to view it.

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

Okay.

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

They can decide how they want to make that. So if they all admit to this one hospital, as an example, and you have a reliable way of getting it, even if you have to go scan it back—

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

Right, also we should be agnostic to—

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

—how they do it.

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

Yes, how they store it, if it's already there, they've got it.

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

Right. Okay, I think this has been a very useful discussion.

M

Could we signal that in stage three now that we'd like to be able to have this information stored in a retrievable and exchangeable fashion?

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

Yes, why don't we do that? And that's one way we signal to HIT SC that they need to start looking for something like that.

M

Yes, because this is only valuable if you can get at it everywhere. The exchanges are becoming more and more robust, I think, that in another couple of years this is going to be something that people will readily want to look to, to find from there their exchanges.

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

And also the point that you raised about having to standardize some way for the system to be able to operate with that information.

M
Exactly.

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

Perfect.

Judy Murphy – Aurora Health Care – Vice President of Applications

Paul, just to let you know, I joined about ... ago.

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

Welcome, Judy. Okay, so the bottom of the second page we talked about the structured labs, and I think we left it that we're trying to influence the use of structured labs coded in LOINC, where hospitals are sending information, because that's our only lever. Allen, just for the presentation, electronic orders received should be in red. That was one of my comments, but it's in black so they'll miss that unless you put it in red

Allen Traylor – ONC – Meaningful Use Policy Analyst

Okay.

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

The 40% of electronic orders received, the word "received" should be red.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Okay.

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

Where's that?

M
We changed it from "results sent" to "electronic orders received." So "orders received," I guess, should be red. That was changed based on my comments after Josh's—

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

What row are you on?

M
The last row.

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

So it would read "hospital labs—

M
It reads as it is today.

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

Oh, got it, okay.

M

... become red so that when we present it to the Policy Committee they know we changed it.

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

Right, exactly.

M

Paul, this is a real problem for small rural hospitals. They generally do all the lab work that's done in the community and to try and build interfaces so you can electronically send these results back to those places before you have an HIE is going to be absolutely impossible. It also creates an unfair playing field for the reference laboratories who don't have to do this compared with us in hospitals that do. It increases our cost and does not make it competitive.

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

I'm not understanding. So you say hospital labs currently don't send the information?

M

They may send the information, but having to do it in structured format when the commercial reference laboratories do have to because they're not covered creates an unfair playing field.

Marty Fattig – Nemaha County Hospital – CEO

The commercial labs will have to because all of the providers and hospitals that use them that are trying to meet meaningful use are not going to use the commercial labs unless they do.

M

Right.

Marty Fattig – Nemaha County Hospital – CEO

So I've never worried about that. If you want to talk about market forces, you have tens of thousands of high volume providers across the country demanding that their commercial labs do this if they don't already.

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

I think, actually, Marty, we're going to do exactly this, which is move the market which includes hospitals to sending information in coded format.

Marty Fattig – Nemaha County Hospital – CEO

Well, I'd just say it may put our labs out of business in that way, and that's going to harm patient care.

James Daniels – Medical College of Wisconsin – Associate Director

Paul, I'm sorry. I came on the call late. But with regards to this point, many hospitals in rural areas, and I'm speaking in particular now with the upstate New York area, are going to rely on statewide HIE services to be able to convert whatever their normal output is into structured format. I think that is the point here is that many of these hospital labs can't afford to do that singlehandedly, but with a statewide service they will just subscribe to that service, which will be much more economical because it's pooling the resources among many hospitals. Until those services are built out, hospitals really won't be in a financial position to accomplish this. I think that's the point.

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

I see.

Marty Fattig – Nemaha County Hospital – CEO

I agree, Jim. The HIEs that I have seen in our area, this is one of the first things that they do is capture lab data.

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

So can we rewrite this? So instead of saying “send” which means a direct output of the hospital, can we rewrite this so that somehow the hospitals who provide lab services get structured information into the provider’s EHR?

Marty Fattig – Nemaha County Hospital – CEO

I think what we need to do is list it so that send structured lab data to available HIEs in the area.

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

That’s ..., yes.

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

You can’t require people to use an HIE.

Marty Fattig – Nemaha County Hospital – CEO

Why don’t we say provide either directly or through an HIE?

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

Yes, that’s—

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

Great. That’s 40% of electronic results received are in structured format using LOINC where available?

Marty Fattig – Nemaha County Hospital – CEO

That will work if the HIEs in fact are developed. Like I say, if there’s not developed this is going to put too big a financial burden on small rural hospitals to do this.

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

Marty, I don’t know if it’s just exclusive to small rural hospitals.

Marty Fattig – Nemaha County Hospital – CEO

Yes, I agree.

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

Again, I can’t speak for the community hospitals. Again, just to be very clear, our focus, and I don’t know if this is an issue for us, has been around, we had this discussion last time around EHRs and qualified EHRs, because that’s in the law, these typically are LIS systems and sometimes separate LIS systems from the hospital LIS because it is for referral work. So again, I know Farzad had an approach to how to do this, but there are two issues. One, vendors like to certify complete, and this would be really hard to certify complete, but let’s fix that outside of here. So that’s one of the issues around it. But secondly, again, it’s bringing something that’s “traditionally” non-EHR to the table in the solution. Not that that should preclude us from doing this, but just to put those caveats in there.

Marty Fattig – Nemaha County Hospital – CEO

How much of laboratory testing results does this apply to?

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

Yes, I mean for those that ... within the hospital.

Marty Fattig – Nemaha County Hospital – CEO

Does this apply to anatomic pathology as well? Because that’s why we’re—

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

No—

Marty Fattig – Nemaha County Hospital – CEO

—we’re saying, right?

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

I'm sorry?

Marty Fattig – Nemaha County Hospital – CEO

We're putting a percentage on it, so if anatomic pathology can't be done then that would be part of the percentage that's not done.

M

But is that included in the denominator or not?

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

I said we were keeping this, if you look at our stage one, we talked about clin lab results. I didn't know that we're changing the denominator.

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

I hope not.

M

As long as that's clear, it—

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

Correct. You're right.

Deven McGraw – Center for Democracy & Technology – Director

Just for the record, I'm nearly positive that the Policy Committee endorsed this because it was first put forward by the Information Exchange Workgroup ... one. I can confirm that, but this is all sounding really familiar, specifically because of the real need for laboratory data to be standardized and a recognition that the hospital labs were going to play a really critical role in getting us there.

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

This is the logic behind it, if I understood you.

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

I think—

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

There are challenges with it.

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

Remember that what we can do is add some text to describe the situation. ONC's going to decide, well CMS is going to decide how to write the definition and the exclusions. They of course know these things about the smaller hospitals, so they can do this. We want to put forth this, for all the reasons that we've said, and the qualifications and some of our concerns, and then these are just recommendations. CMS will deal with the exclusions and the outliers, but even they want this to move in the direction that we're pointing this.

Marty Fattig – Nemaha County Hospital – CEO

I agree with the end result. As a representative of small rural hospitals I feel like I have to—

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

Sure.

Marty Fattig – Nemaha County Hospital – CEO

... state the—

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

The challenges, yes.

Marty Fattig – Nemaha County Hospital – CEO

Yes, the challenges that this is going to bring forward, so this may be extremely challenging.

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

We need to note that and that should accompany this recommendation. I appreciate the comment that we need to include that.

Marty Fattig – Nemaha County Hospital – CEO

Thank you. I appreciate that.

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

Okay, are we ready to move—?

Allen Traylor – ONC – Meaningful Use Policy Analyst

Paul, this is Allen. Can you just, for my purposes, can you read then how it will now—?

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

Okay, I will try. For eligible hospitals, hospital labs directly or indirectly provide structured electronic clin lab results to outpatient providers for greater and equal to 40% of—

Christine Bechtel – National Partnership for Women & Families – VP

... electronic orders.

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

Electronic orders, or it should be results received, of electronic results received.

M

Orders, because you don't—

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

Got it. That's the denominator.

Marty Fattig – Nemaha County Hospital – CEO

Exactly.

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

Okay. So that was approximately it, Allen.

Allen Traylor – ONC – Meaningful Use Policy Analyst

I think I've got it.

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

And it's important, one of the main points was and use LOINC codes where available. Let's move on to the next page. This is moving some menu into core. One of the—I won't read it to you. Any edits to what we heard from the Policy Committee, instead of "received" to "sent" to fix some of the denominator problems and we brought in the age. I think that's captured. I don't know whether we came up with a definition of EMAR. Maybe we have to work with—

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

Paul, on the EMAR we had some discussion around it, so it was really unclear was bar coding included or not. We discussed should the ... of medication management be included in there. So who's going to define that? Was that the intent?

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

I think the intent of the word “automatically” meant that there was some patient ID there. We actually in one iteration had bar code in there, but we wanted to make it technology agnostic, so the notion is that there’s no transcription in recording that something’s administered to the right patient. So I don’t think we were trying to get the ..., etc., it’s basically we wanted to get this automated administration tracking.

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

We talk a lot, the vendors recognize that there are costs rolling out, bar coding or whatever the technology is, but I think there’s pretty strong support for putting in the ... of medication management as part of this. Again, it’s one unit to start with or something like that.

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

But the ..., I mean, all of a sudden we have to audit it, and I don’t know that that’s an MU objective, an EHR objective.

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

All right.

Judy Murphy – Aurora Health Care – Vice President of Applications

Yes, I agree. I actually like the metric the way it pretty much stands. I do not believe that anybody would automatically interpret that as including bar coding.

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

So “automatically” implies the patient identifier is passed without manual transcription, is that—?

M

Yes.

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

Yes, that’s the automatic part of it, I think.

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

All right, we can be clear that that’s what’s meant?

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

Yes, that would be helpful then.

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

Okay, good.

M

It’s 11:27.

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

Yes, should we move on?

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

It sounds good.

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

So now engaging patients—

M

Paul, in my notes I have view and able to download was one of the suggestions of the Policy Committee.

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

Correct, because we didn't want to force people to download if they didn't want to. What we're trying to do is create certification criteria.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Christine, would it be better to say “view or download,” or “view and able to download”?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, “view and have the ability to download.”

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

Correct.

Christine Bechtel – National Partnership for Women & Families – VP

I think what we want to do here in the transmittal letter, Allen, is really specify that we're trying to get this capability in the software for download and that we want this to be countable in an easy way automatically by the technology. So the technology should be able to say “x” number of patients logged in and viewed their information, and “x” number downloaded.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Got it.

Christine Bechtel – National Partnership for Women & Families – VP

And then just backing up a second, I would not put “DROPPED” in all capital letters on copy, because I just think that's bad signaling. I would just say “combined with other objectives.”

Allen Traylor – ONC – Meaningful Use Policy Analyst

Also good.

M

It was partially combined and partially actually dropped, because we decided not to take on the legal record.

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

But on Christine's point, just the visual optics of dropped, you know.

Christine Bechtel – National Partnership for Women & Families – VP

Yes. The view and have the ability applies to both hospitals and EPs, so we need to make the change in both places, George?

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

Say that again?

Christine Bechtel – National Partnership for Women & Families – VP

Saying “view and have the ability to download” needs to be changed in both places—

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

Yes, yes, yes, yes, yes.

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

But why wouldn't it be “or,” because the vendors have to have both. The providers—

M

Yes—

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

—...one or the other.

Christine Bechtel – National Partnership for Women & Families – VP

But you can't download without viewing.

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

Yes, but that's—

Christine Bechtel – National Partnership for Women & Families – VP

So the design, I think, unless I don't understand you, Charlene, you have to be able to count, so you want to count one thing and that's the view.

M

The way I would put it is for the certification point of view we want to be able to both view and download. In other words, I don't want to buy a system that only views—

Christine Bechtel – National Partnership for Women & Families – VP

The vendors have to—

M

—... meaningful use.

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

But the count could be if the patients just view it, that's sufficient, right?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that's why we would say view and have the ability to—

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

Okay. Because what they want, that was a concern was the measurement.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Also, well how can you—?

Christine Bechtel – National Partnership for Women & Families – VP

The system should be able to count both, but the accountability metric is on the view.

M

I would like it to be either view or download as the metric that we end up with, with the presumption that if we download they're going to look at it and that counts as a view.

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

Yes.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I—

M

I don't have anything against that. I just want to make sure the software for each person can do both.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I agree. We're all saying the same thing. I'm just trying to keep it simple, because you cannot download without having first viewed, so I just was trying to keep that clear. But whatever—

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

You can. Sometimes when you go online I can either look at the document or I can just download it.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, but you have to log in securely to download.

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

Yes, I see what you're saying.

Christine Bechtel – National Partnership for Women & Families – VP

And that counts as a view.

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

Yes.

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

Okay.

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

I think it's covered by the language that's proposed.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, it is. So on clinical summaries, I think this is one where I don't know if in our letter or in the criteria we just need to clarify that electronic delivery is okay.

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

Okay, good point.

Christine Bechtel – National Partnership for Women & Families – VP

That was what we heard from the panel.

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

That's correct.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Say that again. I can't remember

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

If you have a patient portal that counts. People just want to—

Allen Traylor – ONC – Meaningful Use Policy Analyst

Oh, okay.

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

They didn't want to be forced to print out things when neither party wanted to have that paper output.

Christine Bechtel – National Partnership for Women & Families – VP

Right.

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

One up from that row, so, Deven, you're going to tackle the concern that, gosh, if you let them put it on a USB drive we've just got a different privacy and security issue?

Deven McGraw – Center for Democracy & Technology – Director

Yes. I mean ultimately we have some transparency issues to tackle on the tiger team with respect to making sure that people understand that they're bearing some risk when they download the information. It's something that, for example, in the Markle Blue Button effort they took care of with a disclosure that was relatively simple but essentially put people on notice that once you take possession of the data you're responsible for it.

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

And how does that language sync up with our MU recommendations?

Deven McGraw – Center for Democracy & Technology – Director

What do you mean?

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

Will there be something that you actually put in our transmittal letter?

Deven McGraw – Center for Democracy & Technology – Director

I don't know that we would have it finished by then.

Christine Bechtel – National Partnership for Women & Families – VP

I think the question is really where is the right place to put it. On the Blue Button there were some very simple language, like five or six bullet point sentences that made clear to the patient, this is what you're doing, this is the potential impact, are you sure you want to do this. I just don't know if that's what the tiger team comes up with or something like that. I don't know if that goes in our letter. I don't know if it goes in the certification criteria, if it's technical function to display that notice.

Deven McGraw – Center for Democracy & Technology – Director

Yes, I think the transmittal letter can take care of it by saying something to the effect of either subject to or consistent with recommendations from the tiger team with respect to notice to patients involving download risk.

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

Right, so it would be nice to have an asterisk here, Allen, to make sure that that is flagged.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I agree.

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

I have two items. On this one let's say the implementation is such that that data is shared in an HIE environment and that's where the patient can access. If I export that data and the patient can go one place to see it, do you still have to have the portal? It's just making availability. That's where I'm a little challenged.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, we've never said this has to be a portal or a PHR or an HIE. We've tried to be technology agnostic.

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

I'm totally with—it's just that it's hospital portal. I'm with you, Christine. I'm just worried on the language. I'm interpreting it wrong then.

Christine Bechtel – National Partnership for Women & Families – VP

It shouldn't say "hospital portal." Where does it say that?

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

In one of my old documents, in one of the past variations, I think.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, that's not on the slide deck, though.

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

Okay.

Christine Bechtel – National Partnership for Women & Families – VP

You're right. I think that became a shorthand earlier, but—

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

You're right, it did. So it's the ability to view and download via, well, it says a Web-based portal.

M

What?

W

Where?

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

I'm sorry. I have an old version that I'm working with.

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

Okay, so let's move on. Anything else on this page?

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

Yes, one more. Another concern that was raised is, is it a 36 hour? There's a concern in terms of how measurements are calculated in that particular case, so most people at the end of the day, you know, would you do your calculation after 36 hours, or how do you process, is it a separate measure in terms of you download within 36 hours? What's the thought in terms of measurement around it?

Christine Bechtel – National Partnership for Women & Families – VP

No, it says information is available within—it doesn't say there's a view and download. It says information available for all patients within 36 hours.

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

So then how do I measure that?

Christine Bechtel – National Partnership for Women & Families – VP

I think that's an implementation issue. I'm not sure how we craft a policy to give people guidance on that. Is that what you're asking for?

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

Concerns from the vendor community with how would they measure the 36 hour piece of it. Is that a separate measure? That was the feedback on that one.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, but I don't know that that's what we're taking on here.

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

The vendors are saying how would they help the provider measure whether they comply, is that it?

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

Yes, yes, yes.

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

Yes, it's almost a workflow thing.

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

Yes. So again doing the measure in terms of whether it's view or download is one capability, but the 36 hours is a challenge, or they didn't know how to do that.

Christine Bechtel – National Partnership for Women & Families – VP

Well, but this is not new. They're doing this in stage one. In terms of measuring information availability, that's already on the EP side. I think it's an implementation issue that I'm hesitant to spend that much time on right now.

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

It probably will be an attestation and then if you get audited, they walk in and say "Show me your charts and let me see the stuff," so I don't know that there's an automated way of doing that.

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

Paul, the next thing on the list for me here on this page is back to the secure messaging component. First of all, I assume again that this is still core, which is what we agreed to.

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

Right.

Christine Bechtel – National Partnership for Women & Families – VP

I think the challenge that I hear, and in fact heard in the Policy Committee, was that 25 patients is not the right construct, that this doesn't account for really large organizations who can just pay somebody to go out and do that in one day. It does not foster the kind of workflow change that we need to see. So I wonder about having different numbers, if it has to be a number count it needs to take a count the size of the organization—

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

When you say organization, this is each EP, so there's no—

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

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

So why does the size of the organization matter?

Christine Bechtel – National Partnership for Women & Families – VP

Because if you have a big practice, tons of people, then this is nothing, and even then 25 messages in the course of one year is an extremely low threshold. I think that the concern that I have is this particular functionality is really a feeder functionality for so many other things, whether it's information reconciliation, as we've talked about, whether it's access to care, there are lots of other functions in meaningful use that could leverage this. So having 25 patients in the course of an entire year is not going to be anything that changes the practice's workflow.

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

Actually, Christine, I would use your argument the opposite way. This is only to make sure that you have the capability and you've got the workflow so that you know how to engage patients. The fact that you will use this for other things is the reason I don't know that we have to insist on any one arbitrary either amount or percent, because that's the whole point of this.

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

We had previously agreed on secure messaging in use, which means ... one patient and we upped it to 25.

Christine Bechtel – National Partnership for Women & Families – VP

Well, no—

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

We could go back to what we agreed on as a workgroup, which said—

Christine Bechtel – National Partnership for Women & Families – VP

It was a percent, I think, threshold originally.

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

No, I'm looking back. It says "online secure patient messaging is in use, proposed stage two for the RF" I'll check the RFC, but I think it said in use.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, I'm happy to pick up, since we're running out of time, this part of the conversation in our next meeting where we'll talk about stage two potential evolutions. But I do want to say that in the letter—and this gets to the last thing on this page. We had agreed that we would communicate that a purpose of secure messaging was in fact what we called "information reconciliation" in stage two, that we wanted people to understand that part of our intent was that secure messaging would already be used for that in stage two. We might consider more structured processes for that in stage three, but that was an important signal that we agreed to send, so that should be in the letter. That's all I have on that page.

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

Okay, good. Let's move on to the next page, which is in care coordination. I think it was a type to say "LTC per se." We really meant you get credit for getting it to where the information needs to go and we didn't intend to limit it to only VPs. That was the point, so we can state that. We clearly had to go not 10% to 20%, I don't know why that was ever there. And now this longitudinal care plan, that's the problem we still have.

Christine Bechtel – National Partnership for Women & Families – VP

I think there's still something on the summary of care record, it's not clear if it's core or menu.

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

Well, we don't have anything that's not core.

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

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

Okay, longitudinal care plan, I think there are a lot of reasons why the industry, and I mean the sector not the sender industry, does not have a clear definition of this nor a mechanism to maintain it. But I think we want to be able to share what we do have, that's sort of where we are, I think, and start moving the ball down the road in terms of what is a dynamic shared care plan. Can we get definitions going? Can we get standards to apply? So in some sense we're asking for that from the broader health sector and trying to understand what is the current state of affairs in the standards community. But are we really asking for a longitudinal care plan with the current state of things, or are we asking for publication of your care plan?

M

I think that one of the things that we had, I thought, decided was to eliminate the word "longitudinal."

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

Yes.

W
Yes.

M
That that was very confusing.

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

M
And it implied somehow consolidating information from multiple sources and whatever.

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

M
So if you eliminate that, I think what we were headed towards was using information that we thought was readily available in the course of care.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can we use that phrase, “summary and care plan” up in that third item, where we say “summary of care records”?

M
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. So could even the recommendation be when we looked at the content of that CCD there was an element of plan of care, or instructions or something.

M
Yes, exactly.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, that’s what we would have—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And it might have to be just a note to get going, right?

Christine Bechtel – National Partnership for Women & Families – VP
Right, yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Like signal that it needs to be part of this in stage two and then it will become more structured as we move out, right, something like that.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I think including the instructions is key. Eva?

Eva Powell – National Partnership for Women & Families – Director IT
Yes, I was just going to say my recollection is that at our in-person meeting a couple of weeks ago that we kind of ended on this with Neil’s recommendation to actually turn the summary of care record into the summary and care plan and make it one document. Because really the summary of care doesn’t make sense, at least on the patient end, without instructions and a plan, which then makes it the care plan.

Neil Calman – Institute for Family Health – President & Cofounder

Exactly. We're trying to make one document out of what we would have thought was going to be a separate one.

W

Yes.

W

Right, exactly.

Christine Bechtel – National Partnership for Women & Families – VP

I think I would add to that two things. One is, because it will include instructions it needs to be transmitted to the EP but also to the patient and/or the caregiver. Then the second thing, and that can be per their preference, right, electronically, whatever.

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

Yes, but we have that under patient engagement going to the patient. I mean, we need to align it so that we're not generating ten different documents, but then they've got to look back at discharge instructions and figure out how that merges. I don't know—

Christine Bechtel – National Partnership for Women & Families – VP

Well, so that's actually, George, where I was going next, and we can talk about this on the next call if we want. But when we've looked across these things it seemed to be a little bit more parsimonious if the care plan, because really every patient could benefit from a care plan, healthy or not. But that could include any discharge summary from the hospital or the clinical visit summary from the EP side, instructions, whether that's discharge or EP, educational resources on the EP side, the list of care team members probably needs to be in there, and then the summary of care record elements, we already said that we would put in there. I think it's actually easier to begin to consolidate under this and I think it's probably easier for folks to consider if we write it up.

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

For instance, as a vendor we would think about creating one document with some different sources to be able to do all those functionalities, not documents, but one concept, if you will, that would meet those different needs.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, and that's what I think we ought to at least look at doing. I think we'll have to figure out if reconciling the various patient populations and the threshold percents across the different requirements and making sure that if we do this it's a core item and things like that. So if folks are amenable to thinking about this a little further, we'd be happy to continue to refine our thoughts and share them before the next call.

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

I think there are a number of things that could be potentially combined or reconciled, the discharge instructions, even the clinical summary and the summary of care. So, would a small group want to go work on that and have something in writing that we look at the next call?

Allen Traylor – ONC – Meaningful Use Policy Analyst

Paul and Christine, I've spoken with the S&I framework and they're going to deliver a paper to me on the 6th of June that does a crosswalk on what standards currently exist and how to combine all the documents given the current standards and given the current landscape. So they're going to try to deliver that on the 6th. I can ask them for it sooner if—

Christine Bechtel – National Partnership for Women & Families – VP

Yes.

M

Yes.

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

Recognizing that we have to present this on the 8th, the So we're going to have a call to finalize this on the 1st. Can they help us even with the matrix? It doesn't have to be the full white paper.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Okay.

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

Christine, just one thing to watch out for. Remember that the discharge instructions, I'm just thinking now, are really optimized for patients to understand here's what I do next. Summary and care plan is optimized for the doctor to understand the context for the patient. Now what I'm looking at, just thinking about it, they are two different things but related, so just be careful that we don't go down to too few documents.

M

Yes.

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

Again, it's just more important to have the elements of those things consistent and aligned so that if we're going to put plan of care or whatever we call it, its intent is kind of the same as if you wanted to cross all or something like that.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, so we were part of the group that did a lot of it, so we may be going back to the consolidation piece. But, Allen, if they can get that document to us a lot faster, even if it's in draft form, because I don't need to know the standards as much as the categories, that would be helpful and we can craft something and circulate it.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Sure.

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

This does harken back to some of the consolidation work you did before, Christine, but recognizing George's point, maybe there are two "consolidated" documents. One is directed toward the patient, which is category two, but the others we certainly don't want to curtail any information going to providers. So maybe that's a category three kind of thing, but still—

Christine Bechtel – National Partnership for Women & Families – VP

... saying I think the question is whether computers are sophisticated enough to take the same data sets and translate them, or whether they really need to be two different documents or not.

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

I think there are two. There's a lot of things that you say, the kind of information that you want to communicate to another provider on the team and likewise you want to say it in a different way to the patients, considering health literacy, etc.

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

Maybe this is a standards issue that is just a little beyond me, but it seems to me like what we're really talking about, at least in stage two, certainly the literacy issues are something we need to tackle at some point. But at this stage what we're talking about is taking the same information and essentially putting it into different reports, if you will. My understanding is that most EHR systems have a reporting capability that even has the capability to customize reports. What I guess I have never been able to understand is why if we're collecting all this information anyway for the providers' sake, why can we not just configure it in a different fashion using a report for the patient?

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

Because a lot of it is into free text.

W

Yes.

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

Even the elements that are in the other criteria? My understanding is that the criteria we built into meaningful use is not free text.

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

Right, there's a lot of high leverage information like problems and meds and allergies that should be coded so that the machine can use it. But there's a lot that we do in our assessment plan part of our notes that are free text and they have different purposes, and we just want to recognize and certainly do not want to curtail the purposes.

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

Certainly not, but my understanding and what I've been trying to work with Allen and some of the ... on is on those things that aren't structured data, and I think there's an awful lot there that's not in free text that can be customized in a report for the patient.

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

The comment that was made, Paul, I like that, where if you think it through from as a provider to patient line of communication and a provider to provider line of communication. Again, the data elements will cross walk across that, I think that's a good way of—and again within provider you might have a few cases in there. But I think that's an important way to think about it.

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

Now, I remember, Christine, working on this with George, are there two different “documents” that we have then for this communication?

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

I think it's not something we can decide in one minute here. Discharge instructions have a long list of how you take care of your wounds, which is something you'd never send to a doctor. So you'd have to really think about it a little bit.

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

I guess where I was headed is are there two groups or the same group working on two documents?

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

Oh, sorry.

Christine Bechtel – National Partnership for Women & Families – VP

I think it had better be one group.

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

Yes, it sounds good.

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

So it was at least Christine and George, and who else wants to join that?

W

Eva certainly has been doing most of the work already.

Neil Calman – Institute for Family Health – President & Cofounder

... as long as I can make the time in my schedule.

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

Charlene,

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

Yes.

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

Well, it's reassembling that group, but we've got a different context now. All right, is there anything in category four, population public health?

W

Paul, can I just do, I have a couple of quick asks.

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

Yes.

W

One of the suggestions under the care team list was in stage two it was okay to put it as structured, and maybe it's coded in stage three. So the vendors typically will store them, so is there a need to put it as unstructured or—

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

How do you structure when everybody's got a different identifier?

W

Most systems have an ID number for their providers, they would—

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

So just have that, but it's not interpretable.

M

But these are out—

W

They can't share it among systems because they're specific to the system that you're in.

M

No, but the providers you're typing in don't belong in your system. So you have no codes for these people, not even internal codes. That's someone across town or someone in another state or something.

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

Or Mayo or whatever.

M

We're not demanding that it be unstructured. We're just saying it doesn't have to be structured.

W

Right, okay. I'm fine.

M

... but it doesn't have to be structured.

W

Okay.

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

Moving on to category four, population public health, these are all as we submitted to them.

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

Paul, I don't think there are any changes. I'd just say that there has been a fair amount of work and discussion around whether there's something additional to reportable cancer conditions that might be part of the menu. I don't think we have standards yet, but there's a group that's working feverishly to try to achieve that.

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

Right, and here's where we had the two on the consider list, we created a new category, it's called a consider list. And really what's going on is we're trying to move some stuff into certification criteria.

W

Paul, the other thing that I think is definitely an issue here is we did hear from specialists that some things don't apply to them, like immunizations don't apply to every specialty type. Art, is that right?

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

There's a way for specialists to say they don't do it.

M

Yes, they can currently get an exemption for that if they don't do immunizations. This is

W

Okay, great.

W

Paul, back to this cancer registry one, ... about it, again, across the vendor community there was concern, not that it's not important, but again are those more specialized EHRs that do that who report to them that kind of thing. Cancer hospitals aren't even eligible, if you will, for the incentives, so there was just some pushback from the vendor community in terms of the—so there wasn't experience with doing this, is all I'm saying, from the folks that I was chatting with. It might be a little harder. There's a development curve here and its applicability was in question.

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

This is not for any hospital. This is for eligible professionals.

W

Then there were the ambulatory folks too.

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

This has been tested at the IHE Connect-a-Thon. So there is capacity, it maybe hasn't fully been played out yet, but I think this has been tested in those environments already.

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

I think we may want to separate this category and we might literally put it on a "CMS to consider list" and not list it as "new," because it really wasn't our intent to, it's hard to feed this so we might find a different way to show this.

W

Okay.

M

What's that, Paul?

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

It's a different way of showing this because right now it looks like we're adding a new functionality when really this is going to a "CMS to consider" list. I think we just have a separate "CMS to consider list" instead of showing it on this matrix.

M

Okay.

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

That's all. It's confusing to people.

M

Okay.

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

Our final category, and I don't think we made any change, is privacy and security. A lot of it is directed towards the certification, and actually this is part of where we had it. And it's a re-upping the whole and you have to ... this ongoing security risk assessment and specifically address the encryption for data at rest.

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

Paul, I just wonder whether this is where we should be also pointing back to the item that I think Deven was going to take back to the Privacy and Security Tiger Team about Is that something that should be in this list?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I was going to say the same thing ... view and download, yes.

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

Great, good idea. Okay, so let me just remind people of what we've scheduled for our June 1st call, which is already full now. One is to pick up some of the loose ends we had here, particularly on the consolidated summary and care records for patients and providers. Another is to tackle the whole certification issue, and the feedback we had from that panel of early experience. A third is to deal with some of the other things on the list from that panel. A fourth is dealing with the specialty question of where things do not apply to all specialists, how do we deal with that? We might have to go through the categories again, particularly the ones that were pointed out to us.

Now we do have this new tool that we added, which is we can prescribe certain functionality to be in all EHRs. One good example is AD, we really do want it for all including specialist EHRs, and yet have some flexibility in terms of accommodating where things do and do not apply to specific specialties through the quality measurement menu set that David said is probably going to be there.

Anything else that I missed?

Christine Bechtel – National Partnership for Women & Families – VP

Paul, did you say going through about how they might have all given the third timing option overall?

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

In theory, we had that perspective as we went through it today. We are still struggling with, this is still fairly We continue to ask ourselves that question, but I think people will think this is still fairly demanding what we're asking for in new functionality here.

Christine Bechtel – National Partnership for Women & Families – VP

Okay, but that was what we agreed to do, so in the Policy Committee and in our last meeting and it's really the only way, at least me I'm willing to support any kind of analysis of that timing option. As I said, I'm happy to circulate some of the areas where we think criteria, particularly those that are based on technical capabilities, should evolve given the extra time. I'll circulate that. I hope there's time on the

agenda because I think we really do need to discuss that, because we did a lot of limiting of ourselves in these criteria based on technical capabilities alone that we should get freed up on, and then—

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

.... Go ahead.

Christine Bechtel – National Partnership for Women & Families – VP

Go ahead. I have another idea in terms of the narrative letter, but that's slightly separate. So did you want to react to that?

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

Can I just comment on that point? Maybe it would be good to assign people to the different sections to come back with some recommendations so we're not going through every single one of the criteria all over again.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, I agree with that, absolutely. I think we should only focus on those where we think we could have ... for each one.

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

Yes, because otherwise we'll never have time in the allotted time of that call.

Christine Bechtel – National Partnership for Women & Families – VP

We've done an overall piece that's in draft form that does cover all the categories that we can circulate. But I think that's a good idea as well, if folks want to take on looking at their particular sections we already had. I remember Art led public health, I led patient engagement, so we said reassign the same people.

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

And David Bates had care coordination.

M

Yes.

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

I think George and I had category one.

Christine Bechtel – National Partnership for Women & Families – VP

So I think that there's almost no way we can do this in a few hours. I don't know if we want to start the call an hour earlier, but we might think about timing for the call.

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

I'm okay. Are other people? That's 6:00 ... my time, but—

Christine Bechtel – National Partnership for Women & Families – VP

Yes, sorry.

M

I can't do it. I just moved a 9:00 to 12:00 meeting to make it earlier so that I can get on the call. I can't ask people to come at 6:00.

Christine Bechtel – National Partnership for Women & Families – VP

Maybe Judy can work with the co-chairs off line, because maybe we need to schedule another one. I don't know. I just don't see how we can—

M

....

Christine Bechtel – National Partnership for Women & Families – VP

... everything in two hours.

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

Could we move it to last an hour longer?

M

I can't go an hour longer. I already moved the meeting to do that.

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

Let's try to do as much ahead of time and vetting ahead of time, because that certainly will save us time. Then your other point was we were going to have a draft of essentially the preamble or the text in our transmittal letter to review.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, and I was thinking if that's a heavy list, Allen, for ONC to do, what we really are looking for are a set of the key points that are going to be made. It doesn't have to be in perfect narrative form, but for each of the criteria what are the contextual pieces of information about the purpose of this thing, what we're trying to achieve and what we want to signal, just bullet points would be a starting place for that.

Allen Traylor – ONC – Meaningful Use Policy Analyst

I think what I'll do is a quick intro paragraph followed by bullet points and then I will follow up with different members here to get more information where I may not have captured it all.

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

That's great. Thank you so much, Allen.

Allen Traylor – ONC – Meaningful Use Policy Analyst

Yes, no problem. Particularly, Jim, I'm going to walk over and talk to you as soon as you get back to the office with the public health stuff.

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

Okay, and we covered the agenda, which again is going to be a struggle to get two hours, so we're going to have to be fairly concise in our comments, a lot of pre-work, and I'll try to control the agenda and we're going to ask everybody's ... for that.

We need to open up the lines for public comment, please.

Operator

We do have a public comment.

W

We have Brad Jacklin.

Brad Jacklin – National Gay and Lesbian Task Force – Program Director, New Beginning Initiative

First of all, thank you, everybody, for your work on this committee. I know it can be a little tedious at times, but definitely appreciate what you're going through right now. I'm calling on behalf of my own organization, the National Gay and Lesbian Task Force, and for the National Coalition for LGBT Health to urge the committee to include sexual orientation and gender identity and patient demographic information. The LGBT community has a number of documented health disparities and healthcare needs that could benefit from the inclusion of sexual orientation and gender identity information and patient level data that's tracked in the EHRs. There are obviously some privacy and comfort level concerns around this, both for providers and patients regarding the collection of such information, but they're no more burdensome or unique than for other special populations. Finally, I will just say that the IOM made similar

recommendations in its March 2011 report for the NIH that addressed the health needs and research needs of the LGBT community. Thank you very much.

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

Any other public comments?

Operator

We have no more comments at this time.

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

Okay. Thank you. Thanks for going through this discussion. It's always rich. I look forward to talking to you on June 1st. Hopefully we'll have done a lot of e-mail communication so that we have concise discussion points on the 1st. Thank you, everyone. Have a wonderful holiday and talk to you next time.

Christine Bechtel – National Partnership for Women & Families – VP

You too, thanks, Paul.

M

Thank you, everybody.

W

Bye-bye.

M

Thanks, everyone.

M

Take care.

M

Bye, Paul.

Public Comment Received During the Meeting

1. MU Measures must be automatically calculated - can't expect providers to manually calculate MU measures.
2. Will Stage 3 final rule be released at the same time as Stage 2 (ETA July 2012)? If Stage 3 MU objectives aren't defined until July 2013, then we'll have the same issue with the short time interval before October 2013 (beginning of FY 2014).
3. Regarding secure messages - what if PATIENTS don't even know how to use the internet??
4. Comment - for the 600,000 patients at Group Health they get labs as soon as resulted (except for path) - no delay
5. NHIN direct is an option to those rural hospitals that don't have HIE.
6. Comment - suggest that the requirements follow the patient - IE regardless of point of entry into EHR that the "chart" should contain basic criteria whether you see a specialist or primary care provider
7. All surgery patients, those with cancer, AIDS etc should have an advanced directive for example regardless of age
8. Reference The Patient Self-Determination Act, 42 U.S.C. §§ 1395cc(f)(1), 1396a(w)(1) and the Health Care Financing Administration's final rule, published in the Federal Register, Vol. 60, No. 123, pp. 33262-33294, should be consulted for the exact requirements of the law on advance directives.
9. Q - why limit advanced directive to those over 65? The Patient Self-Determination Act (PSDA) is a federal law passed by Congress in 1990 which requires providers to inform all adult patients about their rights to accept or refuse medical or surgical treatment and the right to execute an "advance directive." No age criteria
10. Measures like Electronic Copy of Health Information do not make sense; systems can capture "requests" but it is very cumbersome and disrupts provider workflow.
11. The timing of the CMS rule-making process is a concern. Even if the HIT Policy Committee makes a recommendation to postpone Stage 2 until 2014, assuming CMS accepts "option 3" when will this be formalized/communicated as a final rule?