

HIT Policy Committee Meaningful Use Workgroup
Draft Transcript
November 9, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director

Good morning, everybody, and welcome to the HIT Policy Committees Meaningful Use Workgroup. This call will go from 10:00 to Noon Eastern Time. There will be opportunity at the end of the call for the public to make comment, and just a reminder for workgroup members to please identify yourself when speaking.

A quick roll call. Paul Tang?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

George Hripcsak?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

David Bates? Christine Bechtel? Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Art Davidson? David Lansky? Deven McGraw?

Deven McGraw – Center for Democracy & Technology – Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Charlene Underwood?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Latanya Sweeney? Michael Barr?

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

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Jim Figge?

Jim Figge – NY State DoH – Medical Director

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO

Here.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marisue Cody is on for Joe Frances.

Marisue Cody – Veterans Administration – Rural Health Specialist

Correct.

Judy Sparrow – Office of the National Coordinator – Executive Director

Did I leave anybody off?

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

Judy, this is Art.

Judy Sparrow – Office of the National Coordinator – Executive Director

Alright, I'll turn it over to Dr. Tang.

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

Good morning. I wonder if the new members might want to just introduce themselves and their affiliations, so we can introduce them to the rest of the workgroup.

Judy Sparrow – Office of the National Coordinator – Executive Director

That would be Marty and Marisue is in for Joseph Francis.

Marty Fattig – Nemaha County Hospital – CEO

Hello, this is Marty Fattig; I am a CEO of a small rural hospital in southeastern Nebraska. We have made the most ... for the last five years by the American Hospital Association. We have a complete electronic medical record on our critical access hospital. I've testified before the HIT policy committee last October, and then I had a meeting with Dr. Blumenthal and Tony Trenkle in Washington about a month and a half ago to discuss rural issues as well. I have a bit of a background in rural health.

Judy Sparrow – Office of the National Coordinator – Executive Director

Marisue, do you want to just say something about your team at the Veterans Administration?

Marisue Cody – Veterans Administration – Rural Health Specialist

Linda Fischetti, who's been on the committee had asked Dr. Francis to represent the VA going forward. We're with the Office of Quality and Performance, and are looking implementing electronic measures and are working very closely with our meaningful use team.

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

Thank you very much and welcome to the new members. Today's call, we have this call, we have a call on November the 23rd, and we have a face-to-face meeting on December the 3rd. Between now and December 13th, which is the meeting after the November meeting, we need to prepare a draft set of criteria for at least stage two and some placeholders for stage three, so that we can work our way towards getting additional feedback from the full committee on the December 13th meeting and revising our draft so that we can put a set of draft criteria out for public comment in January. So that's the roadmap we're on.

At the last policy committee meeting we had feedback from the full committee on some of our branch points or philosophical concepts. While there's no one way I think that we were directed, we got some feedback in terms of what reactions people had to the different decisions we were making in terms of the philosophical approach.

One of the important things that came up during the comment session was Dr. Blumenthal saying that we were not necessarily limited to 2015 in terms of if you can't squeeze everything you wanted or thought was needed in order to have full exchange of information and getting the data to the parties that need it or to make decisions including the patient, then we don't want to be limiting ourselves to 2015. After the meeting we talked, I had mentioned at our last call that he was talking about, you could take a broader look for horizons and then fit the meaningful use statutory date in the context of the longer horizon.

I'm not sure whether I'm making myself clear, but instead of stopping the world at 2015, think about where we need to get as a floor in order to get information to be able to flow around safely, securely, and fulfilling the needs for decision making regarded to health and health care.

Neil Calman – Institute for Family Health – President & Cofounder

Paul, maybe I'm missing this, but what you're basically saying is we don't have to achieve all our goals by 2015. But we're not resetting anything in relationship to incentive payments or anything like that, right? You're just saying, think about which of these goals as something that's going to extend out into the future.

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

That's correct. So yes, we have no authority and neither wants to change the law that prescribes the timelines for the meaningful use incentives and the meaningful use penalties that occur beginning in 2015, that's not changed. But previously we were thinking of the world, what could the world be like in 2015, and almost shoehorning what does the world need to look like in order to achieve the health benefits we're looking for and finding that, "Well gosh, that might actually be limiting, 2015 is only five years away."

Let's not stop painting the roadmap. Let's not stop describing the destination just because there's a statutory timeline of 2015. So if you look broader, what does the world need to look like to have care coordination to interchange with public health and so on and so forth, and then fit the statutory guidelines in there. Those would be stepping stones or mile posts on the way to the horizon. Does that make sense, I think it's exactly what you said, Neil?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I guess I've always sort of felt like we weren't trying to plan the indefinite future. But I hear what you're saying, which is that explicitly we can call out what the end point is as the goal, even if those end points extend beyond our current timeframe, which I think that's a great help.

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

Yes. I don't recall and I don't think you were on the call, but when I was presenting this to the workgroup last time, David's thoughts about having a further out horizon. There's been a nervousness about, "Wow, that's a whole new task, and can we really accomplish that, i.e., define this future goal set for all of these categories."

So I think as a compromise and here's the proposal for how we proceed is that we would continue our work. We've already started work on the stage two and stage three criteria, continue that. But when we find that we're at 2015 and where we think we can feasibly be at 2015, and it's not yet "good enough" to achieve some of the base goals that we have for the whole program, then it's okay for us to push that out to some other feasible date, even though it's beyond 2015. So that might be a hybrid.

We wouldn't completely define the end goal state for all of these categories and functionalities, but in the context of setting some proposed objectives and criteria for 2013 and 2015, if we can't achieve the base, I try to avoid the word floor, but there's a certain amount of functionality the whole community has to achieve in order to achieve the benefits for an individual patient like exchanging information. If we can't get to a certain mile post by 2015, it's okay for us to say by 2020, that's a ten year mile post, it should look like such and such.

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

I wanted to maybe go back to a visual diagram that helps me to think about this and I think helped the committee when we started when we had that bending curve and the three time points. So are we saying that the curve goes out farther and that the end point that 2015, which was improved outcomes or something like that, I can't remember exactly the term?

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

Correct. It was, yes, improved outcomes.

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

Might that be something that happens at 2017. I mean, if we're just trying to get the mental model here for 2020 as you said, is it allowing us to kind of move out in the future, and that end point that we thought was 2015 is now out there as well?

Then let me ask one other little point, which is I think there was some discussion earlier about the actual stages and how our committee had kind of set that up back at our beginning and how some were sort of questioning those stages. Are we still working towards stages two and three?

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

Yes, we're still working with stages two and three, because those are required in the statute. The statute requires organizations who want to participate in meaningful use incentives, not finish the job, but the last stage for that is 2015. That's queued around the principle of having all of the information in the electronic health records, this is by 2014. If you haven't achieved that by 2015, the penalty phase kicks in.

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

Were stages actually used in the legislation, the term stages?

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

No, that's something that came through the regulatory process, but the timeline, the 2015 in particular, came through the statute. So that's why we started working on criteria's for 2013 and 2015 hoping that we could achieve that same goal of having all the information in the electronic health records by that time. But it may not be feasible, given where we are now. So I think we're just saying, let's not assume that we can achieve certain goals by 2015 just because the statute says that, but let's try to paint the destination so that people can develop roadmaps to that destination at some feasible point in the future, even if it's beyond 2015.

Other comments about the strategy? We basically are saying we'll continue to work on the stage two and stage three criteria that are due in 2013 and 2015. If where we think we can end up by 2015 is still not adequate to meet the goals of the overall program to exchange information seamlessly and interoperably and have clinical decision support to support the decisions made by both the health care team and the patient by 2015, it's okay to put out a future mile post in the year beyond 2015.

Jim Figge – NY State DoH – Medical Director

I would support your proposal. I think in some implementation programs, such as in New York Medicaid, we are seeing some major hurdles for implementation even on stage one objectives. A couple areas which are very problematic are for example the public health reporting requirements where we simply lack the infrastructure and funding to even implement stage one. That's not to say that it's not a desired end

point to be able to achieve those goals, but the reality is it's going to take longer to get to some of these. So I think that keeping the same vision for the end point by pushing it back a couple of years is very realistic, because we don't want to back off on the vision, and we want people to get there. But it just may not happen as fast as we want it to because of some of the huge hurdles on the ground for the actual implementation. So I would support your proposal.

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

I'm on for Christine who's out today, and I would echo that and say that's a great point. In the sense that it would seem to me the key information for this group in determining future stages is to be monitoring some pretty specific information about what providers are doing. What they are struggling with so that we could either provide additional support, but also bear those things in mind as we move forward with future stages. Not to, as was said, not to diminish the ultimate goal, but to ensure that the ultimate goal is met and moving forward at a pace that's doable.

Do we know anything about who is tasked with collecting that information? Is that something coming out of the research center or how are we going to get that information? Because it just seems to me like that's critical to our task.

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

The information about the adoption?

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

Yes, and about what areas are moving forward faster and what areas are lagging behind by your criteria I should say?

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

Yes, we have another workgroup on EHR adoption. George, I think you might be involved in that?

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

Yes, actually these two days we're coming up with—we're adjusting the model of adoption. The data feeding that are the kinds of things you're talking about. The HIT Research Center is the central place where that's collected, and they're working on what data needs to be collected. But certainly, how it's going in which things are going well or poorly or some of the things they're going to learn at minimum from the RECs.

Paul, I think on the recommendation, I think if we name something 2017, it'll be immediately nicknamed stage four. It might be misinterpreted as backing off or it might create comments that we don't really need to deal with. Maybe instead of calling it 2020 or 2017, we just call it the vision, and not yet say what date comes after stage 3.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I think one of the issues here is going to be that we're not really calling out end points, this is going to be an evolution that's going to go on way beyond us. I think in terms of a specific goal, like let's say public health reporting because that's what Jim used as a goal, we can say we want this done by this milestone, this done by this milestone, but in a sense calling out what happens after that is in some cases is not going to be something we're going to be able to predict. Because new uses are going to come along, new technologies are going to come along, probably new needs are going to come along in relationship to things that are going on in public health and whatever.

So I think if there's a very specific objective that we don't think we're going to meet by 2015, we should call that out. But I think in terms of going way out on the horizon, I would agree we shouldn't label it with a year, and we should just say what the end point is that we hope to achieve post 2015.

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

I want to make another, two comments, one is I think, Paul, you raised a real interesting problem, which is penalty phase. Once this turns into penalties post 2015, we're sort of in a whole new world. So we're not chartered with those features. But it does make me wonder shouldn't we try to articulate even privately for the states, not as a formal recommendation, what the criteria for the penalty phase looks like? Where do you fall off the cliff in terms of functionality that would not be satisfactory and would therefore incur Medicare payment penalties? That becomes sort of the real statement in the real world of what those requirements are going to really look like after we're done with stage three.

The other thought I had was more around parsing this by functional interdependencies. I think Jim raised the point and very soundly that there are going to be places where we are describing HIE or public health reporting or as patients say things, communications, that depends upon infrastructure or a build out that is independent of the eligible professionals own world and their span of control. We can't totally control or predict what the pace of those infrastructure developments would be.

I think maybe there are going to be some places, maybe like Neil's clinic or ... clinics, which are going to be way ahead of the pace that we might describe as the minimum to avoid penalties that meet the criteria. There are some that are going to be all along the whole spectrum of adoption rates. If you think about the functional dependencies that have been in terms of less than the span of control of an individual EHR owner and then various functional connectivity they have to have to achieve different things we're talking about.

We might break apart the following into things that are minimum requirements within the span of control of the adopting EP versus those that we realize that under requirements for dependencies that may not make the 2015 timeline. So I'd be fearful of backing off of these 2015 requirements of saying that you're reasonably within the span of control of the provider who's receiving the incentive payments. Instead I think we should at least stay functional, we should be able to do clinical decision support, we should be able to push a discharge summary out, so those are new. That's really a minimum and we don't want to back off of that.

The goal is setting the improved outcomes target to stage three was we think the functional capability for enabling you to improve health outcomes will be available in the marketplace in 2015. We're going to specify what a vendor functional requirements look like. Then we're going to be measuring with critical quality measures whether or not we're making a dent in the target. I hope we don't throw the whole baby out as we think about the phase of adoption, but instead take the problem apart and the things that are core and things that might be needing more flexibilities.

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

David, that was well said. May I ask you a question about that approach? What I understood from what you said is, functional interdependency is one of the issues, let's say the public health, and being able to receive that information and transmit it and have the bidirectional exchange. So I thought I heard you say if we work more on the functionality that an individual entity, whether it's an EP or a hospital, has more control over. My question is wouldn't that reinforce the silos and not take advantage of one of the strengths of the meaningful use program, which is to get things to move around?

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

Well, I agree, I don't like my suggestion. I would want to change, maybe there's three sets of timelines instead of one. You've got to respect the reality that's been described, and the same is true with HIE, and other functions that are not easily controlled by the individual.

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

Right.

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

On the topic, it's interesting I think to set them all in three stages. I wonder if that was done by Carolyn Clancy's group that I think correlates real well with the work that we're doing and it kind of talks about in English where they're going to be at the end of these stages. So that's just input to the process. But relative to this topic, because Sam asked, and this is kind of a clarified question, because Sam has defined where you have to be at each of the stages, and were ultimately defined what is in the penalty phase. I tend to agree with David there that maybe we need to flag that corset of stuff that we think is crucial. I think that might be valuable.

Does it still make sense that we put things into three stages and let the process itself sort it out, the regulatory process, because CMS is accountable for regulating and getting all of this input in? Because it does kind of fall out of our hands at some point, other than our signals to them. I tend to like to leave things in, I like to put an end state in here, and then kind of where we'd like to see it go, because that's kind of what our role is. Then that we backtrack into stage two, that process seems to work for me.

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

Paul, this is Michael Barr. Real quick, maybe a placeholder?

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

Yes.

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

Maybe it's happened before and I apologize for not being able to attend some of the meetings, but the Health Information Psychology Research Center, the one that's going to be looking at how things are going, is there going to be an opportunity for this group to take a look at what they'll be assessing so we can help inform some of our discussions?

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

Yes, that part of the input into—so that at the end of the first quarter we would like to get input both from the REC, as well as the early submitters in terms of qualifying for meaningful use. And use that as a proxy for how things are going in this, as well as any other survey tools that's come about between now and let's say the end of this.

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

But my question is, is there an opportunity to have some input into what they're going to be asking and questioning as opposed to just receiving their feedback?

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

We would as part of the full committee, that's a really good question we could ask at the full committee in terms of how can we coordinate some of the efforts to assess what's going on.

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

Right, because some of the questions being asked about what's going to be in the future, what points of notice, we should be trying to get some sense of that as part of what they're doing in the research. If they're not thinking along the same ways as this group, then there will be a disconnect later on. So I just wanted to raise that.

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

Yes, a good point, very good point. This discussion has been good. It reminds us of the same kind of discussion we had in putting together stage one and the overall framework. It's this constant tension between wanting to accomplish some kind of base level where we have the whole community exchanging data to achieve the improved outcomes that we see that's bending the cost and bending the outcome curve.

Yet we are in the context of statutory dates set for both the incentive, and as David Lansky pointed out, and the penalties. That creates a sentinel mile post for us. We're taking in information about how fast can the industry and community actually go between now and 2015 or beyond? Then what's within the span of control of an individual organization? So all of those things are pulling on us in different directions and causing us to need to respect those perspectives as we put down this criteria. So I don't know that we have a solution.

One of the ways that manifest itself is the decision. Let me call the question on, should we put a mile post, if we can't make a certain point by 2015 feasibly, yet it is really important to achieve the outcome goals that we set out to achieve; then should we put some mile post for achieving that and pick some number whether it's ten years from now 2020, or two years beyond the 2015, or should we have something and call it future? One of the things that George proposed, because not everyone is going to fit in 2017 and you don't want to also create the impression that there's a stage four. What about the date versus a "future?"

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

I vote for future, because again, how all this process rolls out it's going to fluctuate, so I don't think we should get caught up in having to argue whether it's 2010/2015/2020 basically. I think we should let the future state out there.

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

I agree. I think that this should be pitched as a continuous quality improvement initiative that has some expectations by a certain date, but that the expectations go well beyond the date that was articulated in the law.

Neil Calman – Institute for Family Health – President & Cofounder

I agree with two thoughts, one is to support the thought that we're not using this as a mechanism to slowdown in terms of what we can accomplish in 2015. The second, that if there's a very specific thing we can achieve, we think we can achieve a year or two later, we shouldn't just leave that as something indefinite. We should say that we expect to see this happen shortly thereafter or within a year or two or something, so it doesn't seem like we're just sort of leaving every one of these things open ended.

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

I agree with that too, that certainly we should have some goals that we stick to, but there's nothing wrong with when it really is necessary to put something beyond the 2015 date and to talk about a future as opposed to a specific date. Something that I had heard yesterday at a meeting with ONC is that there's already chatter, probably has been from the start, among some providers saying that, and they use the phrase when meaningful use is over; as in life will go back to normal and we can do whatever we want to kind of attitude. I don't know how widespread that is, but I think if we talk about this as being not a finite program, but this is the way health care is evolving, and this is what will become in the future, then we'll be a lot more successful.

Jim Figge – NY State DoH – Medical Director

The only thing finite are the incentives and that should be the key to help motivate people to get things done by 2015.

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

And the penalty.

Jim Figge – NY State DoH – Medical Director

Yes.

Marty Fattig – Nemaha County Hospital – CEO

Yes, I'd just like to state that I agree with the future rather than a date. I think if you put a date out there, people will, if they can't meet the date, then they quit trying. If you put a future goal out there, then regardless of whether they've met in stage two or stage three objectives, they still realize that there's a future that they need to obtain.

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

Okay, that sounds like a good consensus. Maybe I can label that consensus as an annotated future. In other words, it would be a future horizon. What Neil and Eva said for example is that if there's something that's just a little bit beyond 2015, we can try to suggest that in the footnotes, so that's the annotation. But the consensus is around having some future horizon, because it may not be a date certain, but it's important to state where we're headed.

The second decision or conflict I'd like to have people's comments on is, now remember this is not the future state for nirvana, it's the functional interdependencies that David Lansky talked about. It's the future state that would allow us, it's a floor almost, that would allow us to exchange data and get access to data and operate on data to support the health of individuals in the population. So it's somewhat of a floor, it's not the nirvana. Is people in agreement with that kind of concept?

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

Yes.

Marty Fattig – Nemaha County Hospital – CEO

Yes.

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

Yes.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

Great.

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

Yes.

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

Okay, these are very fundamental assumptions then. So with these two things in mind I think we can start making good progress on this back at the metrics. Is that a fair statement?

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

Yes.

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

Yes.

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

Okay. So I think, let's see, could we put the metrics up, please? George has volunteered to help record our decisions on this metrics, which worked so well last time.

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

Let me see if I can accomplish this before 2016. Do you guys see anything?

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

Not yet.

Jim Figge – NY State DoH – Medical Director

But we're hopeful.

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

There we go.

Neil Calman – Institute for Family Health – President & Cofounder

It's not by 2015, by some later date.

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

....

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

It's our vision of the future.

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

That's right.

Neil Calman – Institute for Family Health – President & Cofounder

So far it's a blank vision.

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

I can see it.

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

I can see it now.

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

I can too. It's awfully small though.

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

You can maximize it to the full screen.

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

Yes, thank you, thanks, Mike.

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

Okay, now here's the thing, I can go back and forth. When I'm editing, this view is better for me, but when we're narrowing in on something and everyone needs to see it, I can zoom in at will. So I can do this for a particular area if you're getting that.

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

Yes.

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

Yes.

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

And once I do this, it's hard to edit.

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

Correct. For the workgroup members who have the Excel spreadsheets on their computer, it may be helpful to have your own separate view so that you can refer to things independent of what's on the shared screen. Okay, so coming into focus is our first topic, which is as we've all agreed in the past is one of the most important, which is the whole computerized provider order entry. That's where we're going to effect the orders that are written and that has a huge effect on the outcomes, as well as the cost.

So to recap, this is work we did and that we did a lot of work before we paused for the philosophical discussion. In stage one as you know the final rule said that CPOE for medication orders only. We had proposed that we extend that to medications, lab, and radiology orders by stage two as a 60% threshold, and by stage three we improve all orders at the 90% threshold.

Let's review this and say, are those still, one, achievable, two, consistent with the goal of the entire meaningful use program, the HIT Adoption Program, and do we need anything in the future? It sounds like if we've gotten 90% of all orders by 2015, I think we're doing pretty well; recognizing that there's still some orders that go to outside offices or things like that, outside reference labs, that we won't actually capture. So 90% is virtually all of the orders.

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

For the medication I could understand escalating, because that's pretty standard. But if the goal is to get by stage two 60% of things that people aren't currently being required to do, like radiology and labs, then they're going from 0% to 60% in theory as opposed to from 30% to 60% as with the medication. Then the other question would be, is there going to be an exclusive if they don't have the capability in let's say a rural community to be doing this or in their community at all?

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

I think that the 2013 is okay. It's actually not that hard to do the lab and the radiology once you have people to the table and doing the drugs. The other one is trickier.

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

I'd agree. The questions that were raised on is there an assumption there's going to be an electronic transmission of these orders? I don't think that was stated. The other question and the feedback we got was if you could, 90% of all orders seems to be pretty open ended and if there was a possibility of being more specific in stage three, because that makes it a pretty big jump? The specificity in stage two is really helpful.

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

Let's go to stage three first and work backwards. Then so now we have an additional option that we didn't have when we first developed this metrics and we can have a future horizon if needed.

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

Dave, you said the other one is trickier, which one were you referring to?

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

I was referring to other topic that Michael brought up, which is the exception for rural hospitals. I have to say I'm a little nervous about 90%, just because that's a high proportion. I think most of the good places are probably at 85% right now. Charlene, maybe you could comment around that?

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

That's right. It's the odd thing that is, there's a lot of exclusions.

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

Of course, I'm thinking about the small practice out there, not necessarily the hospitals that would have to, not only go from 30% to 60% of medications, but go from 0% to 60% by 2013 for labs and radiology

orders. Many of them are having difficulty doing any of that currently. So it just becomes a hurdle especially if it's not available obviously in the community or cost too much.

Neil Calman – Institute for Family Health – President & Cofounder

I don't think we ever called out that we expect that the requirement, maybe I'm wrong, but the requirement was to transmit the orders electronically. I think we're talking about here, the thing we called out here was the ability to input the orders electronically in order to engage whatever decision support and other things like that, that the systems have. So even if your radiology group can't accept these electronically, the ability to capture the order going out enables you, even if you're scanning a result coming back, enables you to create a closed loop referral kind of process.

So you order a mammogram and the system then flags you 60 days later that says there's no result that's been scanned against that order and the patient never got the mammogram. So a lot of the medical home concepts are tied into those closing the loop functions. I don't think a rural doc has any more struggle than anybody else to just enter an order electronically so that they can be participating in the decision support functions and be able to track the results and outcomes of the orders that they put in the system.

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

So Neil, that helps immensely, because I would agree.

Neil Calman – Institute for Family Health – President & Cofounder

If I'm right, am I right?

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

If you're right, then that helps immensely.

Jim Figge – NY State DoH – Medical Director

I would agree with Neil, and I think we should explicitly state that the order can be transmitted either electronically or printed on paper.

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

I think that's an important point. I think this also speaks to what David Lansky was raising in terms of the span of control. So this might in fact be a good example of that equal hedge. In the sense of we're getting a lot of the bang for the buck in terms of being able to influence the orders that are written, and yet there's a hedge that if you don't have access to the HIE's functionality, then you're not penalized and yet you're still getting the benefit.

Jim Figge – NY State DoH – Medical Director

But then this is a place where we should definitely have a future state, because—

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

Correct.

Jim Figge – NY State DoH – Medical Director

—we want people to be transmitting these things electronically eventually.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

But we also have a completely separate set of criteria for the process of health information exchange that we're calling out sort of separately in the document. So I'm not really worried that we have to, I think it's

fine to call it out and say eventually we expect this all to be done, but we're going to have some very explicit criteria related to the health information exchange that come later.

Jim Figge – NY State DoH – Medical Director

A lot of this stuff takes place within the organizations, but depending on the size.

Neil Calman – Institute for Family Health – President & Cofounder

Exactly.

Marty Fattig – Nemaha County Hospital – CEO

One of the things that I'd like to mention is that whether 90% is achievable by 2015 or not has a lot to do with where you are with stage one. Once you get CPOE in place and providers are comfortable using it, it's not that big a deal to move forward. But that initial step is what's key to this whole thing.

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

Marty, that's partially why CPOE got reduced to medication orders for stage one. So I think it's not that once you get CPOE when you're at that stage, when you're implementing the CPOE function, then turning on for multiple kinds of orders is much easier than that first step. So I think part of the flexibility that's been demonstrated through the CMS final rule is, okay, let's start with electronic medication orders, that is more prevalent, and then moving into the rest in future stages. So it's partially recognizing what you just said.

Marty Fattig – Nemaha County Hospital – CEO

Thank you, yes, I totally agree.

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

So Paul, I'm more comfortable than I was after Neil's explanation and the conversation so far, that this is something that we could support. I still think 90% might be a challenge for many folks, but the idea that we're talking about in the practice so it supports the decision making that Neil described I think is a very worthy goal.

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

Sounds good. So let's—

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

I'm sorry, just an observation, and I think Neil might have alluded to, but I wanted to be sure is that I just don't— I agree with what has just been said. I don't know what's realistic, so I trust you all to know that, but I worry about what implications this might have for care coordination, which is completely in this category. So should we flag this, just that when we get the care coordination, if we find out that what we've just decided with regard to CPOE prevents us from doing what we need to do in step one with care coordination?

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

That's a good parking lot issue. So when we get to care coordination, let's make sure we've enabled care coordination, so that's a good point. So from a process point of view, let me start asking, so here do we need a future state entry? I did hear one comment from David Bates for example, while the future state might be that we do have electronic transmission of CPOE. We don't think that's maybe necessarily feasible for majority by stage three, but that's some future state that we think needs to be part of the floor. Is that—

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

Yes, I think it might actually be feasible even for the majority. The issue is to—

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

Yes, I would agree.

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

—force everybody.

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

Yes.

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

Yes, I mean the feedback we're getting is not even like an interface. It's really bidirectional, because often orders come back too from the receiving system, so maybe the future states, the bidirectional communication. We have not talked about this in our HIE pieces in terms of the transmission of orders. We have talked about it with ePrescribing. So it seems like, because we've got an ePrescribing and there's an assumption there, we should be building that out a little bit.

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

It would appear to me that this should be a discussion for the HIE requirements.

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

Yes, this I think too mission critical to be left to HIE. I can't imagine—certainly for the inpatient side handling things through an HIE.

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

Agreed.

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

That's a good point.

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

I'm just talking about the exchange of orders. This is too important, exactly.

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

So actually, should we qualify the future state when we're calling for bidirectional in electronic transmission to qualify that as talking about with external parties?

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

Yes.

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

Yes.

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

Okay.

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

Wait, we want to clarify if bidirectional with external and not internal or what are you—

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

No, that's for the future states because we're extending that. For internal I'm anticipating that we're going to make that part of stage three.

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

I'd agree.

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

For the future stage to be both internal and external?

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

Correct. Of course, this applies a lot more to hospitals than providers. So for providers, most things are going to be external except for the large groups. But hospitals, it's basically saying they need to be and have this all going electronically by stage three some large percent.

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

So future is 90% of all orders transmitted electronically internally and externally with bidirectional communication. Is that future?

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

Correct, of all orders—

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

Yes.

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

Yes.

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

Transmitted electronically—

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

Yes.

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

—internally and externally with bidirectional communication.

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

Correct.

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

Okay, and stage two is 60% of—

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

No, let's go to stage three, so we're backing out.

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

Okay, okay.

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

So stage three then—

Neil Calman – Institute for Family Health – President & Cofounder

Wait, wait, can I just make a suggested editorial comment, just if we're calling out something for the future, could we put in a parenthetical clause that orders, and also put in sort of a clause that says, supported when appropriate by clinical decision support?

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

I thought we had that labeled though.

Neil Calman – Institute for Family Health – President & Cofounder

Right, the point here is we're trying to pull these concepts together for a future vision. So it really ought to be all orders supported when appropriate by clinical decision support or transmitted electronically when feasible to both internal and external recipients or something like that.

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

Okay.

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

So Neil, a couple comments, one is decision support is another criteria; and second was the point that you made that decision support can occur with or without the transmission.

Neil Calman – Institute for Family Health – President & Cofounder

Right, but I guess I was just suggesting that as we call out some of these future visions, that these five categories don't need to stay separate anymore. The idea is that we're merging a lot of this stuff. Here we're merging the ability to exchange information with the CPOE. We're also going to be merging other concepts, like we're going to be merging public health with exchange, and things are going to come together. I don't feel strongly about it. I just thought it would be for calling out visionary statements, we ought to show how these things should interconnect in the future, but it's fine if we want to just leave it out.

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

I support Neil.

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

I think it's helpful to look at it from a vision point of view, but part of the reasons for having these rows is to support the certification practice. If you lump them all together, then we basically have a comprehensive EHR and PHR that does everything for everybody, and it's just going to be really hard to decompose that into certification requirements.

Neil Calman – Institute for Family Health – President & Cofounder

That's fine.

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

Okay. So in the future state, we have 90% of all orders transmitted electronically internally and externally with bidirectional communication. So in stage three, the current proposal on the floor is 90% of all orders entered and transmitted electronically internally. I mean that's the default. People can comment on whether you want to modify any of those components to that.

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

The recommendation that we had brought forward was lowering the threshold a little bit, maybe to 80%, but including in that some comment about this. I don't know if you want to put the bidirectional interface that the electronic transmission orders in stage three. Because I feel that the value is so high in terms of getting that information back to your ordering physician.

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

Okay, so let's decompose it into two actually, one is, do we want 90% of all orders to be entered by the provider into the system and consequently getting feedback on that?

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

I'd be happy with 80% frankly.

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

Okay.

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

I think 80% is more realistic, 75%/80%, especially for those who are kind of moving along as the requirements increase.

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

Okay, 80% going once and twice.

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

Are we talking about a future state or stage three?

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

Stage three.

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

Stage three.

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

Eighty percent would be good.

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

Any disagreement with 80%? So this is 80% ordered by the provider into an EHR.

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

Now one question, Paul, would be entered by the eligible professional or could it be among the staff, because obviously some of the orders are entered by others? So is it restricted to say just by what a physician or what a nurse practitioner can order? We want to encourage team base care, so now you're broadening orders beyond prescriptions. There are other kinds of things that can be ordered like labs and radiology tests on behalf of the physician.

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

Well, the stake in the ground and the final rule for stage one talked about licensed professionals. The theory is, one, licensed professionals can order based on state law; and two, if you are licensed and are placing an order even if it's on behalf of the physician, you have a professional responsibility to react to the decision support feedback that you get on those orders. So that's sort of the rationale for why, licensed, not just a staff member sort of a scribe in those terms.

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

I think that's the right way to handle this.

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

Just to push a little bit, I'm not going to make a huge issue of this, but for example if you have a practice that institutes clinical algorithms so that patients get certain laboratory tests at certain parts of their treatment, those could be managed by medical assistants or an RN based upon a clinical protocol approved by the practice, and will that count? In other words, I just think we need to be thinking about how it actually works in practice so we don't exclude certain very quality oriented activities that encourage team base care.

Neil Calman – Institute for Family Health – President & Cofounder

So we're saying licensed professionals, but not eligible professionals. Paul, is that what you're saying?

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

Correct. Well, the final rule talks about licensed professionals.

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

In response to Michael's query being can't really is, not just to be a scribe in a sense. It's completely the support of a team base care, but the people who are going to react to the system alerts and system messages needs to be somebody who can professionally accept that responsibility.

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

Right. The issue has been that a lot of arthropods for example designate their secretaries to write all their radiographic orders. Then this decision support comes up and the individual who gets the feedback can't deal with it.

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

We've got the same problem in hospitals where they do protocols for admission orders and those types of things. So they're set up, and then often the nurses that are acting on that. So we're seeing that issue pop up from a ... perspective too.

Neil Calman – Institute for Family Health – President & Cofounder

I wonder whether we're creating an artificial environment here though. I mean, I hadn't really thought about this before, but it definitely happens. So maybe the point here is to think about that team base care would be fine and that people could enter orders as long as the orders were countersigned and the decision supports were also presented to the people countersigning the order.

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

Thank you, Neil, that's what I was getting at, because otherwise you're going to be changing practice as it is. I agree, some change has to happen, but—

Neil Calman – Institute for Family Health – President & Cofounder

Right, so I mean—

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

—we have to be careful we don't lay too much change on the desk of the physician sort of speak.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I mean for example like people are using diabetic educators. Well in New York State they're licensed, but in other places they're not. I think so you end up in a situation where they may suggest changes in therapy. They can't sign those orders, but it's very helpful to a provider if they input them for the providers review. So then as long as the decision supports are presented at the point of countersignature, you haven't lost any functionality there, and it might create for a less artificial environment for places that are really developing team base care.

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

So let me define your countersign. I think it would be okay if literally the order was not acted upon until a countersignature, which meant that—

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

Absolutely.

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

—yes.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, absolutely.

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

Somebody can literally enter information, but the person who triggers the order being carried out and gets the decision support feedback should be the people accountable.

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

Paul, I think that would be a good compromise and allow the practice to do the workflow they need to, while making sure the appropriate professional is making the decision.

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

I don't think we can get to this. I like the idea, but we don't know the workflows that actually happen in sufficient detail to engineer how countersignature works. I think we may need to leave it vague like the word professional. Every time we go and try to design the system like this in a more detailed way, we get in trouble because we find out there's all these caveats that you didn't think of about how real practices operate.

Neil Calman – Institute for Family Health – President & Cofounder

But I like the way Paul said it, which is that it's not really the entry of this stuff in the system that we're concerned about, it's the ability to trigger that order to be executed. So I think we could be completely silent on the entry part, because it really doesn't matter who's entering it.

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

Neil, could we say the orders would be processed through the system so that it's not dependent on who enters it? It's just that it's in the system and processed by the system so that appropriate decision support, etc., is applied.

Neil Calman – Institute for Family Health – President & Cofounder

The nurse orders the x-ray.

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

No, we need to have a licensed professional—

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

The nurse orders the x-ray, the patient goes to the x-ray ... the orthopedic surgeon.

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

No, no, that, Mike—

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

So that's how it works, that's what people do, because the orthopedic surgeon can't see people twice. So they get the x-ray, then they see the orthopedic surgeon, and maybe they countersign it at the end of the day or something, but it's not at the point of the decision making, that's not how it really works.

Neil Calman – Institute for Family Health – President & Cofounder

Do you really want them to be doing that at the point of decision making?

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

I don't think it's meaningful uses job to fix that.

Neil Calman – Institute for Family Health – President & Cofounder

I think it is meaningful uses job not to put new obstacles in the place of efficient practice.

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

Well, I don't think we should be engineering the solution for that.

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

Yes, I agree with George, I actually do think it's reasonably important to get people to the point of care. There's good evidence that if you don't do that, it doesn't affect utilization. That's at the end of the day what we're trying to do.

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

Wait, George, I think was arguing for a nurse to be able to order, no wait, actually a nurse is a licensed professional and probably able to act on protocol in most states.

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

Right.

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

So to turn that into the secretary, I think that would not give us the benefit of the decision support, let's say for high proximity tests.

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

Correct. I think George was arguing for not over engineering things, that's what I'm—

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

Yes.

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

—arguing for too. Charlene, you have a lot of experience in this, what do you think?

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

Okay, I was on mute, I agree. Again, I think we've seen all those cases in the hospital setting, but I think I was comfortable with what Paul said, the nurses act on protocol, if it's been prescribed by the physician. Typically what happens is there is a signoff process, the problem is the timing of that. I don't think we can state that.

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

So in this case, the key here was the licensed professional to take professional responsibility. Do I have people in agreement with that? That's different from having a secretary

Neil Calman – Institute for Family Health – President & Cofounder

Yes.

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

Paul, unless there's a standing order. I mean, if you have a standing order, then anybody on the team could potentially enter that into the system.

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

Well, you can't have a standing order for a secretary.

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

Correct.

Neil Calman – Institute for Family Health – President & Cofounder

You cannot do that. It's not legal.

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

So that's the change that we're making. So in other words, in the scenario that David Bates has talked about, the secretary ordering imaging tests without provider involvement would not fulfill this requirement.

Neil Calman – Institute for Family Health – President & Cofounder

Correct.

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

And yet the nurse ordering that same imaging test would, because there's a different level of accountability.

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

Okay, Paul, but if the secretary enters it based upon a script, but then it goes to the physician to actually execute, because I know we don't want to over engineer it, but ultimately it's the physician's decision to hit the button, but they're pre-populating stuff, that should be okay?

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

Correct. If that's what happens in that EHR, that would still be consistent, because the radiology procedure would not be executed until the physician hit that and signed it.

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

Okay.

Marty Fattig – Nemaha County Hospital – CEO

Can I make a couple of things here? First of all, what was your intent with stage one? What happens there? Because I think it should be the same, I think it should be consistent.

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

I think what we've just described is consistent with stage one.

Marty Fattig – Nemaha County Hospital – CEO

The other thing is that within at least the system we use, an order entered by anyone other than the licensed practitioner would be considered a vocal order of which would have to be signed off then by the licensed professional, and everything's cool.

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

Yes. In general though, in the hospital setting in which I think is what you're referring to, sometimes these things don't get countersigned until after the fact. What we're saying is, the main goal here is to get feedback from the system as your shaping your order, and that wouldn't happen unless it's prospective. No matter who actually does the entries, some licensed professional who's authorized in that state to order this test, procedure, or drug should have to sign before it gets executed.

Marty Fattig – Nemaha County Hospital – CEO

The practice of medicine whether you can perform those functions without the authorized signature I think is the function of the state requirements and that's pretty tough to regulate at the federal levels.

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

I think we're saying we'll be consistent with what happens at the state level, I think that's how the final rule is written.

Marty Fattig – Nemaha County Hospital – CEO

I understand.

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

Okay, so I think we have agreement then. We're staying with the same language as stage one, meaning it's a licensed professional authorized in that state should be entering CPOE that's entering orders, and

that the threshold would be 80%. Let me get agreement on that first, then we'll move to the transmission piece.

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

Paul, just under all, I'm just sitting here thinking about what else would fall into that category, because you're jumping from prescriptions, labs, and radiology orders, to all other orders; referrals, consultations, transportation support, that could all be considered "orders," is that what we all mean?

Marty Fattig – Nemaha County Hospital – CEO

Also DME.

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

Correct, DME, purchase of a glucometer.

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

That's a very good point. So should we go back to enumerating the important, the key ones, the meds, the labs, the radiology?

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

It's where you want the decision support. I think we'd be more comfortable specific.

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

Yes.

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

I think if you lower the bar a little to accommodate the ones you're not going to capture or be specific.

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

Correct, I think we—

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

There's more likely to be some clinical decision support that would make a difference.

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

So our criteria here should be where clinical decisions of what would make a difference. First of all, if we don't enumerate, then we have the counting paper problem. So it seems like we should enumerate what are the key orders where clinical decision support has been shown to make a difference.

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

That goes back to Neil's point earlier, that this is all supposed to support as we said, all the decision making here. So for things where we don't have that support, to say 80% of those things have to be entered when there's really no other reason other than documentation I think would be superfluous. I think focusing on the things that will make a clinical difference is what we should be doing.

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

Good point.

Marty Fattig – Nemaha County Hospital – CEO

I personally hate laundry lists, because I always miss something that should be included. The second thing is that if I were writing software, trying to capture everything on the laundry list is a lot more difficult than catching all orders.

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

But in this case, we're really just talking about three categories of orders, prescriptions, labs, and imaging studies.

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

The only other one that you mentioned, which could be helpful is referrals. It turns out that's a benefit to the practice anyway and helps with care coordination and so on and so forth.

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

I could support referrals as being one of those as some sort of tracking mechanism within

Neil Calman – Institute for Family Health – President & Cofounder

Yes, referrals are very important.

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

So have we missed anything, we have meds, labs, radiology, and referrals? I think that was in our original list actually for stage one.

Marty Fattig – Nemaha County Hospital – CEO

Well, discharge might be pretty important.

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

I think the hospital has motivation to do that already. And then if we add discharge, then it's sort isn't uniformed between hospitals and EPs.

Marty Fattig – Nemaha County Hospital – CEO

Good point.

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

Okay, so how do people like the current list, so 80% of meds, labs, radiology, and referrals are entered by a licensed professional authorized by the state?

Marty Fattig – Nemaha County Hospital – CEO

What about respiratory, PT?

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

I think we're avoiding a long laundry list, we're trying to keep the key ones. There's plenty of motivation in that case for a hospital to go ahead and automate those. Remember this is the floor.

Marty Fattig – Nemaha County Hospital – CEO

Yes, sounds good.

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

I think all that falls under our future vision.

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

Yes, that's correct, too.

Neil Calman – Institute for Family Health – President & Cofounder

I think referrals is going to be very vague.

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

Right.

Neil Calman – Institute for Family Health – President & Cofounder

I think we could either leave it vague intentionally, which I'm fine with, or all of those kinds of things could be considered referrals.

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

That's a good point. Would being

Neil Calman – Institute for Family Health – President & Cofounder

A respiratory therapist is a referral.

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

Yes. Would people object to calling it, well, I don't have a better term right now.

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

I think leaving it vague intentionally is probably the best way to go.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I agree.

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

It's going to invite lots of questions, but okay.

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

We'll get public comment. We still have more opportunities to tighten this up. Now turn to the second component, which was the electronic transmission. So right now we have the ability to get feedback on all of these orders. Is it important to have electronic transmission, important, feasible, etc., to have electronic transmission by stage three for everyone?

Neil Calman – Institute for Family Health – President & Cofounder

Let me throw something out that might be heretical, but once you put the orders in the system there's going to be a natural evolution to electronic transmission. We almost don't even have to call this out. Once people do this, it becomes in everybody's best interest to be able to figure out, whereas I can just tell you in our own situation, people are constantly pushing to say, "Well, why can't we interface with that person? Why can't we do that? We send all our cardiology there, how come we can't transmit those orders?" I think it just becomes part of the natural drive to make processes more efficient. So I'm less concerned about calling out specific things here, because I think we're just going to evolve in that direction, once you've required people to enter the orders.

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

Earlier, Jim Figge made reference to the absence of the public health infrastructure maybe even to meet meaningful use stage one. There are a lot of activities that would require ordering to a state facility like newborn screening. I don't know that those facilities are ready to receive. So there might need to be something here about where feasible.

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

Well, if you take Neil's suggestion, which I think follows are principle of floor, then one, you'll have the natural market forces of wanting it to become electronic, but two, you would avoid the problem that you just mentioned, Art. So where it's not feasible, people are, even though they want to, they won't get to, but they'll keep driving towards. But by avoiding this as part of the certification process and regulatory process to get your money and avoid penalties, we avoid that kind of an unintended consequence.

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

So if the state does not create that infrastructure as Jim was describing earlier, what happens here when we start figuring out the percent? Are those not counted?

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

They would still be able, an individual provider or a hospital for that matter would be able to meet the 80% rule, because they would be entering 80% of their orders and getting feedback, but the transmission is left up to the availability of the market forces.

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

Right.

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

So if you print it on paper and sign it and fax it or whatever you're able to do.

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

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I think this is also especially important, because the issue of ability to receive on the other end is so vague and it's so unverifiable. It's like, who's to say whether a lab can or can't receive it. Also how much effort there is and whether or not the labs using standard kind of formats to do it or whether or not people have to go through huge hoops to be able to get there. I just think it's hard to verify what we're asking. If we basically say based on somebody else's ability to accept this stuff. We also don't have certification criteria that we're calling out for those recipients.

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

Right. We have no incentive money for those recipients. So many of those entities have no incentive to do this under this program.

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

Good point.

Neil Calman – Institute for Family Health – President & Cofounder

I'm feeling comfortable by where we are here.

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

Okay, do you want to move over to stage two then? So we've already enumerated, do we want to keep the same set that's listed or do we want to add this referral to this one and then we'll work on percent?

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

I'm not sure we want to add, I don't know, referrals a little vague, I'm not sure we want to add it to stage two or not. I'd have to think about that.

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

That's fair. Other people agree with that?

Marty Fattig – Nemaha County Hospital – CEO

Yes, this is Marty, I agree, leave it off.

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

Okay. Now what about 60%?

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

Well that's what was foreshadowed by CMS, right?

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

I'm trying to remember, I think they were referring still to net orders.

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

Right, right, who is 60%. I mean, in my opinion if you look at the way order entry gets deployed, if you're at 60% for meds, and you also have radiology and lab running, you don't really need to go to 30% to get to 60%. If you're at 60% on orders and the other two are running, you generally can get to 60% on those other two relatively quickly.

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

Yes, you're right, it's really a 0% to—

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

I don't think we need to go to 30% on those.

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

Correct. So 0% to sort of 80% kind of a proposition, you're either going to have less turned on or not, and same with radiology.

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

The only issue I have and I'm hearing where you're going, I'm trying to keep remembering what Neil said earlier about the internal use. But thinking about the work, I think it's pretty safe to say that ePrescribing 60% is fine, but if there is no external exchange of information through labs or radiology, then what we're really doing is creating dual workflows for the practices. So it could be entered in their system, but they're also going to have to do something else.

Therein lies my concerns about establishing a 60% threshold for those two things without requiring the exchange, and we know the exchange of that information is something we're pushing off. So that's my only hesitancy, because I agree with the idea that if you're using ePrescribing, then you're probably doing labs and radiology. But we can say that ePrescribing is okay, because you're going to be able to exchange it, you're going to be able to send that electronically. Not so necessarily for labs and radiology in which case you're going to be doing two things if you're in the practice, entering it there and then pulling out a form to fill out.

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

Now why would you pull out the form, Michael, wouldn't it print out and potentially even

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

It depends, so for example, you might enter in your EHR, but the national lab might have a separate form you need to complete. It may not be something you can print out, I don't know, I'd be interested to hear what others have to say about that. But for example in my practice here at the UC, I manually enter what I'm going to do in text, I just told you what the system is, but I still have to fill out a lab form.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, and that's kind of— I have a question about this, are there systems where labs can be brought back into the EHR electronically if the order does not go out electronically? Because our system matches the lab order with the result return.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

I think it's important that results come back electronically and digitally into the patient record.

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

Yes, but that's the system—

Neil Calman – Institute for Family Health – President & Cofounder

Is it possible to do that without putting orders in electronically?

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

That's exactly what happens in the current system I work in where you get the report electronically, but your sending paper out.

Neil Calman – Institute for Family Health – President & Cofounder

But you get it electronically into your EHR as digital data?

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

Yes.

Marty Fattig – Nemaha County Hospital – CEO

Being the new guy on the block, this is Marty, I don't know what's been done in the past, but is this a place where different requirements for physicians offices versus hospitals is in order?

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

That's a good question. We actually did split it in our recommendations and then it got converged to 30% proposed. You make a good point, this should be easier to do in the hospital than in at least smaller practices.

Jim Figge – NY State DoH – Medical Director

I mean, and worst case scenario in a smaller practice, you're going to end up printing these out, signing the script, and probably faxing them or handing them to the patient.

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

I think this will work.

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

Unless there's a prescribed form by the receiving entity that's not reproduced through your systems.

Jim Figge – NY State DoH – Medical Director

That's something you can work out with those entities though, you can

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

I'm just saying with the workflow

Jim Figge – NY State DoH – Medical Director

Yes, but you can go to the entity and say, "If you want my business, I'm going to give it to you on note."

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

I don't know that a solo doctor can go to LabCorp or Quest

Neil Calman – Institute for Family Health – President & Cofounder

Absolutely not, even our group of hundred

Jim Figge – NY State DoH – Medical Director

The LabCorp and Quest takes scripts.

Neil Calman – Institute for Family Health – President & Cofounder

You couldn't do that.

Jim Figge – NY State DoH – Medical Director

I mean every LabCorp and Quest will take a script, so I don't think that's an issue.

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

Not very nicely though, I can tell you, if you get phone calls on them.

Jim Figge – NY State DoH – Medical Director

Especially if they're a printed script that they can read, they'll take it.

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

Okay, so let me try to bring the discussion back to this core issue, so 60% CPOE, let's start with the hospital and we'll see if it's kind of like that way. So is this a reasonable requirement 60% of these three order types to be entered by a licensed professional, not necessarily electronically transmitted? Is it fair for hospitals?

Marty Fattig – Nemaha County Hospital – CEO

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

I think so.

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

Yes, okay. Now let's look at the provider side and hear the question with the workflow. I'm not sure the workflow is better or not with the structure ... it's sort of just on or off. You either have to excuse everyone from doing let's say labs, in the necessary example you mentioned for or not, would you agree with that?

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

Paul, I'm very supportive of the entering of the orders, I'm just trying to think about the appropriate threshold, given that in some cases it'll require dual workflows or dual pathways with paper. So that's the only reason I'm hesitating.

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

But I don't know that there's a magic threshold that doesn't cause—so a threshold of any kind—

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

I agree.

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

—other than 0% is going to cause the effect that you've mentioned, but is this along the way to improving practices and the care?

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

I agree. I'm supportive of this, I don't know if 60% is the right number. Because I agree with you, 50% is going to be almost as bad. So perhaps in the interest of consistency, it's better to leave it and hopefully this will drive changes in the marketplace. I really don't know, I'm thinking out loud in front of the group.

Neil Calman – Institute for Family Health – President & Cofounder

I think this is okay for public comment.

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

That's a good point, too.

Neil Calman – Institute for Family Health – President & Cofounder

I think this is, I mean, 60% is what CMS says they were going to do on medications, and we want to stick to whatever was signaled that concretely. The question is do we add labs and radiology or not, and that is the only move forward from that, so I think we can put this forward for public comment.

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

I'm okay with that.

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

Okay, so do we have agreement on 60%?

Marty Fattig – Nemaha County Hospital – CEO

I'm okay with it.

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

Okay.

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

Yes, that's fine.

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

Yes.

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

Okay. I think we made some major decisions in terms of both as future states, the annotated future, and the floor concept in this very important criteria of CPOE. I think worked our ways in the three different stages quite nicely. So are people happy with this process?

Marty Fattig – Nemaha County Hospital – CEO

Yes.

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

Okay. The other agenda item we had and just to remind ourselves in time, I think we wanted 15 minutes for the CDS group to talk to us about what's going on at the RAND Group, and that we're leaving towards the end of this agenda before public comment. So we'll get through as many of these criteria's as we can in this category and then break for that discussion before our next call.

Okay, so the next one in this metrics is the drug/drug, drug allergy interactions. In our stage three, we had, if you could move it over to the right a little bit—

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

....

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

I'm sure you are.

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

There we are, can you see it? I'm not sure what's going on right there.

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

Okay, so I'll try to read off of our formal one. In stage three, we had employed drug interaction checking on appropriate important interactions without creating noise. So this was the concept of right now. The drug databases have such a low threshold that most of the alerts, the drug interaction alerts, are ignored. This is work that David Bates' group has approved, that one, most of the drug alerts, when you use these commercial databases are ignored because the threshold is too low. Yet, when they worked on some

key drug interactions, they were able to reverse that and have most drug interaction alerts accepted in that

So that's where we had, and I'm repeating this for David's benefit, I don't think he was on the last call, is that we came up with, can we agree on certain important interactions and have that be implemented by stage three? Let me give you an opportunity, David Bates, to comment on that whether you think that's an appropriate goal for stage three or a future? David Bates, are you still on?

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

I guess not.

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

Okay. That's where we were with the last discussion is to narrow it down to "important interactions" for stage three.

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

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

So that little pattern, that statement that says who defines I think is a critical issue here.

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

Right.

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

Our idea was that we would be inviting, so one example is ONC could, well actually, I think there was work going on at RAND.

Marty Fattig – Nemaha County Hospital – CEO

Yes.

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

Are the RAND folks on and are they involved in that project?

Cheryl Damberg – RAND – Senior Policy Researcher

I'm on. Can you repeat the question? I wasn't actually listening to you at the moment you asked that question.

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

Right. I think during our last discussion, someone made us aware that ONC has a contract with RAND dealing with drug interactions, is that true, am I remembering that correctly?

Cheryl Damberg – RAND – Senior Policy Researcher

Yes, as part of the larger CDS project, there's a component that deals with that. I'm not leading that, but the folks at Parkers are, yes.

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

Okay. That would be appropriate. Let's put aside for the moment, unless we want to come back to this category in a future discussion. We're shooting for a set up drug interactions that are, one, important in clinical practice, and two, which there's an evidence-based, and three, to then employee that in the drug interaction checking to avoid this problem of way too high false/positive rates. And really trying to make drug interactions meaningful. The only way we saw in that last conversation was to create another list. So we didn't know who was going to create it and that's why we were thinking ONC could create this body of work.

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

Can we add the term evidence-based to stage two and three, I think that would be important?

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

Sure.

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

Okay.

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

So we can leave this as a placeholder and then invite ONC or RAND to comment further on it in our next call.

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

Wait, what's there now?

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

Right now you just enable drug interaction checking. The thought is right now almost no one is happy with the current state.

Jim Figge – NY State DoH – Medical Director

Paul, in the future state could we also envision some other types of interactions, such as drug/lab or drug/disease state? I know that may not be practical in stage three, but down the road you might want that as well.

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

Let's put that in our parking lot, so I think that would create a new criteria—

Jim Figge – NY State DoH – Medical Director

Okay.

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

—that's very appropriate. So let's put that on the parking lot for discussion when we get to the end of this. That's seems like an eligible new criteria objective.

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

Okay.

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

Okay, so currently our future state is that we would employ drug interaction, checking on appropriate evidence-based interactions without creating noise, that's the false/positive problems. What do we think we can accomplish by stage three if we had such a list? It seems like we could accomplish this for stage three do you think?

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

Yes.

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

I think by 2015, we should be able to create something, create a more useful drug interaction checking.

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

Yes, I mean, we're talking about ratcheting down from stage one in effect as far as the doctors are concerned. We want to do what we did in stage one, but send fewer alerts. So in effect, we're not asking

doctors to do more, we're asking the producers of the systems, not exactly vendors, but in concert with the government to produce fewer interactions so they're more important.

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

Well, in a sense, we're trying to drive the industry to creating the ability to produce more meaningful drug interactions.

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

Paul, Jim brings up a good point. I know you said maybe we should make that another criteria, but maybe stage three could be moving to a small number of disease state or laboratory drug interaction checks rather than trying to make— We run the risk of having too much noise. Maybe there's a small number that would not incur that much noise in those other areas.

Jim Figge – NY State DoH – Medical Director

Yes, let me give you an example, diabetes is a major epidemic in the country, and type II diabetes, Metformin is usually the drug of choice. But if somebody's creatinine is too high, Metformin can actually be lethal. So that's a very important clinical check. If you prescribe Metformin, do you check the creatinine level? If you miss that check, you can kill somebody. So that's something that most clinicians would value having there.

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

Right.

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

That's a different category of drug related alerts.

Jim Figge – NY State DoH – Medical Director

Right.

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

This is the category, drug/drug.

Jim Figge – NY State DoH – Medical Director

Right.

Neil Calman – Institute for Family Health – President & Cofounder

So are we going to make a suggestion that, is it germane to make a suggestion that we expand beyond drug/drug interactions? Because as someone who did the tiger team for patient safety, there were five or six different categories, I think maybe even seven of drug something interactions, drug/lab, drug/disease, drug/medications in the elderly, drugs and lactation, drugs and pregnancy, all of these things. The reason I think it's important to maybe call out examples of all of those is because what we discovered in talking about them is that if you don't capture information on pregnancy and contraception's, you don't know who's at risk of taking drugs that are potentially dangerous in the first trimester.

Do the EHRs capture information on women who are breastfeeding? No. So you can't even look at drugs that are dangerous to women who are lactating. So there's a whole series of things to call out here that would be more important in my mind in terms of helping to signal functionalities that have to be developed in EHRs and things that are going to be important in terms of patient safety, then just drug/drug interactions. I don't know how to put that on the table, but I would like to put it on the table.

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

In acknowledging that and Jim's suggestion, could we create a new row 11 that talked about medication alerts. Because I think we don't want to miss an important category of drug/drug, because it depends so

much on these medication databases, and we really need to address that problem. Do you see what I am saying?

Neil Calman – Institute for Family Health – President & Cofounder

Yes, I'm fine with that.

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

Yes, I think everything and the intention is all up to define, and important, and drug errors, errors related to medications is clearly one of the top, top classes of errors made. So we want to start capturing that, but there is also this special drug/drug, which is really mostly independent of the context of the disease in terms of whether it does or doesn't interact with each other. We have a special problem to solve, because we don't have good solutions right now.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

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

So we're trying to stimulate the market and the regulatory process to make better solutions available.

Jim Figge – NY State DoH – Medical Director

Right, I think what Neil and I are saying is you want to capture other patient specific information from the record and apply that to the decision support.

Neil Calman – Institute for Family Health – President & Cofounder

Yes, so another category called medication alerts where we could call some of these things out specifically would be helpful.

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

Yes. So the title, I think all the way to the left maybe, is there, no, the

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

....

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

So maybe over in the comments or something, call it medication alerts, then we can flush that out.

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

Alright. Okay, so this is getting into now decision supports, so why is it drug x and not disease/disease or lab/disease or something, and then we're suddenly solving decision support. So that's what, I'm not sure that a new row versus incorporating what we're talking about into whatever we do for decision support makes more sense?

Marty Fattig – Nemaha County Hospital – CEO

I would agree, this sounds like decision support systems to me, things that could be included there.

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

Okay. So right now, this is serving as a parking lot for us.

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

Okay, I'll just put a question mark after medication alerts.

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

Yes.

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

So does that mean we want to— If you look at future, should this be specific to drug/drug and drug/allergies?

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

I think for this row, yes.

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

Okay, I'll fix that.

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

Then the latest question on the table is, what's about to be written in the stage, in the future, which I think is the same as stage three, is employing meaningful drug interactions using evidence-based interactions, a good goal for stage three? It seems like that's possible within five years and really urgently needed. That would be my argument as far as bringing it in from the future, bring it to a date of certain.

Jim Figge – NY State DoH – Medical Director

Do we need to keep the phrase without creating noise, because in theory if they're appropriate and important and evidence-based, you don't really need to say without creating noise?

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

Right.

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

On appropriate and important evidence-based, it doesn't actually capture the other side of the utility analysis. It may be appropriate just because they're may be a lot of important evidence-based interactions, but if you actually gave them all, you'd be overwhelmed. So you'd have to look at the—

Jim Figge – NY State DoH – Medical Director

Well, we have the word appropriate in there.

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

Yes, appropriate maybe covers it.

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

So what's shown in this box be moved to stage three?

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

It may be too vague, like what is stage one doing that's not in stage—what's in stage three, the future stage, let me move it, okay, that's that. Now what's in stage one and stage three, how are they differ?

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

Stage one just turns on decision support as it's currently implemented in systems in use.

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

But how?

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

I think the evidence has shown that the false/positive rate is unacceptably high. We want to by stage three—

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

I agree with the sense in it, how do we judge if a doctor is doing the important evidence-based ones as opposed to some other ones? In other words, it just too vague right now.

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

So we're setting that as the criteria, so between now and 2015 evidence should be generated, and already there is some evidence about what lists would be an appropriate list. In our conversation, we talked about creating a new sort of community standard list, that gives people the protection of the standard practice. That was our thinking back then.

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

Okay.

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

Other comments about that line of thought?

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

Is that feasible for all the specialties? So is that a parsimonious list?

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

To?

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

For drugs, the alerts you would want to have seen?

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

I think there are some important common drugs that cause the ... of the medication errors.

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

Okay. I like the idea, I mean that's what we hear most often in terms of concerns about the drug/drug and drug allergy interactions.

Jim Figge – NY State DoH – Medical Director

I think one important comment is that this evidence-based list needs to be kept up to date. So I don't know—

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

Right.

Jim Figge – NY State DoH – Medical Director

—do you want to put that in the comments, there has to be a mechanism to keep it up to date?

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

Good point.

Doug Bell – RAND – Research Scientist

Paul, I'm sorry, I'm in a cab on the way to a meeting, but I thought I would jump on and listen to your show. But I'll just mention that the RAND project we're doing, it has this, developing this list as one of our tasks that we are contracted to do what you're talking about. Although, the maintenance, we're not contracted for, so we'll have some recommendations on that, but we're very interested in that. Now I'm going to go back on mute.

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

So Doug, you'll be recommending that RAND be contracted to do the maintenance, right?

Doug Bell – RAND – Research Scientist

Yes, maybe, but no, no, we like to develop things and sometimes turn them over to bodies like NQS or similar bodies that might have maintenance more of a charge.

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

That's so good.

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

So let me try to get a consensus around what's listed for stage three. So what we're saying is, it doesn't currently exist, but we're proposing that between now and five years from now, there is some mechanism to produce such a list for use in systems by 2015? We heard that—

Doug Bell – RAND – Research Scientist

We will produce such a list. It is a deliverable, so there is no question that we will produce it. You probably may not want to

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

Will RAND have it by 2015?

Doug Bell – RAND – Research Scientist

Oh, yes, we'll have it in six months.

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

So could we move it to stage two?

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

There's a difference between getting a contract to produce a list and having it adopted.

Doug Bell – RAND – Research Scientist

Well, right.

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

So I think we're going to need a little time.

Doug Bell – RAND – Research Scientist

You'll want to look at it.

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

So given that additional information, are people comfortable with what's listed under stage three?

Jim Figge – NY State DoH – Medical Director

Yes.

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

What I've done though, I'm comfortable with what we have so far, but we haven't answered the hard questions. Because look at the comment field, number of meds check, number not overwritten, how do we do this reporting? What are we actually measuring? Is this a quality measure or is this a functional measure? Are you just saying just turn the thing on?

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

Who was on, I think when Neil was the on the patient safety, I think we were relying on the quality measures group to come up with the measure, but this would be the concept, the objective.

Jim Figge – NY State DoH – Medical Director

As long as you have this functionality in place, you can develop various metrics around it.

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

Well for CPOE we picked 60% and 80%, so here we're not going to pick a threshold at this point, we're just saying the concept is that we want to do drug interaction checking.

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

On appropriate evidence-based interactions, that was our contribution here.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

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

Okay.

Neil Calman – Institute for Family Health – President & Cofounder

I think in previous conversations, we had moved away from sort of calling out some level at which people have to pay attention through it or show evidence that they've heeded the warnings or whatever. Because I think there was feedback that people didn't want to get into that discussion, basically, to be—

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

So I think one of our approaches is if we state something like we have here, that moves into the standards committee and moves into certification. So what we wanted to do was make this functionality available to providers. Then as a measure for validate purchasing as an example or quality reporting, there are quality measures associated with this, but that's for other people decide, one, that the quality measure group to recommend a measure, and for CMS and ONC and HHS to decide what the threshold should be. But our goal is to have this functionality be available to the providers.

Neil Calman – Institute for Family Health – President & Cofounder

Right.

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

Okay.

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

Our contribution is the appropriate evidence-based interactions. Fortunately, there is a clinical path to getting there. So for stage two, what's the interim?

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

Well, previously we had said a small number ... but that's what we had said.

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

Okay. So that's interesting, because there are some drugs Warfarin being one of them ... being another. There are some small number of drugs that create a lot of important interactions, and that was part of our thought of saying, well, there is something in between stage one and stage three.

Jim Figge – NY State DoH – Medical Director

If the RAND report is out, there can be some interim application to get some of that going.

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

Yes. What do people think about that strategy?

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

So CMS would name the drugs or you just have to do five, whatever five you pick?

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

Well, that's an idea. Yes, that probably be a—

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

Let me think about it, too.

Neil Calman – Institute for Family Health – President & Cofounder

Well, the systems don't really let you do that I don't think.

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

It's too bad you couldn't write your own alerts.

Jim Figge – NY State DoH – Medical Director

Yes.

Neil Calman – Institute for Family Health – President & Cofounder

I don't think we're interested in having people start writing single decision supports for the five drugs or drug interactions or whatever. We really want people to use the functionality of these databases or a new database to be developed.

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

So I don't know, it's looking like we just have to do this. In other words, make it stage two like stage, I don't know what else we could say in stage two. Either stage two, there's no halfway point, either stage two looks like stage one or it looks like stage three.

Jim Figge – NY State DoH – Medical Director

Yes, I agree. It's going to be one or the other, it depends on how fast the industry can gear up and implement the RAND report.

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

But George, what you had before with the small number, I think you can create that. It clearly is a bit of work around, but it is something both concrete and achievable. So I have no idea what will come out of the RAND report, but there's a couple to change there, and there's some industry reaction that has to happen. So something concrete along the way might be useful. I mean, at least for a placeholder, and again, we have the opportunity for putting this out for public comment.

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

That's true. Because what's a single doc in the fields going to do, you don't want single docs to go out and start writing five alerts in there system.

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

Correct.

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

This would mean the vendors would have to, so then CMS would have to specify which drugs or which states has them, so I guess we can't really tell yet.

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

This is sort of a placeholder for ourselves that we have to deal with, with stage two, and we can get some ideas from the public.

Jim Figge – NY State DoH – Medical Director

Wouldn't it be better than to leave it phrased as we have for stage one?

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

I'm not sure a lot of people are happy with just enabled drug interaction checking.

Jim Figge – NY State DoH – Medical Director

Okay.

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

This is at least a hint that we're after something better. I mean, that's just one way to look at it.

Jim Figge – NY State DoH – Medical Director

I just don't know how to interpret a small number.

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

Yes.

Jim Figge – NY State DoH – Medical Director

It just seems like that would create a lot of confusion. I agree with whoever commented and has to look either like stage one or stage three.

Doug Bell – RAND – Research Scientist

I agree, it's hard to see in interim, but I'll bring this up with David Bates and show who are leading this task and see if they can think of an intermediate ...

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

Okay. So of the two, I would favor in looking more like stage three. What do other people think?

Jim Figge – NY State DoH – Medical Director

That's fine. Why don't we put the same verbiage for stage three.

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

Right.

Jim Figge – NY State DoH – Medical Director

And we can see what other comments come up.

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

Okay. Then feedback from David Bates would be very useful here. Alright, this is good work. I certainly am comfortable with the direction we're going here, other people?

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

Good.

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

In terms of how we're approaching stage three and future. Alright, so this might be a good break point for us to hear the presentation from the RAND folks and then we'll conclude with public comments. So this is a presentation about the contract RAND has with ONC related to clinical decision support. The way we would apply it is to take this as input and when we get to the clinical decision support, objective, and criteria.

Judy Sparrow – Office of the National Coordinator – Executive Director

Cheryl, I think you're on the line.

Cheryl Damberg – RAND – Senior Policy Researcher

Yes I am, can you hear me?

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes. We've got your front slide up there.

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

Cheryl, we have until 11:55, and then we'll break for public comment.

Cheryl Damberg – RAND – Senior Policy Researcher

Okay, well I'll try to make this very quick. First, thank you so much for the opportunity for us to share this work. It is work in progress and it would be very helpful at the end of the presentation if you had any thoughts to guide our work we'd be most interested in hearing those.

If you go to the next slide, as you folks have been grappling with at least from the small portion of the conversation that I listened in on this morning, it's really how to populate the stage two and stage three meaningful use measures. Some of these measures are still in a state of development. The focus is clearly going to move more in the direction of CDS rules that are specialty specific; and that these CDS rules will likely be tied to reportable quality measure sets to be able to assess the performance on this.

If you go to the next slide, this is where the RAND partners teamwork fits in related to this particular project. There were four core tasks in the overall contract and I'm just going to speak about the one that relates to setting CDS priorities. You did hear from Doug that we are working on other tasks, particularly the drug/drug interaction one, and we'd be happy to give you an update on that at a future meeting. In the context of this particular task of the project, the goals are to develop a more generalized process for engaging specialists in the development of these CDS meaningful use objectives and measures. We're really looking at this more generalized process as a method that could be replicated moving forward across a much broader array of specialists. The other goal of this work is to inform the development of future meaningful use objectives and measures for 2013, 2015, and beyond.

The focus on specialists is really important because of their low EHR adoption historically. The fact that they have few CDS tools that are appropriate for the type of care that they deliver. The fact as was mentioned earlier in the call, that they have these unique workflows. So how do we fit in clinical decision support in a way that is meaningful and will be used by them? The work being done in this task is a collaboration between the RAND team and some folks at the American Medical Association, a PCPI.

If we go to the next slide, I'm going to take you in a very high level way through how we're approaching this work. We're building on the existing AMA/PCPI panels where they exist. We are supplementing with additional specialists based on the areas of focus. We have added a CDS expert in that particular specialty area, who is co-chairing the panel and is bringing a lot of CDS expertise to the discussions. Our approach is to use a modified Delphi panel process, which we will be doing via phone with these clinical specialists.

We're asking them to consider two key questions, one is, what are the most important clinical performance gaps within their specialty? Then secondly, where are there feasible CDS opportunities that could address these gaps? To develop this more generalized panel process, we have identified four specialty areas to give us some sense for how this would play out. So the first is percutaneous intervention, which is a procedure-based focus. The second is oncology, and because of scope issues, we're limiting our focus to breast and colon cancers. Then pediatrics will give us a sense of how if we look across many conditions, this will play out. Then lastly, orthopedics, and our focus there is on joint replacement.

I'm moving to the next slide, So again, a very high level how this process will work. If you look to the left part of the slide, we at RAND and with our AMA partners, have been in the process of developing gap statements and a list of CDS opportunities based on a scan of existing tools, as well as in discussions with our CDS expert in that specialty area. We have formed a set of matrices for each specialty, and I'll

show you examples in the next slide. We will be taking this information to the panel, so now I'm in the middle part of the slide, and engaging in a structured rating process and discussing both the gap statements, as well as the CDS opportunities to establish priorities. So coming out of this will be a prioritized list of gap statements, as well as CDS opportunities addressing those gaps. Again, the goal is to feed into the setting of meaningful use measures for stage two and three.

If we go to the next slide, so now I'm going to show you an example of what these parts of the metrics look like. The first step in the Delphi rating process will be to ask the panelists, and we've developed these gap statements, sort of a list of 20/30 gaps within their clinical specialty area. So I pulled out the three different gap statements for a PCI, and the panelists will be asked to rate each gap on a scale of one to nine, based on the importance of that gap. By importance we mean prevalence, the consequences associated with that gap, the adequacy of the evidence, and also its contribution to more patient centered care. The panel will go through the first round of rating outside the meeting, then they will come into the meeting, we will discuss areas of disagreement, and ask them to re-rate these. We will be looking to take those gap statements that are most highly rated to the next level.

If you go to the next slide, the next level is looking at CDS opportunities within each gap statement. Again, we've been developing this metrics and we are looking at what information is needed from the CDS system and what types of CDS opportunities could be used or developed to address those information needs? They fall into sort of these core areas around documentation, relevant data presentation, order set, protocols or pathway support, reference information, and alerts and reminders.

So the panelists will take the shorter list of gaps that they've prioritized, and they will be asked to rate the CDS opportunities that could potentially address that gap. This is really the rating on sort of the feasibility of CDS for addressing that gap. We're asking them to focus on both the compatibility of the CDS opportunity within that particular specialist, clinical practice, so can it be introduced into the workflow and would they be likely to use it? Then the impact of that particular opportunity on helping to close that particular gap.

I'd like to move to the last slide, hopefully I'm still within time. So coming out of this project we will have a prioritized list of these performance gaps that could be addressed by CDS. We will have high priority CDS targets where there are at least some effective and feasible CDS opportunities that could point to closing that gap; as well as emerging CDS targets, where we have a highly important gap that the specialists have identified, but we see only equivocal feasible CDS opportunities to address them.

The second piece is this list of highly rated individual CDS opportunities. This would really be to provide suggestions for targeting the gaps that we expect to be feasible. The list is meant to be non-prescriptive and leave freedom for innovation for other types of CDS targeting the gap. Our work will also be engaging in analysis of specialty workflow insertion points where these CDS opportunities could be inserted. Then lastly, we will be eliciting the panelist satisfaction with this process as a mechanism for providing input into establishing meaningful use measures.

I'm going to stop there, would be happy to entertain questions and would welcome any feedback since we are not yet in the field with these panels we're about to launch the PCI panels, that would welcome any guidance at this stage.

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

Thank you, Cheryl. I think this was a good report on a very meaningful project that addresses, one, specialties, two, the sort of gaps and opportunities, and three, the potential role of CDS in these opportunities. Some of the things on her metrics, the potential CDS opportunities and some assessment on the feasibility, and that would be important input to this group coming up with CDS functionality that we'd like to see certified in the EHRs.

So if you remember our strategy that we agreed upon, instead of prescribing you must use three alerts and two health maintenance reminders and three smart forms. We would describe and enumerate lists of a CDS functionality that we think are very important to have in an EHR and make available as a tool to the providers using those EHRs. So this seems like a good input stream to that to say based on clinical gaps and particularly those ... to CDS functions, that this would be a good input for us to use as far as enumerating a list of important CDS tools and certifications.

How do people feel about that?

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

Paul, I just had a quick question, because I agree, I think this is really important work. I understand the need for some degree of catch up among specialties to identify what those gaps are within their specialty. But I also am wondering if maybe there is part of the plan or if there could be part of this plan to in addition to that address the role each specialty sees for themselves and cross-cutting kinds of measures, such as care coordination, patient engagement, efficiency and those kinds of things?

Because what I worry about and focusing on individual specialties, even though I understand the need to catch up, is that we still are left with a siloed approach. I just don't see how we're going get to the potential that HIT holds for enabling us to do better care coordination and management of multiple chronic illnesses if we don't start looking at some of these cross-cutting issues that we really are struggling with identifying how to measure those and identify the meaningful use pieces of those. Until we start having conversations with people about what their role is, I'm not sure how we get beyond this hurdle. So Cheryl, are there plans to do that?

Cheryl Damberg – RAND – Senior Policy Researcher

So Eva, one of the things that we've been grappling with in some of our panels, and orthopedics comes to mind, is there may be some measures that do cut across related to care coordination. I think the challenge that is going on in this space, not in the context of our project, but is sort of taking the time to step back and be thoughtful about the process and how one goes about defining gaps and sort of getting that broader input. Then again as you say, engaging the specialist in a conversation about what is their role? Because my guess is, is that many of these specialists right now probably don't see that as part of their role. We'll make note of that, because again, we're in the process of testing this more generalized process. I think we could potentially look for ways to think about how we could build that in moving forward.

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

Great, yes, this makes me think of the work already done by NQS, which is different, and I think can be complementary. But the high impact conditions work done by NQS, and they even state in their report that the artificial dissection of interconnected conditions really creates difficulties with weighing the importance of dimensions in criteria. So they even found this and they conducted a very similar process, which seems to have been successful. I just see a role for CDS here. Knowing that this is specifically focused on CDS that that could be a useful tool for helping various disciplines and various specialties see their role in helping to coordinate care across patient level concerns as opposed to disease specific.

Cheryl Damberg – RAND – Senior Policy Researcher

Yes, I mean, we did have one, I'm thinking back to some of the work and I think it was in the PCI area, where some of the work around CDS tool development has been around risk calculators and trying to work with the patient in effecting the risk of undergoing say a procedure. So we have been open in our discussions to considering those kinds of opportunities.

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

Great, thanks.

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

Any other general comments before we go to public comments?

Neil Calman – Institute for Family Health – President & Cofounder

Well, I just find it peculiar the things that were picked as the test cases. I think what's important to the vast majority of physicians in this country in relationship to what orthopedists could contribute is the general management of things like back pain and joint pain and other things like that. I just think to call out these very, very specific procedural specialty things is going to be helpful, but only to a very, very small number of people.

In terms of testing a process, I think it's fine, but I think the harder stuff is all left undiscussed or unexplored in this. The harder things are, the things that have huge numbers of people who are effected with enormous costs to the health care system and relatively poor coordination between community-based providers and specialists in terms of being able to agree on what those important conditions are and using clinical decision support to support both more efficient care and better outcomes. I hope that we'll at least be able to take on some of those in like another round.

Cheryl Damberg – RAND – Senior Policy Researcher

Did you want me to respond, I know you're trying to finish your meeting?

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

I see that you are targeting orthopedics for example and some of the things that Neil mentioned. So I think it's good input to make sure that we do things that are prevalent.

Neil Calman – Institute for Family Health – President & Cofounder

Targeting joint replacement.

Cheryl Damberg – RAND – Senior Policy Researcher

Yes, so I think one of the challenges that we have determined in trying to think about creating this more generalized process is that you likely will need moving forward, panels that kind of breakdown these component parts. I think we recognize the things like low back pain, joint pain, kind of osteoarthritis issues are highly prevalent, and they are another area that is really ripe for development of this type of work. I think the challenge for us was thinking about running a couple panels that were very broad to say, "Can we cover the waterfront," such as we're doing in pediatrics versus sort of a deeper dive and a more narrow focus.

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

I think it's a very relevant comment, and hopefully we'll bring that back to your group and the ONC. When do you think you'll have your report out?

Cheryl Damberg – RAND – Senior Policy Researcher

Well, what we're targeting is that these panels would happen in the December/January/February period, and that we would be summarizing the findings sort of in that March/April period. But we certainly can come back to this group sooner before the final report is done and give you an update on what we're hearing from those panel discussions.

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

I think that would be very useful. As you know that's approximately the time, well, if you meet March/April, then I think that would be useful. We're supposed to come out in the summer with our final recommendations.

Cheryl Damberg – RAND – Senior Policy Researcher

Sure. As I said, coming out of those panel meeting we'll know which performance gaps they rated highly, as well as the individual CDS opportunities addressing those gaps. So that is something that we could share with you sooner.

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

Well, thank you so much, Cheryl, that was a very useful report in a very important project. Thanks for the update. Could we open up for public comments now please, Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director

Operator, could you please open the line for the public, we'd like to invite public comments at this time?

Moderator

You have a comment.

Judy Sparrow – Office of the National Coordinator – Executive Director

Great, thank you, if that person could identify themselves?

Richard Thurman – TrustNetMD

Sure, it's Richard Thurman. Hello, Paul, hello, Judy. The organization is TrustNetMD. The question is, given every nuance of so many of these areas known, whether it's a drug/drug interaction versus drug and other areas, and the RAND process, the Delphi process, it would be interesting to have social media somehow involved. So that you're not just depending on a few discrete inputs from people in time, but rather new issues will arise, you'll get questions, you'll get answers, you'll get comments on the answers. I know this kind of concept has been broached in a couple of the other HIT policy and standards meetings as well. I think for the policy committee to start leveraging, especially as these areas start getting very nuanced and take advantage of this opportunity for continuous input.

Judy Sparrow – Office of the National Coordinator – Executive Director

Any other comments? Okay, Dr. Tang?

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

Okay, thank you very much, and thanks to the workgroup. I think we've come up with a good way, a good process, a good frame for the process of how to march through the different objectives and criteria for stages two, three, and future. I think we can just execute with the rest of the objectives. We'll be meeting again on the 23rd.

Judy Sparrow – Office of the National Coordinator – Executive Director

Yes, and shall I send out the revised spreadsheet then?

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

Yes, please. Then a face-to-face on the 3rd.

Judy Sparrow – Office of the National Coordinator – Executive Director

Right. Thank you.

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

Thank you very much. See you next time.

Judy Sparrow – Office of the National Coordinator – Executive Director

Goodbye.

Public Comment Received During the Meeting

1. Some of the discussion on CPOE raised questions about how the workflow would actually play out. Will there be opportunity to explore how functionality will be used in more detail?
2. Are you including DME in "all" orders?