

Meaningful Use Workgroup
Draft Transcript
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Mary Jo Deering, Ph.D – Senior Policy Advisor – Office of the National Coordinator for Health Information Technology

Good morning everybody and welcome to the second day of the Meaningful Use Workgroup. This is a public hearing and it will take place until early this afternoon. Just a reminder to the workgroup members to please give your name when speaking because we are preparing a transcript. At the end of the meeting there will be an opportunity for public comment. Let's go around the table and introduce members of the workgroup and staff who are here beginning on my left with Josh Seidman.

Josh Seidman – Office of the National Coordinator

Josh Seidman, ONC.

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

Allen Traylor, ONC.

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

Neil Calman, Institute for Family Health.

Eva Powell – National Partnership for Women & Families

Eva Powell, the National Partnership for Women and Families.

Arthur Davidson – Denver Public Health Department

Art Davidson, Denver Public Health Denver Health.

Judy Murphy – Aurora Health Care – Vice President Applications

Judy Murphy, Aurora Health Care.

Paul Tang – Palo Alto Medical Foundation

Paul Tang, Palo Alto Medical Foundation.

George Hripcsak – Columbia University NYC

George Hripcsak, Columbia University at NYC.

Marty Fattig – Nemaha County Hospital Auburn, Nebraska (NCHNET)

Marty Fattig, Nemaha County Hospital, Auburn, Nebraska.

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

David Lansky, Pacific Business Group on Health.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Amy Zimmerman, Rhode Island Office of Health and Human Services.

Michael Barr – American College of Physicians

Michael Barr, American College of Physicians.

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

Okay Paul.

Paul Tang – Palo Alto Medical Foundation

Very good. Thank you and welcome to day number two. Our major agenda item today is to sort of de-brief from yesterday's hearing and then start working on the elements or the framework for strategy for Stage 3. Our agenda has a couple of, it reflects that at 10:00 a.m. there's something called other topics to consider, those are part sort of our parking lot and we sort of want to check our work and make sure we've covered these things as we go through and develop a strategy for Stage 3. One of the things we have at the top of our agenda is a presentation by Seth Foldy from CDC on population health and that was to update us a little bit on the, make sure we include some of these, some of the needs from the population and public health perspective. But I think we're, is he here? Oh he's on the phone, okay, got it. Okay and Seth I think we have you for five minutes to talk and then we have another 10 minutes to discuss.

Seth Foldy – Center for Disease Control & Prevention

Thank you very much. I apologize for my inability to be there in person with you. I thought I would just give you a wrap up report of the first year of the Meaningful Use program as it relates to the public health population objectives. And to the first slide "Why It Matters" I'd like to remind the committee that there were three public health reporting objectives as part of Stage 1 of Meaningful Use. The first, the electronic laboratory reporting of reportable conditions. This is important because it creates faster more complete reporting of communicable and toxic conditions that often require immediate public health response. Electronic laboratory reporting has been shown to increase both the speed and completeness of reporting and the Listeriosis outbreak in melons is just one of literally hundreds of situations which such types of reporting have led to the identification of an outbreak, the identification and shutdown of the source.

Immunization registries are documented to improve vaccination rates at the community level. They are tools that help clinicians, in many cases schools, health departments, and parents, know and understand the completeness of vaccination of their children by collecting information from all of the clinicians that are providing immunizations and thus help lower rates against killer diseases like measles. And again, the importance of this is sometimes underscored by the resurgence of measles due to observed drops in measles vaccination rates that occur in some communities.

The syndromic surveillance objective helps leverage the ability to deliver packages of information to public health in a fairly simple way that allow public health to track the utilization of healthcare and sometimes identify aberrations that might indicate an outbreak or an emergency, or to help track outbreaks and emergency utilization of healthcare during these situations. And of course those are the three that are called population and public health objectives, but the use of electronic health records, their quality reporting capability, their decision support tools, their disease registries are all critical tools to improve the prevention effectiveness of health care, lest we forget that those functions too are important for population health, and in particular, cardiovascular disease which is recognized as the number one contributor to premature death, and the leading cause of health disparities, and disparities in premature death. We know there are several evidence-based medical interventions that can bring those rates down, the so-called Million Hearts Campaign just being one illustration. And so we see the movement towards electronic health records and these other important objectives of Meaningful Use as also being critical public health tools.

Going to the next slide, in July of last year many public health officials addressed the committee and laid out some of the challenges they were going to face in Meaningful Use and the first of course being limited state and local informatics capacity. In fact, since that time budget problems, furloughs, and program defunding has continued to be a major problem in public health, and nevertheless we have a good new story to tell about the capability of agencies to rise to the challenge of the electronic health environment.

As we heard from many of the testimony yesterday there's also a certain aspect of a forced march from old message standards, old transport standards to new standards that public health systems have had to undergo to stay abreast of the Meaningful Use regulations and to be good partners in the electronic exchange of information. Something that we've discovered through the year is that there has been somewhat of a loose match between the certification requirements for electronic health records and the

actual implementation guides and implementation practice in the field sometimes leading to some disappointment where a provider might purchase a certified EHR or EHR module believing it should be able to connect with little bother to public health, but that looseness of fit has sometimes created disappointment and certainly is creating some level of work at both ends of the exchange equation. The uncertainty regarding the transport of electronic messages, the fact that there are many standards out there, the fact that public health had a well-established legacy standard, which is probably ready to be retired, but that makes public health like many other sectors of the Meaningful Use community anxious to know and anxious to adapt to what will be the next means of securing and transporting with a high degree of privacy and security messages between healthcare and public health agencies.

Now, these challenges were met by a response and this included an emergency mobilization both by CDC and by public health professional associations and their members. It included intensive education of the public health community, intensive technical assistance, the creation and marketing of tools that helped validate and translate different messages for these Meaningful Use objectives, the creation of mapping tables, and tools to provision vocabulary such that public health messages could be sent in the appropriate format and constructed appropriately, the active engagement of public health agencies with their HIT coordinators, their RECs (the Regional Extension Centers) and with the vendor community, and the alignment of public health grant language that gave state and local health departments the leeway, and the instructions to begin to adhere to ONC compliant standards. And one thing not on this list, but it is worth mentioning, there was also undertaken this year a redesign of the biosense syndromic surveillance platform such that when it rolls out in the next few months it will easily accept hospital reporting using the ONC endorsed standards and protocols and to the extent to which it's adopted by state and local partners as their syndromic surveillance mechanism. It creates a centralized catcher mitt that will really help adapt to this new environment while still permitting local control to the state and local government about how the information is used at a very high level of security of course.

Going to the next slide, so let's talk about our achievements, the most important thing is to credit these achievements primarily to the ingenuity and the determination of state and local health departments with CDC and other federal agencies trying to provide if you will essential missing ingredients to make sure that we keep moving forward. The good news is, despite our fears, at least 38 states and large cities are now actively testing messages with their eligible provider and hospital partners. So they have come to the table in very high numbers actually compared even to the hospital and the provider community that are receiving financial incentives. Several are now in full scale production with these data providers, although many health departments recognizing there was going to be many providers that needed to test their systems had been focusing on the testing and then put providers and hospitals in a queue for the orderly on-boarding of production data transmission.

The interoperability tools that have been developed at CDC and elsewhere are widely used and their use is rising fast and I provide a website to help find some of those tools. And as we heard yesterday from CMS, actually the number of providers and hospitals that were forced to claim exclusions on the public health objectives is quite modest, less than some of the other objectives, and so we believe that we have overcome this first year of what is somewhat of a crisis for a good reason with a high level of success.

To the next steps and challenges, I would say that we in the public health community are looking to continue this rapid transition of public health information systems to the Meaningful Use standards. We're aware that Stage 2 may bring a monoculture, if you will, of HL7 251 messaging for immunizations and syndromic surveillance. This will require further development in the public health technical community. We see the need and we are happy to participate in any way we can in bringing the EHR certification process closer to what actually happens in public health practice. We are gearing up to prepare for what the new secure transport protocols will be for the Nationwide Health Information Network. I'd like to point out to the committee that often when we ask about transport the answer we often receive from our public health partners is that they are looking to rely in very substantial ways on either state based or

regional health information exchange notes and so the health and the role that those notes may play may be very important for public health information exchange with providers.

We want to improve the communication and the predictability of the population of public health exchange elements of Meaningful Use to increasingly create one source of truth where one can find out for example “is the EHR module or system I’m going to buy actually able to connect to the public health system or agency that is serving my jurisdiction?” and perhaps linking to the registration and attestation processes a very clear statement by public health agencies about exactly whether they are engaging in a public health objective exchange, how and other information that will greatly reduce the anxiety and confusion that sometimes providers face as they try to figure out how to connect and with whom.

And finally, we do also want to look ahead and we know that electronic laboratory reporting, immunization reporting, and syndromic surveillance are relatively mature use cases for Meaningful Use, but there are many, many types of reports that are legally mandated from healthcare providers to public health, everything from birth and death certificates to cancer registration, birth defects registration, depending on your jurisdiction. We know this imposes a heavy load on health care providers and we know that this creates a heavy load on the public health community, and we are very interested in looking for lighter weight, easier to use ways of extracting information from the future electronic health record to reduce the load and to improve the speed and efficiency for both parties. Therefore, we are delighted to see that cancer registries have been considered for inclusion in Stage 2. They are actually well prepared to use a CDA form of exchange of information out of the electronic health record and we are actively participating in the standards and interoperability framework to try and leverage such models for many different forms of public health reporting possibly using the same implementation guide.

And finally, it’s not on the slide, but we do intend, and will continue to leverage the quality reporting disease registry and clinical decision support capabilities of EHRs to build strong relationships between public health, and clinical providers, and increase the uniformity, and predictability with which the public receives strong clinical preventive measures against cardiovascular disease and other killers. So that’s our first year of this exciting first year of Meaningful Use.

Paul Tang – Palo Alto Medical Foundation

Ok, very good, Seth, thank you very much. Any comments, questions from the committee?
No? Amy.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Hi Seth, it is Amy Zimmerman. Thanks for the presentation. I had two questions, one was when you talk about 38 states and cities offering Meaningful Use testing do you have a breakdown, that’s some testing but that may not be in all areas, do you have a breakdown of that at all?

Seth Foldy – Center for Disease Control & Prevention

We do. The majority are testing in ELR with strong runner ups in immunization and a lesser number in syndromic surveillance.

Amy Zimmerman – Rhode Island Department of Health & Human Services

That leads to my other question and you probably know where I’m going to go, but you were talking a little bit about biosense and syndromic surveillance. What is your perspective on syndromic surveillance coming from ambulatory settings and practices?

Seth Foldy – Center for Disease Control & Prevention

All right, so just a quick background. Syndromic surveillance has had relatively low uptake because there was no standard implementation guide that was adopted widely in public health for this purpose and as Amy knows an implementation guide has been reviewed by the

Standards Committee and will be used next year for eligible hospitals. The Biosurveillance Program at CDC is working with state and local clinical partners, I'm sorry public health partners to try to define what would be the desirable and important elements of reporting from eligible providers or if you will physicians and predominantly ambulatory physicians, as a supplement to hospital reporting. There's less experience in the realm of using outpatient records for syndromic surveillance on a broad basis, although there is considerable experience in areas such as flu-like illness tracking. So the anticipation, the anticipated schedule is that before the winter of 2012 and in time for consideration by the HIT Standards Committee, it is hoped there will be an implementation guide for review by that committee in order to consider if it's mature enough for adoption in Stage 2 of Meaningful Use. That timeline would presume that Stage 2 might begin a year later than currently in the regulations.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Thank you.

Paul Tang – Palo Alto Medical Foundation

David?

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

David Lansky, Seth, thanks. I had two questions, one, the National Quality Strategy document that HHS put out puts a, you know, strong signal around cardiovascular health and I'm thinking about Farzard's work in New York with the ABCS for example and I'm wondering if you think there's an opportunity for us to leverage that focus on cardiovascular indicators as we think about the sort of public health dimension of our Meaningful Use program in Stages 2 and 3, that's question one.

And the second is, I like the reference to the cancer registry opportunity in Stage 2, but could you amplify a little bit on how that, what that might look like within the Meaningful Use toolkit that we have, how would we give visibility to cancer registry reporting in the next phase of Meaningful Use?

Seth Foldy – Center for Disease Control & Prevention

Very good. So, first of all about cardiovascular health, there are a limited number of clinical interventions such as the appropriate use of aspirin, the control of blood pressure, the control of cholesterol, and dyslipidemia, and the intervention against smoking each of which has a strong evidence base in medicine and public health to reduce premature death from cardiovascular disease. The Million Hearts Campaign seeks to harmonize the efforts across government and the private sector to get everybody focused on this big problem. We believe there's a good corpus of eMeasures that are built into the first years of Meaningful Use and that hopefully will be additionally supplemented in the second stage of Meaningful Use that address these ABCS, as we call them, aspirin, blood pressure, cholesterol and smoking. We think that, so including them as measures will be very important. To the extent to which those are made core measures and perhaps even non-optional core measures would allow the nation to know that we have set one or more of these as a quality priority across our health system, and also incidentally create the capability of measuring the nation's progress in addressing some of these critical steps. Now that may or may not be practical for everyone, but the public-health perspective is we should consider focusing and we could consider driving towards universal adoption of some of these measures. And of course, by establishing a measure we start establishing pressure for clinical decision support, disease registries, and other tools in the EHR that we know are being built in and that could be used to improve quality.

The cancer registry reporting is reportable in almost every state of the union and in almost every state of the union there is a single entity that receives clinical information about cancer. A lot of what we know about cancer comes from these registries, is the incidence rate going up, is the cure rate going up, are death rates dropping, are there disparities? They collect a variety of information. They have fairly well-established systems for hospitals to send information and we

don't anticipate disrupting that legacy. What is currently lacking in most cancer registries is a good way for ambulatory health records to send clinical updates about the care of cancer patients to these registries. So the goal is to get clinical EHR information from the ambulatory EHR to the cancer registry. The approach that has been already tested, you know, developed through the IHE process and which is going to be tested in a second set of pilot implementations this year is the use of a CDA document that would be populated with information from the ambulatory electronic health record and the EP EHR and sent on a periodic basis to the cancer registries. The cancer registry software, you know, unlike some of the confusion around electronic laboratory reporting and immunization reporting, they are all very similar and they are all building up to the standard as we speak. So the readiness to receive for cancer registry is believed to be high.

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

Very good. Thank you.

Paul Tang – Palo Alto Medical Foundation

Good thanks. Art?

Arthur Davidson – Denver Public Health Department

Yes. Thanks, Seth. I just want to go back, on this last slide here, the second bullet about bringing EHR certification closer to public health practice; maybe you could just describe a little bit more. Maybe you were just describing this, you may have answered that with the discussion about the cancer registry, but are there other areas that you think we should be working on certification methods or processes or goals to align with public health practice and maybe you can just describe that a little bit more.

Seth Foldy – Center for Disease Control & Prevention

Right. Well, I think the, one can construct messages, for example using the NIST evaluation framework or testing framework for Meaningful Use, and pop them in the electronic mail and have them arrive at public health and have it make no sense, and it's nobody's fault it's just the constraints on first of all, which vocabulary you used, second of all, how carefully structured the message is, and thirdly, the degree of uniformity with which public health systems accept those messages, meaning that it's possible to buy a system at either end and the looseness of fit still creates a fair amount of difficulty so that people go back and have to start creating interfaces and changing the way they're doing work. One of the things that we have to do is be more specific about vocabularies, in other words, to improve the implementation guides that are published.

And then the second thing is to improve the extent to which the certification testing protocol adhere to those implementation guides. And we know that this is going to be iterative and in fact it's never fixed because implementation guides will always change. So in fact, one of the challenges will have to be how does something like an EHR certification continue to keep pace with changes, and this is not a problem that is unique to public health. So that's one aspect of the problem and it actually involves a lot of close working together, and this is why we're for example, excited to be participating in the S&I framework. We think that there's progress to be made and that has been made in electronic laboratory reporting, for example, using the S&I framework, and the process of bringing industry, providers, you know, the vendors, providers and the public health stakeholders together to hash out the solutions is an important part of the answer to the problem.

Arthur Davidson – Denver Public Health Department

Thank you, Seth.

Paul Tang – Palo Alto Medical Foundation

I'm sorry Eva; I mistakenly overlooked George here to my left.

George Hripcsak – Columbia University NYC

Hi Seth, I'm just following on David's question about cardiovascular, and I'm sorry if this is obvious, but I just, so is there a program at CDC to help local health departments take a population view of these reports that are coming in? So if we start sending all the cardiovascular data to the local health department then there's going to be duplicates and what you want to do, as Neil pointed out yesterday, is have a view of how it's going in the population so it might require query population surveys, which are then, you know, added to by having these direct reports from the providers. And you know, mechanisms to figure out when three different doctors saw the same patient so you shouldn't count it three times, so you can really tell where you are. Is that already a formal program that CDC is helping the departments with?

Seth Foldy – Center for Disease Control & Prevention

So there is a community transformation grant initiative that has focused both funding and technical assistance on unfortunately, still a somewhat limited, in other words, we can't reach all the 4000 local health departments with a program like this, but there is a focusing of fire, if you will, on implementing effective community level interventions. Remember that cardiovascular disease can be reduced in part in the doctor's office but must be reduced in many ways with community level policy and environmental change as well. Those grants tend to focus on the latter, of course, you know, the better food, starting with better food in schools, more exercise, more walkable communities, many interventions that can increase the heart health of Americans writ large.

Where you're going to start seeing very creative combinations of health data and cardiovascular community interventions I think I would look to the Beacon model because that would be a fairly early stage of development. However, you take a tool like syndromic surveillance and you recognize okay maybe originally we were interested in looking for anthrax or smallpox, but isn't it interesting that we can also know that emergency room visits with chest pain are rising in the community or falling, or actually, as was demonstrated in New York, that following prohibitions on public smoking the sale of nicotine replacements immediately went up. These information exchange tools do provide supple ways for public health to try to analyze and then refocus their efforts at both community and clinical prevention.

George Hripcsak – Columbia University NYC

Okay, thank you, Seth.

Paul Tang – Palo Alto Medical Foundation

Eva, final question?

Eva Powell – National Partnership for Women & Families

Thanks. This is Eva Powell with the National Partnership for Women and Families. We heard a good bit yesterday about the need to make sure that we're addressing large systemic issues and also I think Michael brought up the notion of making sure that we understand who it is that's adopting, and that we really break that down by practice type, and at least what I took from his comment was that we need to get at this issue of disparities, which is of course pervasive in the National Quality Strategy, and if you look at the recently released report relative to that it's clear that in order to make progress on the National Quality Strategy we're going to really have to look far beyond the healthcare system and learn how to connect the healthcare system with other community supports in order to meet those goals.

And I've been a little, I understand the reason for this in Stages 1 and 2 to look at some of these well-established public health reporting mechanisms, and forgive me if I'm going to reveal my lack of knowledge about how public health actually works, but the policy priority for Meaningful Use is population and public health, and it seems to me like we have focused on public health, and rightly so, but to the exclusion of population health in terms of things that actually get at what contribute to disparities, and those things obviously are often times things that go beyond the healthcare system, but even if you look at the CDC website, which I'm

giving a talk on Friday relative to this topic, so I've been on the CDC site recently, to look at the contributors to disparities, and they include things like social economic status, community level supports, and those kinds of things, and what has constantly bothered me is that I know from having worked as a social worker in the healthcare system that these things are being collected, at least in a lot of circumstances, but we've not yet addressed how to capture those in the clinical record, at least the electronic clinical record. And I just wanted to hear from you, what some first steps are that we need to be taking as a committee to make sure that we don't leave the disparities issues behind because right now we've got a pretty minimum amount in Meaningful Use addressing that.

Seth Foldy – Center for Disease Control & Prevention

You ask a very interesting and challenging question. And remember the amount of time the, as large as it is, the amount of time that Americans actually spend inside the medical system is a pretty small part of their life, most of it is spent outside and trying to use the medical care system to measure all of the social determinants of health might be a bit quixotic, but we're extremely encouraged by the emphasis that's being placed on measuring racial and ethnic demographics in the medical record. Let me just give you an example, for example when it comes to sexually transmitted diseases, being a former state and local health officer, I knew that there were massive racial and ethnic disparities in those areas, but the data was almost universally rotten because one could not routinely retrieve that kind of information, and so I must admit, I'm a little excited, that in the future that kind of information is going to be supplied far more reliably. And let me say that I personally, and I know there are others at CDC, I don't know if it's a universal acceptance, believe that occupation is one of those social and economic factors that it would be wonderful to see coded far more uniformly, and effectively in medical care in the future, although I do not know how practical it is in the short run.

But, so here you hear me talking about the information collected in healthcare. To be honest, I've been working very hard on the three public health objectives because I am frightened that public health could be cut off from its supply of information. The same information that the nation uses to know that there are disparities, to know that healthcare is not being delivered in the most prevention effective ways, as we move from paper practice to electronic practice we're are trying to make sure that the public health agencies that need to assemble, not only the data, but the strategies have the information supply that they need. But using the information systems and particularly shared information systems, let me give you an example of immunization registry.

Immunization registry begins to enable communities to ask the question in what neighborhoods are children well vaccinated and not? In which clinics are children well vaccinated and not? In which social and economic groups, now that we are starting to get better demographic data, are children well vaccinated and not? And then we can start asking the question in a far more sophisticated way, how do we develop a combined strategy that deploys both healthcare and community action to address those deficiencies? And we've done this with lead poisoning, we do this with food safety, that's what public health does at the community level. So, the critical point is of course to keep those relatively poor and technically not terribly sophisticated, at least not always, local public health officials at the electronic table and working with their healthcare partners through the Meaningful Use program.

Paul Tang – Palo Alto Medical Foundation

Very Good.

Eva Powell – National Partnership for Women & Families

Great. Thank you.

Paul Tang – Palo Alto Medical Foundation

Thank you very much. Thank you Seth and this is important input for our Meaningful Use, sorry?...Okay, let's move on to some de-briefing from the hearing yesterday. Let me propose a

process, one is a de-briefing on yesterday's hearing, the second is looking at the goals, the end goals for Stage 3, and then the third activity is to connect the two. How does that sound? So, for de-briefing I think it would be useful just to start with the top three and then do a round-robin in terms of the other ones, but I think we all know which probably the number one, one is and just go through the attributes of CQM and what are the challenges, now it's not a complaint about Stage 1 it's what are the challenges that we need to consider as we look at both the goals and the process for achieving the goals in Stage 3? Okay, so CQM, what were some of the attributes or the challenges? Actually, you want to break that down a little bit? Okay. Others?

M

Data capture.

Paul Tang – Palo Alto Medical Foundation

For anybody on the phone or internet, we're writing on a flip chart.

M

Alignment.

Paul Tang – Palo Alto Medical Foundation

Alignment.

W

Also for, yes there's a need for specification, but I also heard a need for value for whoever the user is which would also require some flexibility and I think that's a particular challenge for us, is how do we do both?

Paul Tang – Palo Alto Medical Foundation

So, could I write that as relevance to the...

W

Right, right, yeah I think that's good, yeah.

M

Paul, redesign the work flows to capture the information as designed in the electronic health records, which is different than the way folks have been collecting, if they have been collecting, clinical quality measures previously.

Paul Tang – Palo Alto Medical Foundation

Would that go under data capture or is that...

M

Well, I mean...

M

I meant those both.

M

Well but it's a subset, I mean it's designing the data capture but then also having to re-design workflow so that you can capture the data as part of the workflow. So it's, you know, the technical and then the cultural process.

Paul Tang – Palo Alto Medical Foundation

Certification.

M

Correction.

Paul Tang – Palo Alto Medical Foundation

Correct?

M

I mean there are some folks who are saying that the specifications are wrong.

Paul Tang – Palo Alto Medical Foundation

All right. So how's the integrity of the certification process?

M

For the sake of, it goes along with alignment, but one thing that wasn't said, but is in the testimony, is alignment with for example, the better qualified health center UDS quality measures, there's a disconnect, they have to collect UDS as well as these measures and there may be other instances of that. So it's part of alignment but I think that it merits, there were lots of different alignments mentioned yesterday. So we ought not lose sight of all the different ones. That one is one that wasn't said verbally but it's in the testimony among the others that were said verbally.

Paul Tang – Palo Alto Medical Foundation

How would you write that one?

W

When we get to alignment, the question is really align what with what, that's like a whole, that needs to be a sub-conversation if we're just sort of brainstorming here because, you know, there are all different kinds of quality measures and everyone has their perspectives on what and how to align so.

Paul Tang – Palo Alto Medical Foundation

So, let's go back to alignment as another high-end.

Judy Murphy – Aurora Health Care – Vice President Applications

Make another bullet for harmonization because that was a word that was used a lot yesterday.

Paul Tang – Palo Alto Medical Foundation

Is that the same thing as alignment, the way they were using it?

Judy Murphy – Aurora Health Care – Vice President Applications

Well, I think it meant, and it could be because it was harmonization between the different programs that were expected to submit quality measures for.

Paul Tang – Palo Alto Medical Foundation

Let's repeat that under our alignment topic when we break that one out. Other CQMs?

Judy Faulkner – EPIC Systems Corporation

Simplify.

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

...complex.

M

Paul where was field testing in there?

Paul Tang – Palo Alto Medical Foundation

That's a good one.

M

Before there actually is.

M

That's a really good one.

M

Yeah. Because some of the challenges people mentioned would actually have been discovered if they were tested.

Judy Faulkner – EPIC Systems Corporation

Well and I think the other...

Paul Tang – Palo Alto Medical Foundation

Update is another one, maintenance.

W

I would say feedback too, sort of aggregation and feedback because that's how you'll drive the change as result of them.

Paul Tang – Palo Alto Medical Foundation

Okay and then somebody mentioned like real time feedback. Anymore challenges for CQM? Yes?

M

So one of the comments from the written testimony that I reviewed, because I couldn't make it here yesterday, was I think implied with some of the statements around audit. There's not just an integrity of the certification but its integrity of the measurement and the behaviors that result when you have dollars in value based purchasing ultimately attached to this. And so how do you go around, just as there's an auditing process for the consent of payment, there needs to be some kind of assurance that people are not messing around just to change their ranking.

W

Well, and one other thing and this may go under another category we have, but I think it was Neil that made the point about we need to be supporting not just quality for reporting, but also quality for improvement and those are two very different things, and we have to have both and particularly when it comes to the value case for providers, the value to them really is in the quality for improvement.

Paul Tang – Palo Alto Medical Foundation

Yes.

M

And you can tolerate a certain amount of noise in the data when you are doing improvements.

W

Right. Right.

M

But it gets very hard when there's.

W

Right.

M

We're struggling with tremendously in our system.

W

Yeah.

Paul Tang – Palo Alto Medical Foundation

Okay. Let's go back and add...alignment...different kinds of alignment.

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

Well, one of them was alignment with different requirements. So requirements that hospitals have or that providers have for licensure or re-certification, hospitals have for accreditation.

Paul Tang – Palo Alto Medical Foundation

So those different requirements could be for example, CMS programs.

W

Joint Commission.

Paul Tang – Palo Alto Medical Foundation

Accreditation programs.

W

Then there was some around ACOs, patient centered medical homes, whatever that whole set.

Paul Tang – Palo Alto Medical Foundation

...programs, maybe inpatient, outpatient as we blur them more and more or we want to blur them more and more.

M

Right, I mean, just provide all federal programs because that would include the federal qualified health center, UDS, uniform data set.

W

Yeah, well and also the private sector because it was mentioned a couple times about the Joint Commission as well. And there's precedence for that I think in terms of aligning hospital measures, hospital core measures between Medicare and Joint Commission.

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

I would also put down just alignment with health reform goals in general, more generally than just ACOs.

Paul Tang – Palo Alto Medical Foundation

Okay.

M

...

Paul Tang – Palo Alto Medical Foundation

The what?

M

The board certification.

Paul Tang – Palo Alto Medical Foundation

No...

M

Okay.

Paul Tang – Palo Alto Medical Foundation

Okay another main topic?

M

Paul there was a comment from Siemens that said, I'm just looking here, misalignment between the standards required for certification and the standards used in eMeasures. Is that a valid one to throw up there? I'm not.

Paul Tang – Palo Alto Medical Foundation

I put that one under integrity, where did it go? Oh.

Judy Murphy – Aurora Health Care – Vice President Applications

Yeah.

M

Yeah it's a different kind of alignment than I think we're talking about but I just wanted to check.

Paul Tang – Palo Alto Medical Foundation

Yeah. Let's just call out there is essentially the re-tooled eMeasures, the integrity of that... Another topic was EHR certification; it relates some to CQM, but certainly a problem.

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

What was the last one you wrote up there? Oh, this, you're on a new category?

Paul Tang – Palo Alto Medical Foundation

On a new category, EHR certification. So one had to do with the CQM and the comment was you're required to have a button but not to have any, you're not tested against the accuracy of what you produce. There's no use case in effect, I guess.

M

Although Paul, I think, just so I'm thinking right, when people talk about the accuracy of the measures I don't think they're talking about whether the computation is carried out correctly. What's usually the underlying question is, is did the data end up, and are the assumptions about the data right. And so I just want to make that distinction because I didn't want people thinking that it was a...schlocky software here that did the math wrong. That might happen.

M

Well $1 + 1$ is 3 of course.

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

But the other part of that data. I'm sorry were you done...?

Josh Seidman – Office of the National Coordinator

Well, I was just going, I mean it sort of underscores a really hard issue about EHRs which it's really a three-part problem. Right, there's the EHR, the data, and the workflow that all have to come together to succeed.

Paul Tang – Palo Alto Medical Foundation

And it gets certified only, now here check me Josh, it gets certified one way and I think you have to actually spit it out for that certified way.

Josh Seidman – Office of the National Coordinator

Yes, right.

Paul Tang – Palo Alto Medical Foundation

Which means from the data sources, the vendor decided for everybody etcetera, is that correct?

Josh Seidman – Office of the National Coordinator

Well and the data is sort of prescribed which makes sense otherwise how do you know what data you're going get?

Paul Tang – Palo Alto Medical Foundation

Well, I know, but let's say smoking, it has to be the data in this field captured on this screen, is that correct or no?

W

No that's an option. I mean, it doesn't require, my understanding is that a large part of the problem is that that can be documented in multiple different places. The problem is it may not come out in the, it may not get spit out because the vendor's going to only pull it from one place.

Paul Tang – Palo Alto Medical Foundation

Correct. So then people are changing the workflow to put the data only in the vendor specified certified way. Is that, I think that, so that whole notion is problematic?

W

Yeah. And that's part of the accuracy I think.

Paul Tang – Palo Alto Medical Foundation

One thing Mike used to say, a vendor gets certified to be able to produce the CQM. If the provider decides another way, that's up to them. I mean that's one of, and also it includes the, and using a reporting system, a separate database versus it has to literally come out of the EHR, which we heard a lot about. Because people had their legacy way of getting it and it usually it included some reporting database, and then they had to get it out a different way from the EHR. So that, I mean it seems like that's an area we could make some suggestions on. But how do we, so a single certified method.

W

Well and Paul.

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

But that's not going to happen.

W

One thing that I heard Sean, Paul say that may capture this kind of at a higher level is that the way things currently happen is that certification is based on the ability to produce a result, but that result is not required to come from a real world situation. So essentially, the complaint was there is no real world testing and so that may be a way to capture this more broadly is that that can kind of accommodate the workflow kinds of issues.

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

But Paul, I'd go back to this point, because I don't think we want to be in the business of telling vendors, you know, we want it to appear on the right side of the screen, you know, in three bullets and when it gets updated to use a single button. I don't think we want to get into that stuff because one of the things we've been cognizant of from the beginning is not sort of stifling the kind of innovations that are going to take place in this. So I think it's important that we say that it needs to be EHR based and be able to be produced from the EHR, but I wouldn't want to get into that component of what we're doing.

Paul Tang – Palo Alto Medical Foundation

I think the unintended side-effect is the certification process required it almost to have a certain way and that was defined by the vendor and then everybody worked around that way. So I think one of our recommendations, you know, one of the counter proposals we can have is what you suggest. It needs to come out of the EHR, the vendor needs to prove they can get it out of the EHR but the user doesn't have to do it that specified way. You see what I'm saying? I think right now the user has to use the EHR in the specified way.

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

Right because yesterday we heard, I mean, if a vendor is able to develop the capability so that somebody can enter smoking information in free text then they can extract it and produce a report from that, we wouldn't want to not allow that kind of mechanism to be developed in the future, you know, so I don't think we want to be into prescribing how people are going, are going to capture this data.

Paul Tang – Palo Alto Medical Foundation

I think we're saying the same thing. Okay we're trying to not prescribe, but inadvertently in Stage 1 we did.

M

Well Paul, but we are talking about some sort of in the field testing of something so that it actually not only can produce a number but actually can be used in practice without specifying how it's designed, but I think that's one of the things that came up a couple of times people referred to the CCHIT process prior to the current certification process. And I'm not as familiar with it as I should be but it seemed like people referring to some part of that testing that is missing in the current certification process.

Paul Tang – Palo Alto Medical Foundation

Yeah. Okay.

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

One thing that I don't think we have on our list yet is about clinical case definitions. The clinical case, how we define, somebody had a better way of saying this than I'm saying it, but, you know, clinical case definitions, how we define diseases, the need to standardize how those are defined.

Paul Tang – Palo Alto Medical Foundation

Is that for the purpose of CQM?

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

Well it came up in relationship to I think the Query Health kind of situation, but it's just as relevant in relationship to CQM because you know you can't report on your diabetics without some definition of who they are and I think those kinds of things need to be on this list.

M

Okay, even more so than the case definition is inclusion and exclusion criteria for the purposes of measurement. Measurement is a rate that you have to specify numerators and denominators you want to get a, you know, we struggle for instance with, you know, what, who do we include in the denominator, does a one off visit count versus someone who sees us on a continual basis over time. That we have that relationship and that's the challenge even more so than defining the disease.

Paul Tang – Palo Alto Medical Foundation

David?

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

Well I have a hesitancy about the path I think we're going now down because we are not the actual measurer's or measure specifiers. We were trying to find a set of quality measures that signal the effective implementation of EHR, but actually we're not actually using these data for anything, they're not being reported, they're not being used for payment, they're not being used for benchmarking feedback, comparison or anything. All they are is a test of performance of an introduced technology. And I understand this is a slippery slope. We're teetering and I think we have to think about how to, I think the second half of our discussion today Paul, what you suggested is where are we going with Stage 3? What are we really trying to accomplish as a policy initiative?

There are many other bodies who are delving into very complex details of the kind that we just listed to solve their own particular problems and we aren't them, but we do want to create an enabling technology to make their work easier. So I think we have to go only far enough to feel that the technology capabilities are there, whether it's the VA or PQRS or IHA or whoever, can then come in and overlay a set of specifications that are implementable, but I think we have to find a way to both calibrate it ourselves and then communicate it to the public because part of what I heard yesterday that was of concern is they were over-interpreting our purpose and requirements as if performance on these measures had to be so carefully calibrated and the significance testing enabled that they wouldn't be somehow disadvantaged by incentive payments which isn't really our job.

Paul Tang – Palo Alto Medical Foundation

It isn't our job but it's a, there is a little bit of an implicit implication of what we are doing. So we're trying to find ways to specify the EHRs so that they can produce, flexibly produce a set of measures. We have some exemplars, which is the approach that we took and if we do, if we do a fantastic job with the exemplars, they certainly can find themselves into the policy section.

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

Well my emphasis, I was trying to project yesterday, is I think our emphasis is more on the question of flexibility than on the precision. I would rather see us enable a technology environment in the country that can in the future produce and adapt measures as needed then get these perfect.

Paul Tang – Palo Alto Medical Foundation

I think that is one of our goals is that we want to list for Stage 3, because it looked like the observation is that we've gotten too precise and almost hardwired into specific things and that became almost a liability and certainly a burden. George?

George Hripcsak – Columbia University NYC

Okay. Two things I want to, so I think comprehensiveness versus parsimony or exemplars should be one of the issues up on the list, in other words, how much do we have to do per provider? But, you know, CDC had an answer yesterday so what's your comment on CDC's answer to my question yesterday, which is what are we trying to do here? And they kind of leaned towards we're doing it. I was expecting them to say yes, you are just proving that the EHR works and we'll take care of the program.

M

You mean to CMS?

George Hripcsak – Columbia University NYC

CMS, what did I say CDC? I'm sorry, I said the word CDC because Seth was just on the phone, but I meant CMS, yesterday.

M

I'm not sure that I remember...

George Hripcsak – Columbia University NYC

Well the CMS was kind of, I asked CMS are we just doing the EHR part, the other programs will take care of the content, or are we doing the content and expecting the answers, we're just proving the EHRs work and the answer we got was well you guys are doing the content, go ahead, full steam ahead.

Paul Tang – Palo Alto Medical Foundation

Well they didn't say it exactly that way.

George Hripcsak – Columbia University NYC

I know, but that was their implication.

Paul Tang – Palo Alto Medical Foundation

But it was not beyond us taking somewhat of a lead role and trying to make it as burdenless and meaningful as possible...

M

So, I think part of the problem about drawing boundaries is first of all so many of us are working on all these other committees too with CMS or with NQF, or the NAF or the National Priorities Partnership, and I think that is a good thing. I mean, I don't know enough about information systems design to understand can you create infinite flexibility for measurement constructs in the future in population health. I know that we've struggled trying to measure things in today's measurement environment with a legacy architecture that lacks flexibility. And you know that has to be addressed in our world as we move forward with a new record with DoD, but that's, you know, unless we know what we're going to be building it's hard to know exactly how to spec it out.

Paul Tang – Palo Alto Medical Foundation

Other, other lessons learned? Amy?

Amy Zimmerman – Rhode Island Department of Health & Human Services

Well, I was going to say another large theme I heard yesterday was around the patient engagement area. So I don't think we want to forget that and, you know, one of the, maybe to help get the dialogue going, I struggle, I didn't get to ask the question yesterday, but I struggle with, you know, a patient portal on every EHR and hospital system, and personally as a patient if I'm crossing them how many patient portals do I want and will I go to. And, you know, I think there's, I'm not saying it's not important to have that, but I think from a patient perspective if we want to get patients engaged having them have to go, you know, to multiple different places, you're ATM you use one, you know, one card, one thing, and whatever bank, or maybe that's a bad example, but I really struggle with patient engagement and the way.

Paul Tang – Palo Alto Medical Foundation

And you have to pay a fee every time you use one.

M

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

But, yeah, all right. All right I said it was a bad example, but I think the whole patient engagement and the best, and I mean I heard a lot of themes around, you know, what should and shouldn't be, you know, the discharge summary, the instructions on the portal, not on the portal, but I think there's a whole discussion and deeper thinking about what is logical and makes sense and will engage patients.

Eva Powell – National Partnership for Women & Families

Well and this is Eva. The other thing that I found interesting about the conversation yesterday was how it was almost automatically linked, or at least from what I heard, to the issue of workflow for the provider, that there's a real opportunity when we're talking about technology to both engage patients and to relieve provider workflow if we figure out how we can enable patient entry of data and information because they're the source for much of the data anyway. And so that would seem to be a very pragmatic approach that would please both and that achieves the patient engagement because the patient's right there doing part of the effort. But also the step beyond that and the portal I think there's a piece of that that goes along the lines of what Neil said in that we don't want to prescribe the actual method or technology in a portal is but one way.

But the other thing that I heard yesterday was again, this need to be specific but also offer flexibility and I think that's our ultimate massive challenge because a portal is not for everyone. Texting is more effective in some communities so how do we as a committee put some stringent criteria together but that offer providers working in any given community the option to do what works best for their patients. And so perhaps, and I think there's a piece of that that also is linked to encouraging innovation. So how do we encourage innovation in the area of patient engagement that achieves the transparency that we've been after in terms of giving patient's access to their own information and also the meaning behind that information? So, I don't know, I mean I appreciate your comment because I think there's a lot of validity to that. At the same time, I wouldn't want to lose that transparency that we've grown so close to getting.

Paul Tang – Palo Alto Medical Foundation

I think one of the unintended side-effects of the clinical summary, because we have heard about that a lot, was during this period of transition from 0-60, the prescribed way it turned out to be paper for the clinical summary just because we're in transition even though our intent was to just make it available and that's very easy to do. But so everyone virtually had to resort to paper and then you had the complication of well.

M

Well wait a minute, clinical summary was paper because patients might want it on paper, not just because we're in transition. It could be 50 years from now they'll still want paper and that's okay because that's what the patients want.

Paul Tang – Palo Alto Medical Foundation

That's true but that's the only method available to them, speaking of flexibility was paper in 2011 for the majority of folks. So, you end up getting a lot of paper that didn't end up always in the patient's hands.

M

Just building on what Eva was saying, you know, it seems like this is sort of a policy versus procedure issue and we sort of are in this funny place where we're tending to specify more procedure when we really want policy. And it's tough because policy is a little more blunt and a little less specific so we all want to nail it to the wall. So for example, to your point Eva about patient communication and collaboration, there's a half-dozen ways you might do that today and probably three next year that haven't been invented yet, and so to the extent, especially in phase 3 where we're trying to really look at change, and looking several years out, it's hard to predict exactly how it will get done, and to the extent we can specify what we want to happen in a specific enough and measurable enough way.

Paul Tang – Palo Alto Medical Foundation

But we tried to do the what and it turned out that the limitation of 2011 made it inflexible. Other themes from yesterday?

Michael Barr – American College of Physicians

This is Michael. I think you're going to a completely different theme now?

Paul Tang – Palo Alto Medical Foundation

Yes.

Michael Barr – American College of Physicians

I think we still are underestimating the workload at the level of the practices and we heard a lot of that. We saw the stars come to this testimony, but in the testimonies also some of the challenges that they are experiencing. So again, I think what Marc said is, you know, is a lot about skating to the puck. We ought to just send a signal where the puck's going to be and let the innovation take place but also test a lot of these things in practice before we mandate them.

Paul Tang – Palo Alto Medical Foundation

Now the interesting thing is we have to balance, okay so it clearly worked to go from paper to an EHR. It has also clearly worked to be able to cope with or adapt to value based purchasing. They're probably the same in a sense that people are going to need EHRs in order to do value based purchasing effectively and efficiently. So, it's not necessarily the "Meaningful Use Program" that's causing the work, it's the requirement to go to value based purchasing and Meaningful Use actually gives a leg up in two ways, one is it's giving added functionality to the product and the second is there's actual incentive money.

Michael Barr – American College of Physicians

Yeah Paul, I agree with that, but what I'm trying to say is we need to understand the environment that the practices are in. Throw in there ICD-10 and now you get a real picture of the day to day existence. So I think your absolutely right, I think the things we're doing are going to help putting them on the pathway, but the pathway is still really bumpy, and I've said earlier, I mean, I think we have expectations of practices and we have expectations of vendors to produce the tools, and right now they're kind of on the same train. But I'm wondering whether we can actually separate and say here's where we want vendors to be and here's where we want the clinicians and practices to be, they don't have to be there at the same point though. So we can say where we want things to be built and how they should be built to the level we feel comfortable saying it but not necessarily hold the clinical teams at the same pace to get to that same point.

Paul Tang – Palo Alto Medical Foundation

Okay. Other themes?

M

One of the things I'd like to have noted is that we had, as Michael said, we had the stars here yesterday. There are a large percentage of the hospitals and clinicians that aren't on the bus yet so we need to make sure that this escalator doesn't get going too rapidly or too steeply. Because I think the ultimate goal is to get the maximum number of providers and hospitals onboard.

Michael Barr – American College of Physicians

And Paul, just to be clear, I think, I'm agreeing with, we want to set a high trajectory for where we want to be, but I'm just saying we can't hold expectations that all the clinical teams and hospitals are going to get there as fast as we want the vendors to get and build these things.

Paul Tang – Palo Alto Medical Foundation

Okay. We can certainly add more later. Let's switch to Stage 3 goals and objectives.

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

Can I just put an item on the parking lot that.

Paul Tang – Palo Alto Medical Foundation

I'm sorry?

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

Can I put an item on the parking lot for us to consider?

Paul Tang – Palo Alto Medical Foundation

Yes.

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

We keep talking about and we've done this after multiple hearings, how we bring the people in who are most successful and most worthy. And we do have a resource through the Regional Extension Centers to identify people who are struggling. It would be great, I know it would be hard for all of us to hear, but it would be great to have a panel of strugglers both institutional and provider to just sort of share some of the, some of the, you know, the places where they're running up against the wall, whether it's knowledge or, you know, financial, or vendor issues, or whatever. I just, you know, I know that there's problems we keep hearing it, but I would love to have a much better feel for it and I think we can make more intelligent decisions if we had a better feel for the things that people are running up against.

M

And just to add.

M

I was just going to say, certainly we can do that. I mean obviously there are 100,000 providers that are being served through the Regional Extension Centers and we can do that. I will say that both Paul Kleeberg and Carol Steltenkamp, who are, you know, leading Regional Extension Centers, are working, you know, and particularly Paul is working really on the ground with, you know, practicing docs, you know throughout all parts of Minnesota and North Dakota.

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

Yeah. I appreciate that, but we've sort of abstracted one level. We hear directly from the winners, but we don't hear directly from the people who are struggling. And I say that because, you know, I think sometimes there's a, you get a sense when you talk to people like that, and I'm not talking about people who are just saying I'm not interested in this I'm going to quit my practice, I'm talking about people who really want to do it but are still stuck and haven't been able to and are trying to understand that better. Maybe it's not.

Deven McGraw – Center for Democracy & Technology – Director

Yeah. This is Deven. I would agree with that and I certainly would much rather hear what the struggles are from someone actually struggling than one of the associations that sort of represent something writ large which is also part of the problem with having the RECs testify to it is that you get more of a top of the tree snapshot. And that's all good to know, but I'd like to drill down on it too. And I wonder if, in addition to sort of talking to people about it, we can do a little bit of crowd sourcing of some of that by deliberately reaching out through whether it's through the blog or through some other type of medium where people are actually invited to share the thing today about trying to achieve Meaningful Use that really like unnerved you and created such a hassle in your day like, you know, and just encourage people to put up the short sort of frustrations that it would be interesting to sort of hear. Plus it lets people vent.

M

The other thing, I want to pile on with Neil though, I was impressed and made note of even the people who where succeeding I heard a big debt that they took on, I heard using a scribe in a primary care practice, I'm going, how do you pay for that? And somebody else was talking about the extra time in each clinician's day which, you know, I mean even the successful succeeding people I was going, wow.

Deven McGraw – Center for Democracy & Technology – Director

Yeah.

M

And the distractions of things that they weren't doing because they were doing this which is the opportunity cost we have to understand.

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

We may have just solved the employment problem. If we linked every single physician up with a scribe we would create a million jobs today in America...well fund it.

Paul Tang – Palo Alto Medical Foundation

Okay. Goals and objectives for Stage 3. And you can also look at some of our parking lot issues from before. Is it outcomes over processes, that's what we had thought about before. Do you even waive some of the process things by getting two states, like getting a tier in one of those games.

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

One of the things that was mentioned yesterday was sort of a return to the original value statements, sort of the original goals that we had put up at the beginning to sort of test some of the Meaningful Use things that we've done against them to see if there's gaps where we're not meeting objectives and we're just, you know, Eva just mentioned before about, you know, the disparities issue. I mean it's on our list of big, you know, big ticket goals, but are we really doing enough to address that? Patient safety, you know, we have a couple things about safety and the efficiency piece which we've talked about before has really kind of fallen off our plate as a direct objective. We don't really have a lot out there that's really looking at cost and efficiency and how do you use electronic health, I mean, we're all saying that everything we do is going to, you know, in some way improve the cost structure, but we know that there are potential ways of using the electronic health records around targeting over utilization and things like that that we haven't really built into the system, although we've talked about it a couple times over the past few years. But I think it's worth revisiting some of those big picture things to figure out how to fill in some of those gaps.

Paul Tang – Palo Alto Medical Foundation

As you mentioned that I realized that we missed a couple big things from yesterday, HIE.

M

Yeah.

W

Yeah. I was going to say that.

Paul Tang – Palo Alto Medical Foundation

So actually why don't we even go through some bullets for HIE. Like one they aren't around.

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

One of the things, I think one of the things we heard is that they're evolving, I was surprised from Aetna, you know, to hear that they're evolving in lots of different places including through, you know, managed care companies, developing. I mean we know that they own some of the HIE, but he said more than that. He said basically we are the HIE for the members that are there and we're collecting the information and creating the exchange. That was something I hadn't, what Marc's shaking his head. That's what he said though isn't it? I'm not attesting to the validity of the statement I'm just basically recalling that we're building a lot of stuff on a yet evolving structure and still a morpheus structure of information exchange across the country. And I think we need to recognize how flexible and yet ill defined that is in most places in the country.

Eva Powell – National Partnership for Women & Families

And HIE to me seems to be a critical link to both the goals that we set out early on, which I think Neil's right that we need to take a look at those. But I think we need to take a look at those in light of the new things that we have, which are the National Quality Strategy and the recent report released last month that outlines specific goals and objectives. And again, when I read that list I see HIEs, not in every single place, but pervasive throughout that, and much of that is being able, per my comment in the public health presentation of having some mechanism for linking health data with community data. And I don't know the why's and wherefore's or how's of that, and obviously the electronic health record cannot contain every bit of information about patient social and economic and everything, but there are pieces of information that were missing and there are places where we need to be defining touch points and connections and that all will need to happen through some variation of HIE. So I feel like that's a huge missing piece in making a giant stride towards the National Quality Strategy.

Paul Tang – Palo Alto Medical Foundation

So in our original, somebody referred to it as the swoosh, the arrow, we thought we'd get information into the EHR in Stage 1, we would spread it around Stage 2 so that we could improve outcomes in Stage 3. What we heard yesterday is still the vulnerabilities of that middle section which is the exchange. And clearly, some of those areas that are progressing more are the point-to-point, it's sort of like the directs of the world and the other way is whether it's through a payer or, you know, a vendor. People are getting connected to some of their training partners because they need to and it's not exactly according to plan that we thought two years ago. So we just have to recognize that.

Deven McGraw – Center for Democracy & Technology – Director

It does make me wonder, and when I asked the question about why isn't exchange happening more robustly and I only got one vendor answering, and basically his response was well put the incentives in place to exchange and it'll happen. So sort of really dismissing that there's a technical issue at stake here and maybe there is no technical issue. I mean, we know when there's an imperative to coordinate together whether it's financial or otherwise people will find a way to do it. So, I wonder whether we think a little bit about trying to link up some of the exchange objectives to specific payment initiatives being undertaken by CMS in the Medicare and/or Medicaid program. Like the never, you know, not paying for never events or ACOs, or you know a host of other things in the pipeline ideally, and not just, I mean CMS gives us some obvious targets. There may be some way to think about sort of private payer initiatives and state initiatives in that bucket too.

M

I totally agree with what you're saying Deven and even the folks like Kentucky, I visited with Carol after our meeting at the noon break and they have everyone connected through one system but she says it is not financially sustainable once the grants are announced so I don't know what we're going to do then. So, I mean, I think the business plan, if there was some sort of a business model for this being successful I think it would succeed.

Paul Tang – Palo Alto Medical Foundation

The thing that did come on the scene since 2009, when we came out with our, well like HITECH spec, is a different angle on the business model which is the ACO kinds of things, it's the reform things, it didn't come until last year. Eva?

Eva Powell – National Partnership for Women & Families

No, I was going to bring that up that in addition to what Deven just said about looking at the federal programs, also figure out how we can encourage, I forget the person's name but she said if we can figure out how to incentivize collaboration and she was talking about very much on the local level, I think specifically she was mentioning collaboration between hospitals and physician practices, but I think you could extrapolate that in a number of different ways at the community level, and since this is a community based effort, I mean we're doing a lot here on

the federal level, but not much is going to happen on the federal level in terms of implementation, it's all community based, and so I feel like we need to figure out how to leverage some of those things going on in the community, which obviously are impacted by some of the federal programs, but they're community based projects. So I think, again, I forget the gentleman's name, but he was mentioning Meaningful Use fit in perfectly with some of their medical home efforts I think at the state level.

M

...

Eva Powell – National Partnership for Women & Families

Right and so those kinds of things, if we could learn more about those things and how to design Meaningful Use Stage 3 in a way that really does support those then we've gone a step further in terms of sustainability and incentivizing.

W

I think our struggle here is, I don't know that we can take Meaningful Use criteria to drive payment reform and what this really requires is payment reform because the way the payment system is today there is no, there are often not many financial reasons to want to do health information exchange, in fact, it would work against your business case, or not the case of the HIE, I mean it works against the business of the private sector. So, I mean, I clearly struggle with this all the time as well and I just worry about how we can, I don't know that we can take Meaningful Use criteria to drive that. We need to consider it though when we want to drive health information exchange so there's...

Deven McGraw – Center for Democracy & Technology – Director

Piggyback on it, not drive it, yes.

Paul Tang – Palo Alto Medical Foundation

So in a sense, yeah, we were the enablers. The whole reason we put in the "test" criteria was really to make sure the vendors did it, had the capability to do it. And what we're trying to do with the Stage 2 recommendations was to start using it with their clinical training partners thinking you have a, you know, a vested interest in doing that, but it's to motivate you to start applying that technology as opposed to developing one of your systems. David?

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

Just want to talk about that, one, we are part of the Policy Committee and the Policy Committee does have a larger latitude to speak to the issues of what policies that HHS might consider that would, like payment policy, that would drive the ecosystem we're talking about. But secondly, we could do a little bit of an engineering exercise and go to the anticipated payment program through 2015 and say what is it in your payment model, because I think right now we are in a Catch-22 where they put in place let's say the ACO quality measures given a current environment of what's doable, they think, and we then are kind of constrained by aligning with those. If instead the exercise were where is the ACO program going to go or the episode payment going to go, or the hospital value purchasing going to go, in the next two or three years, are there elements of their programs which would become payment incentives for information exchange if they opened up the aperture a little bit of how they think about it.

Paul Tang – Palo Alto Medical Foundation

So what I'm writing down is potentially HIT policies that support anticipated payment policies.

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

The second point I was making was really in the context of Meaningful Use that we might bring into Stage 3 of Meaningful Use elements of information exchange enablement of the test kind that you suggested, but those that are paid to where the payment policy is going.

Michael Barr – American College of Physicians

This is Michael. I like that idea but I would try to get even a little bit more specific because I think if you look at all the demos and all the projects they're trying to get savings in two or three specific areas, avoidable emergency departments utilization, avoidable admissions, avoidable re-admissions. A lot of that relates to transitions in care in exchange of information. If we worked, and of course, from the American College of Physician's perspective, worked on the patient centered medical home neighborhood, which is sort of communicating between primary care and specialists, and subspecialists. So, if we kind of put the ink on transitions in care and say the health information exchange has to occur for those particular use cases. I think that'll both align with the payment model because there are going to be incentives for those types of better behaviors, better clinical outcomes, better processes and we can put the technology in place to facilitate it a little bit easier.

Deven McGraw – Center for Democracy & Technology – Director

Yes.

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

That's good.

Paul Tang – Palo Alto Medical Foundation

So as an example one of the ways we use "drive" change, so care coordination, what came up, problems at least in the written testimony, problem list is a problem and we, in our profession, and yet we almost have to iron that out using, hopefully using technology that is applied by the EHR in order for us to even hope to do care coordination. So in a sense when care coordination is important and if there's a business model for that to support that, which would be payment reform, people are going to have to get to this point and why don't we start them getting to this point early. That was, it's a problem list, it's the care plan, it's those kinds of things. And, but we can play a role in driving some of the cultural change because the doc has to get together, okay what's the problem, who can enter it, so there's some some basic things.

Michael Barr – American College of Physicians

Paul, I agree with you, I'd just say the transitions in care is a subset of care coordination and nobody is paying specifically for the broad care coordination outside right now. But they are looking at specifically transitions. I completely agree with you, don't get me wrong.

Paul Tang – Palo Alto Medical Foundation

Right. Right.

Michael Barr – American College of Physicians

Let's say if we're looking for an economic case to build information exchange, I think it's going to be around those use cases related to transitions and care. I'd love to see it through all the other care coordination, but I'm not sure it's going to meet the criteria that we're looking for in terms of stimulating the business development.

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

The transitions in care piece fits perfectly into sort of the reduction and readmissions sort of criteria, but, you know, just to take it one step further. CMS is putting out all of these sort of innovations and while the transitions in care one, which I'm familiar with, sort of put out that technology would be a good thing to be used, it wasn't a requirement of the program. But you can make it a requirement which would really stimulate, you know, to be able to suggest that it be requirements for some of these innovation programs I think would really, would really stimulate activity there because, you know, what gets put out there is what gets done.

Paul Tang – Palo Alto Medical Foundation

Well I think CMS has already had very strong signals that they're with this program. For one, Patrick Conway, virtually said those words, and if you look at the ACO and PRM it said, by the

second year, half the folks have to be in Meaningful Use, which is basically incorporating this whole program. So, there's no question that that's what their intent is. But, I think we just want to make sure that we're aligned with those anticipated intents and I think almost a step ahead. So like I say, the problem, there's a lot of culture change that goes into implementing EHR and then doing some of these things that prepare you to do transition and coordination, etcetera and maybe we're part of those changes. So the simple word like up-to-date problem list, which we sort of anticipate for Stage 3, is very powerful. It's one of those things it's hard to get there, but then once you get there, you know, like some testimony said, people realize just how valuable that is to have an up-to-date accurate problem list that you all share. And I think that maybe one of the places where this program can help draw it in a meaningful way that really feeds right into future programs.

Arthur Davidson – Denver Public Health Department

Paul, I agree with everything that's being said. I want to go back to something that Seth brought up this morning and then Eva kind of questioned him on. So it'd be great if we can do what Deven is saying that we could get CMS initiatives to support the activities that we're describing. It'd would be great also, as Seth was pointing out, about the community transformation grants that are trying to change the way that the medical community relates to the community at large and how that interface is promoted through this exchange, and that there's ways to evaluate communities more broadly than just in this small primary care transition to specialty, but more what's going on out in the community, and how exchange can support community efforts. Now that to me is kind of a stretch, but it seems like something we should be thinking about if we are trying to align many different federal initiatives at the same time.

Eva Powell – National Partnership for Women & Families

That fits with the issue of nonprofit status and having to do a community assessment and prove that you're benefiting the community and that there's been a crackdown on that from a tax standpoint, and so I think this creates an opportunity for us to do exactly what Art has said is that using technology can really help you do this and doing it in these particular ways basically gets you that requirement.

Judy Murphy – Aurora Health Care – Vice President Applications

This is Judy. So the interesting thing then is it cycles right back to the quality measures to me and some of the things that we should be looking at from the quality measures standpoint which is not just those process things to do during the an individual encounter but impacting more on the overall health of the individual and the community.

Paul Tang – Palo Alto Medical Foundation

Okay, is informal sort of a suggestion for Stage 3?

Judy Murphy – Aurora Health Care – Vice President Applications

Yes.

Paul Tang – Palo Alto Medical Foundation

And how, so make it more concrete. She was talking about quality measures that measure the community health status.

Judy Murphy – Aurora Health Care – Vice President Applications

Yeah. So I'm struggling a little bit because for example you said an updated problem list and that's a thing, but that could lead to better quality care, right? And so that's why I'm sitting here saying that's kind of a process measure to a greater outcome that could be considered a quality initiative. So you're not going to find that on any NQF, you know, eMeasure list.

Paul Tang – Palo Alto Medical Foundation

Yeah.

Judy Murphy – Aurora Health Care – Vice President Applications

And so I struggle a little bit with articulating what you're, what you're.

Paul Tang – Palo Alto Medical Foundation

Well, but it's a kind of measure, metric that would come out of this program used to implement its incentives that has this, has the underpinnings of enabling, you know, an entire goal, care coordination, for example. And so, maybe, it's like you said, so neither the measure developers nor NQF are going to get into this business. And so nobody is really going to help make the problem list far more useful than they are now. Do you see what I'm saying? And this could be, and neither is an ACO.

Michael Barr – American College of Physicians

Unless there's a business case behind it, in which case, I'm just saying that makes the connection.

Paul Tang – Palo Alto Medical Foundation

Well you need somebody else to have, this is the connection. This is the EHR role in reforming the health delivery system. That's sort of the picture I'm trying to paint and nobody else is going to do this and nobody else is, so none of us who have EHRs, have the ability to reconcile problems. We barely have the ability to reconcile meds. Yet we need to do that. And it is our role to cause those things to be done in a really good way in the tools we're asked to use to do the new things, ACOs, medical homes, etcetera. Do you see what I'm saying?

Deven McGraw – Center for Democracy & Technology – Director

Yes I do, but I think the thing that's missing, for me in what you are saying, because it's so internally focused to how well populated the EHR is, which is, we've all recognized is absolutely critical as the sort of the first traunt of this, what I think I'm, what I know I'm getting at and what I think I'm hearing Michael getting at, is that when you set the criteria, some specific criteria around exchange, that you drill in, I like this care transition idea, that you set the exchange requirements to match up with and support the care transition payment policies, therefore linking the financial incentives to exchange to the actual exchange requirements under Meaningful Use so that it's knit together.

Paul Tang – Palo Alto Medical Foundation

Okay, so help me understand where you think up-to-date accurate problem lists do not fit in.

Deven McGraw – Center for Democracy & Technology – Director

No, they do but it's like that is step one. So, okay, you're talking foundation, I'm talking, I am assuming foundation and saying, how do you build that to the next step. You said an actual metric around exchange that builds on the accurate problem list. You don't measure exchange by just requiring an accurate problem list. That's the link that I am missing. I'm not, I'm not disagreeing with you at all. I'm saying there has to be the next step piece to that.

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

Well it is another context for actually the insurance exchanges, this principle was argued that we should require outcome measures, outcomes to be reported in every category of interest and only where we can't do we have process measures. So you begin the discipline of first taking each of these buckets and saying what's the outcome of interest here? So even the problem list case, which is kind of a tough one, is really a structural measure but the outcome of this is that the problem list might be, there is an accurate problem list available for the clinicians and the patient and family. The test of that, the outcome measure, you have to think about, like med rec, it may be the patient says you know it's an accurate problem list where they're capable of doing that. But there's some kind of external outcome measure that is important to their health. And then if you can't do that for a lot of reasons you back up to the processes that we might able to measure in our infrastructure. So, I don't know if that works very well for this

particular example but I think if we could find a rule of thumb like that, that would guide our filtering of these options that would be helpful.

Paul Tang – Palo Alto Medical Foundation

Here's a way of explaining it. Left alone, the EHR vendors have not supplied a way to help clinicians reconcile their medications efficiently. Left alone the products do not allow us to reconcile the problem list. Adding money to an ACO model doesn't make that happen. So that's an example of where I'm saying making it a certification does make that happen. I mean, has the potential of making that happen, that's why, in this particular case, because I'm not a fan of process measures or structural measures even, this turns out to be one of those things we, users, do not have available to us but we need to do to do the bigger job. And only incenting the bigger job hasn't made it happen.

Michael Barr – American College of Physicians

Paul, I think what we're trying to achieve is sort of a balance between making things required because it's the right thing to do that wouldn't happen if there wasn't a requirement, and there's no question of the value, and I think the things you just talked about fit into that category. Then there are the others that we want to drive people to use things because we're making it easier, it creates value, and it's better than the status quo. Those you want to sort of have to create requirements for because people will go that way, but this foundation of the building blocks is what you're talking about, and that's where we should focus on the requirement. I still would emphasize the requirement to build it and then the requirement to use it follows, but not necessarily at the same time because of the testing, the validation, and all of those kinds of things.

Paul Tang – Palo Alto Medical Foundation

So, other goals? I don't know where we are for that structural one but.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, I mean, I guess I sort of see it as not either or but both/and right? So I wasn't disagreeing with your point I'm saying let's do that and let's do this.

Paul Tang – Palo Alto Medical Foundation

Okay, so, what's an example of the this?

Deven McGraw – Center for Democracy & Technology – Director

Linking the exchange requirement to specific payments, like focusing what we might require in the bucket of Meaningful Use objectives that are under care coordination or exchange to payment policy initiatives so that we are following and supporting where the dollars are driving people to go. That could arguably be also in the alignment bucket.

Paul Tang – Palo Alto Medical Foundation

So give me an example, so I've captured that goal. Just, we're not getting down to the specifics right at this moment, but give me an example of how you would specifically write an objective or criteria that would do that? Amy?

Amy Zimmerman – Rhode Island Department of Health & Human Services

I have a question and this is to Josh. Can you, where is ONC on their work around care plans and how does that fit into here? Because I thought there was a whole initiative to really push and drive care planning and I think we're sort of losing an opportunity as we get into this conversation to think about what that means technically for EHRs in Meaningful Use.

Josh Seidman – Office of the National Coordinator

Yeah, no there's, the S&I framework initiative around care plans is fairly, you know, well along and certainly the idea is to provide that sort of standard infrastructure for that. Is it more specificity that you want?

Amy Zimmerman – Rhode Island Department of Health & Human Services

I'm just trying to figure out how to fit that into thinking about Stage 3. Is it, you know, is that framework and those requirements going to be sufficient to put a Stage 3 requirement to say you have to create a care plan and/or I don't know enough, I haven't followed that enough to know the technical aspects to know what that means, but it just seems like that links to the transitions of care and that whole push from ONC.

Josh Seidman – Office of the National Coordinator

Oh, absolutely and in fact there's the Stage 2 recommendation from this committee that certainly includes, you know, an expansion of the expectation around that.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Okay.

Josh Seidman – Office of the National Coordinator

And there's more detail that the S&I framework has been working on and that work is now, you know, kind of going into the standards and certification criteria discussion.

Amy Zimmerman – Rhode Island Department of Health & Human Services

I'm saying this with a caveat, I'm speaking details that I'm not sure are accurate, but as an example, with the issue of care planning, I'm not sure the approach would be necessarily to say you must do a care plan that includes x, y, and z elements. Maybe it will be, maybe it won't be, but another way to go about that, along the lines of what Deven was saying, is you ACO are going to be judged according to the outcome score of the patient experience of care and one of the main elements of that is did your provider follow your needs, preferences, and values, and did you work together on your goals? Well how are you ever going to score well on that if you are not even aware of what the goals are or if you've not made time to focus on goals and record them, and have all of the care team members know what those are? And so that would then in essence, is this what you're getting at Deven?

Deven McGraw – Center for Democracy & Technology – Director

Yeah.

Amy Zimmerman – Rhode Island Department of Health & Human Services

Is that that would then be a forcing factor in okay we've got to have a way to record and share goals and then perhaps use technology.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, I mean, that's one possible example. I think I am handicapped in coming up with something specific because I, you know, I do privacy work, I don't do payment policy. I hear about these things intermittently and I think they're great ideas. But I, so right now, the exchange requirement, you know, in Stage 1 it was test. In stage 2 it's, you know, three clinical trading partners, right? Instead of, you know, let's give people credit in Stage 3 for exchanging care plan related to reducing hospital re-admissions, right? So that's not just randomly pick three people and send them a document. But it's linked to, you know, you get to check off this box if you are participating in it and if you are involved in that program and sharing care plans with not trading partners, but, you know, the other participants in your ACO, like, you know, I think there's a way, and it's not, you know, sort of forcing people into ACOs necessarily in order to qualify for Meaningful Use, but instead saying, you're participating in these programs, you get, here's a credit you can take in this category. I mean this is just an idea throwing out there. But again linking, you know, some of these programmatic, some of these programs that are coming out from the health care reform perspective to more closely to the Meaningful Use objectives is sort of what I'm thinking about.

And I'm very unspecified I acknowledge that but I'm trying to figure out a way and maybe we just need a little more time, and I need a little more information to think about this, to have the Meaningful Use, you know, to link the dollar flow and the financial incentives that are ultimately going to drive exchange to whatever sort of exchange coordination and sharing objectives that we come up with.

Paul Tang – Palo Alto Medical Foundation

So to fit that that model, let's say you were a CMS ACO which does require Meaningful Use. So you would get a check mark because you are using your EHR in a value based purchasing program that employs health information entities?

Deven McGraw – Center for Democracy & Technology – Director

Yeah. I mean ideally one that is actually working but...

George Hripcsak – Columbia University NYC

...example is different. That's two different things. I don't think we should go the route of a checklist of federal programs that if you do it now you qualify for Meaningful Use. I think what Deven described is readmissions are important in this program so we're going to use case of readmission. Then if you're in that program because you have to do readmission you're going to be able to check it off. But our criteria are clinically phrased not program phrased.

Deven McGraw – Center for Democracy & Technology – Director

Right. Yeah.

George Hripcsak – Columbia University NYC

I mean that's what I would do and we can make the threshold so they match.

Deven McGraw – Center for Democracy & Technology – Director

Yeah. I like that better.

George Hripcsak – Columbia University NYC

So they're aligned but I don't want to put anything about an ACO in our...

Deven McGraw – Center for Democracy & Technology – Director

Yeah. I like George's articulation better. Yeah he drilled down on it in a much better way.

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

So an example would be instead of saying, maybe you could say, instead of saying you know trade with three clinical trading partners or if you are in an ACO and you're exchanging information, well listen, if you are exchanging information with the ACO, the ACO is already exchanging information. That already gives you access to multiple partners.

M

I would, you can do that...

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

We can suggest that there's different ways of meeting the criteria but I wouldn't suggest that we change the criteria.

Paul Tang – Palo Alto Medical Foundation

Okay. So.

M

I just don't want to say the word...

Paul Tang – Palo Alto Medical Foundation

This fleshing out is what we'll do in the next stage so other goals? So, one is link the capabilities of the EHR to the payment reform model and we'll figure out how to do that later.

Deven McGraw – Center for Democracy & Technology – Director

Yes. I wanted somebody else to do the details on that.

M

But it's important when we generate our mission statement for Stage 3 we have to define what we mean by link and so I'm saying by link we shouldn't be mentioning any of those programs, so an ACO goes down, you know, we decided ACO is not the way to go we don't have Meaningful Use go down with it. So I guess link means align. I think it's align more than link.

Eva Powell – National Partnership for Women & Families

It's like not specifying a technology, don't specify a program.

M

So pick the use cases and thresholds so that they match.

M

Right.

M

Which is different than saying if you do ACO then you qualify.

W

Yeah. Yes.

M

Otherwise we don't need Meaningful Use we just say do the exercise.

Paul Tang – Palo Alto Medical Foundation

Other objectives or goals for Stage 3?

Judy Faulkner – EPIC Systems Corporation

Can you just reread what you have there?

Paul Tang – Palo Alto Medical Foundation

So far, it has been check, check, and check what we've done so far with some of our original goals, care coordination, reduced disparities, safety, efficiency we haven't touched. Revisit those and see are there outstanding goals that we need to make sure are included in Stage 3. This whole notion, I think this link between David and Deven is try to have some of the Stage 3 requirements support the anticipated payment reform model in some ways. And then there may be some structural things that complement that, like up-to-date med and problem lists. More goals?

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

Paul on the regional level bring patient and family engagement up there as well. I'd go back to trying to think more about this question of what outcome would we like to see in 2015 in each of those categories. It's hard for us not to be backing up the process way of thinking.

M

Right.

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

I think this stuff's going to come out if we go back to those original goals. I think if we just sort of work our way through some of those, that a lot of these issues will come back in that same framework. I mean we were pretty happy with those. They were pretty inclusive.

Paul Tang – Palo Alto Medical Foundation

Well, let's start working on them now.

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

Yeah.

Paul Tang – Palo Alto Medical Foundation

Category one was improve quality, safety, efficiency and reduce disparity. So, we've been working fairly heavily on the quality. I think safety and quality are pretty linked and there are some let's say medications, drug interaction, things like that. We've not touched on efficiency.

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

I think one of the things about the safety piece that continues to trouble me is how that information, and I don't know whether this is out of our purview, but I worry about how the information is current and updated, you know, that this is, that the information on, especially when you think about the pharmaceutical information and stuff like that, we're becoming increasingly dependent on the technology around pharmaceutical information and new information is coming out all of the time. And the question I asked yesterday about you know, how's that being updated and to what extent are vendors required or even engaged in thinking about the content component of this? I don't know where to go with that but I know it's a huge issue and people on different systems are being supported to very varied degrees by this. So is there a way that we could enter into this space without drowning?

Paul Tang – Palo Alto Medical Foundation

Well one of the ones you mentioned was pharmacy and it's, I'm trying to remember, we had a requirement that, I remember John Hopkins I think tried it, and then it just totally tanked because the pharmacy systems and the retail pharmacy maintain and in all of your meds expired, used up or not. So if you go into look up, you know, one of these retail pharmacies as I just did you'll get all this, and that's really hard to reconcile with your "active" meds. So, in fact, yeah.

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

When you're talking about med reconciliation kind of situation.

Paul Tang – Palo Alto Medical Foundation

Well yes.

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

Can I just give the example that I was thinking of, was like around the new information comes out around simvastin 80, okay and every, are we looking to a point where every physician in the country has to now figure out how to integrate that into their electronic health record? Is there a way to take a requirement that says at a minimum, within a certain amount of time, the systems that people use, you know, that we suggested the systems that people use, you know, have a month to be able to at least include new black box warnings in their medications, you know, medication warning system. I mean can we get to something that's more sort of timely, in a way that really connects information to providers at the point of care in a better way than we have done so far, at least around some of the big, big, big important critical things because that's where I think we could create some real contribution around patient safety and medications.

Paul Tang – Palo Alto Medical Foundation

So, I think our issue is we don't have any leverage over the medication databases.

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

Well we have leverage over, we have indirect leverage over the vendors to move in that direction by suggesting that it become a certification requirement, that black box warnings be part of the certification criteria, you know, that at least information on black box warnings be part of the certification criteria for electronic health records. I mean I'm out of my comfort zone here.

M

So let's think about this. So, I mean this is like a bigger issue which is to what extent do we need to have, and I'm just being a just a little bit facetious, have a big control panel where someone, you know, centered in Washington can flip a switch and then every EHR would follow that. Now it sounds silly, but I mean to some extent, you know.

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

Exactly.

M

So what does that mean and how and when we discover that some drug is killing people, we want to be able to flip that switch quickly because we'll save more lives, but then that we want to have competition, we have vendors and so on. So figuring that out is part of our mission to figure out our strategy how you would get information.

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

We have a federal agency that puts out, that mandates that people get warnings for critical, for critical information.

M

That's right so we already have the switch.

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

So we already have one, we already have the content.

M

We just need to get the switches is going.

M

...

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

Yeah and get it incorporated into the EHR.

M

You're right we have the flipper; we don't have a way to manage it into the EHR.

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

See what's ridiculous is that we can manage a change in a formulary, right? So if some payer decides to stop paying for something we can manage that, but we can't necessarily manage a timely connection between a new FDA warning and what people are being presented at the point of care. That to me seems ridiculous.

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

I think this is one of these things that we're getting in, and I don't think this is exactly where you're going, I understand where you're going and I agree with it, but in the specific, you know, the FDA warnings for example, and because of some work we've been doing, I've come to understand much, much more about how those get in there. Our good example of where there

needs to be some clinical judgment involved in the decision-making about that and it shouldn't be an automated process. That a black box warning does not mean, for example, we have had FDA officials assert this, do not mean that that drug causes that problem and so, you know, so do you really want to deprive a bunch of patients, you know, if.

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

Well what it means in my practice is I would like everybody to at least consider that warning.

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

Yeah.

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

Not necessarily that you can't prescribe a medication.

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

Well perhaps, I mean that may or may not be what you want to do.

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

Okay.

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

I mean you may want to do that, not everybody may want to do that given the level of evidence and the cost. I don't mean the financial cost, I mean the time, the patient inconvenience, and the patient risk that goes along with that. So that is why I mean where it gets into some judgment for some of those things and that's more a specific, but your general assertion that we ought to have a good way to get medical knowledge available to people when we know what it is in a timely fashion is clearly, you know, one of the reasons for doing all of this stuff, and so we are starting to talk about how knowledge or clinical decision support rules, or workflows get shared, disseminated the same I think.

Paul Tang – Palo Alto Medical Foundation

Joe?

M

So, this gets into the issue that David raised which is the boundaries of what the EHR system is. I'll tell you in our system, the way we do it is we can take a whole bunch of information from our EHR system and we have to put it in a separate sequel server database. When an FDA black box warning comes up we can run some SQL procedures to pull up lists of veterans, we can send those lists to the providers and they can exercise exactly the kind of clinical judgment that Mark just described. Whether or not that's a built-in function of the EHR, you know, or whether you encompass the whole information management process as part of your healthcare delivery, you know, I think you can make this so big that you can't comply. I mean all you need is a system that you can basically, you know, spit out data and then you can process it in other ways.

M

Just as an anecdotal information the way our system works is we subscribe to micromedics and as soon as those things are available, they dump them into our system and that's the program we use that gives all of the drug-drug, drug alerts, the drug-drug interactions, and the drug-allergies interactions.

M

The only problem I'll just say is that won't work in small or medium-sized practices. It won't be able to export that kind of information due to the analysis and then make an executed clinical decision. So I think somewhere in between there is the answer.

M

It doesn't work in our world either. We use micromedics but it's the pharmacist that does it not the doc.

M

Well there you go.

W

I just wanted to say that I know we're being conservative about like too much clinical decision support, putting too much in, but this is the last bite of the apple. There's no other stage after this. So the fact is we can, I'm afraid to be not prescriptive enough because it can always be overruled through the rulemaking process than too prescriptive, because I think there's a lot of science that comes out that doctors don't have time to review, don't have time to read done at the point of care. My best example is when I was visiting Neil one of his physicians actually mentioned that there was an outbreak of East Nile virus, of West Nile virus in New York and he said, you know, he was the one, he had a patient come in three days in a row, didn't recognize the symptoms and the alert popped up that he should check for West Nile virus. The surprising thing was, he had put that into the system two weeks earlier from looking at the medical literature, but he had forgotten because he had a long day at the practice.

So what I'm trying to say is I think some of this putting the information at the time, not necessarily telling you you can't prescribe this medication, or this is how to practice medicine, but helping doctors get the information in real-time is the role of an EHR, is the role of clinical decision support, and I think prescribing it is something we can do and the rule making process can always overrule us later on, but I think if we don't take our bite of the apple now, we'll never have a chance.

Paul Tang – Palo Alto Medical Foundation

So let me point out that this isn't the last stage. The last stage is incentives but the HITECH authorizes the secretary to have future stages but there's an indefinite penalty period. But, can I capture what was just said as timely, safety and public health notifications, West Nile virus is a public health, so as a goal, and then we can worry about an instance of example was the medication black box warning or West Nile virus in even your locale, but that kind of thing. The function is to get timely information that comes from the community. It can be meds across all, you know, simvastatin 80 or it can be West Nile virus in your locale, but that kind of notification at the point of care is the function, is the goal. Did I capture that correctly then? And again, we have to drill down on well how do you turn that into an objective in criteria.

M

I mean that's not just safety it's quality but that's fine, that's close enough.

Paul Tang – Palo Alto Medical Foundation

Other goals at that level? So we talked about the alignment with the anticipated payment model. The timely notification for safety and quality and David you look like you're about to say something.

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

Yeah I was just going to throw in on the patient safety one.

Paul Tang – Palo Alto Medical Foundation

Yeah.

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

Around that. In the original 2009 draft we once had a version that had essentially adverse event knowledge as to how many alarms are going off, what results from them to the extent we could come up with an outcome measure that was really are we reducing patient safety events

in the practice setting, that's a more powerful, and then we don't care so much which decision rules or interfaces with, you know, other vendors are in place if we are able to monitor and get feedback that adverse events are reduced, and whether it's just in a medication area or other areas that would be desirable. So the spirit of our 2015 objective was to get to that where we can and by then we'll be four years into medication monitoring.

M

And then you tune your system to have the best signal to noise ratio.

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

That which is really important.

M

...

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

Are there other hospitals safety things that we want to, I mean, I know we have VT prophylaxis but is there anything else from the hospital safety side that would be relevant?

Paul Tang – Palo Alto Medical Foundation

Well should we just characterize it as never events? Because you certainly always have “decision support” but what global rubric would you want to work towards? Joe?

M

So, one thought's that I had, a lot of the discussion around EHR tends to be physician centric, you know, what does the doctor do, what does the doctor order or not order or document. There's a lot of things that are events in hospitals safety related that are nursing oriented and I think paying attention to patient functional status, skin integrity, pressure ulcer, both identifying risks, and mitigating risk are hugely important and they've tended to be under discussed in most of these types of settings. So it's sort of, you know, nursing and ancillary care, and maintaining functional status. Again, you know, we're looking at some algorithms that could identify risk for falling and then interventions that could make a difference there.

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

You see we addressed this when we were looking at the measurement stuff. We were looking at measurements around patient safety. But we never really looked at documentation, you know, potential requirements for documentation, the way we require CPOE, you know, we haven't really looked at the potential documentation issues around some of those things that may or may not currently be included in hospital based electronic health records if some of them can contribute to increasing patient safety.

W

And. Sorry go ahead.

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

No so I would just put that on the board for people who know more about this than I do, but.

Paul Tang – Palo Alto Medical Foundation

So the documentation of...

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

Whether or not some additional inpatient documentation requirements around areas that might improve patient safety should be added to, you know...

Deven McGraw – Center for Democracy & Technology – Director

Is the pressure ulcer issue a safety issue or a quality of care issue, the one that was raised by the testimony yesterday?

M

This may be another area for alignment with JACO requirements?

Paul Tang – Palo Alto Medical Foundation

But do we really want to go, back to the link thing, if we did something like never, ways to depend and mitigate and prevent a never event, then as the field changes the never event you catch that. And really it's a, you know, we have to get into a combination of surveillance technique, it's coding, it's documentation, it's decision support, it's reporting that capability, and that's sort of where we wanted to go. How do you have all that capability to deal with never events? That's what we want in the EHR. Do you see what I'm saying? I'm trying to avoid the structural and yet something that can grow over time because there will be an increasing number of never events. And a different alternative would be to look at readmission. That's specific but it's encompassing. So readmission all of a sudden talks about transitions of care, it talks about timely notifications, it talks about surveillance, you know, a care plan. Trying to find these global things that we can build up the structural ways to tackle those goals. Does that make sense?

Eva Powell – National Partnership for Women & Families

Another idea along the lines of what Neil just said in terms of documentation is as we move toward greater transparency of information to patients and their families; they then become part of that safety equation in terms of validating whether or not the information is accurate. That's the main way it's linked up to that. So there may be something there as well. I see a lot of connection in a lot of these in these areas that we've opened up by moving in the area, in the direction of transparency to patients where patients can be part of all these things. But we need to design systems and criteria and policy to make sure that they're used in that way. So if there's something that we can do around the notion of without saying exactly how this is done, patients and families should be part of validating the information or I don't know.

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

You mean accessing. I mean the whole issue of accessing information, you know, on the inpatient side is huge. It's a leap but it really, you know, it's the right leap whether or not we want to put that part for Stage 4, but I mean people should have access, people and families need access to timely information when somebody's in the hospital not just when they're outside the hospital and, you know, both to be able to validate information there, but also to be able to say what's missing and to be able to know what's going on. We should definitely put that on our list of things to consider.

Eva Powell – National Partnership for Women & Families

Yeah, as I heard it put at an IHI meeting, said by a patient "who cares more about my safety, me or the health care worker" and obviously both care but the individual patient is primary.

Paul Tang – Palo Alto Medical Foundation

I'll put that under patient engagement in the goal.

Eva Powell – National Partnership for Women & Families

Yeah, but I think it's helpful to make those links too that we're, it's not just patient engagement it is also is a strong component of safety as well.

Judy Murphy – Aurora Health Care – Vice President Applications

This is a really important area I think to go toward, you know, Eva's right, the most current research on patient falls regarding, as a safety issue in the hospital, is related to patient engagement, that if you help the patient see how important this is as a topic for them and how their potential mentation has changed while they're in the hospital, because of the medications

or whatever, engaging them and the family in some of the strategies to prevent the falls is just the most important thing to do. So, I don't like that documentation word though and I don't know if we can live with, you have documentation up, because that means you're like just writing about it. Usually we refer to that as the orders or the care plan to address the safety issues or address the quality concerns. It's not just the documentation. Well I would say care planning.

M

I would say care plan and practice support, in other words not just decision support or something like that, it's the moment in time the doctor had when writing in the order. It's really about over the longitudinal episode of care you provide practice support to all the healthcare team and that could mean access to information, it could be clinical decision support, protocols, hospital approved protocols, or you're preventing functional decline.

Paul Tang – Palo Alto Medical Foundation

Marc?

Marc Overhage – Siemens Healthcare

Are we getting down this hole where we talked before about policy and process a little bit or at least I did, it feels like we're getting into these very narrow things and would it make sense to sort of say what do we need the systems to be able to do here? We need the systems to be able to measure these bad outcomes, adverse drug events in some way. We need to capture or measure them. We need to capture the fall events. We need to be able to measure and characterize those. Somebody else is going to help us say which things are important right now. This gets to David's point a little bit about these policies will evolve. You don't want amend regulation, you want them in, so I'm wondering if we're getting too far down the plinko, yeah, I like that analogy with ICD-9, and only come up and say what is it that you need in order to be able to do that. Well you need to be able to measure the events at least in some way. You need to, you know, have the tools that you need to improve it so those might be alerts and notifications and so I don't know are we.

Paul Tang – Palo Alto Medical Foundation

Yeah, so is that affected by adverse event surveillance?

Marc Overhage – Siemens Healthcare

It is. And I guess I was trying to think about how we level the rest of the things that we have there sort of more at that level.

Paul Tang – Palo Alto Medical Foundation

So, and then work our way down. And in fact, I mean, this can be a strategy for future, 2015 out, and say, look, you know, if we're going to turn this whole thing around in two years you may have to have a roadmap, but actually that's what the vendors were asking for anyway is a roadmap for future years. Let's go back and realign our goals for future stages and try to get them at the same level. So, let me start with, I think one, so what we just said adverse event surveillance, right? Its detection, surveillance and mitigation let's say, because then there's a lot of things that support that.

Judy Murphy – Aurora Health Care – Vice President Applications

Maybe add the word prevention?

Paul Tang – Palo Alto Medical Foundation

Prevention?

Judy Murphy – Aurora Health Care – Vice President Applications

Yeah, we should have caught them when they happen right?

W

That's good.

Paul Tang – Palo Alto Medical Foundation

Okay, so that's, another one is this whole alignment with, alignment with future payment models is that at that level? That might be a little higher, but.

M

...

M

...

Paul Tang – Palo Alto Medical Foundation

Okay, another is if the patient is, patients and, is there a more descriptive word? Perhaps a little narrower than engagement? So it's like keeping them informed? Keep them as partners?

W

Partners?

W

Did you say partner?

Eva Powell – National Partnership for Women & Families

Yeah, I mean, the way I think, because I think Marc is right and that we should stay at the policy level, but I feel like so much of Meaningful Use has been geared toward and the discussion has been focused on physicians and understandably so. But I think part of what we heard yesterday and part of just what's inherent in our conversation, is that future criteria really have to move more into ancillary staff and perhaps that's just a point of clarity on our part in terms of making sure people understand that when we call for certain information to be collected or however the technologies is to be used, it doesn't have to be by the physician, it could be by whoever. But then also the notion, and this is a cultural change, which is why I feel like we need to somehow incorporate it in our criteria of making sure that information is not just transparent to patients and families, but that they are actually included in the team in terms of effort. And so, I don't know how to say that.

Paul Tang – Palo Alto Medical Foundation

How about partnership?

W

I like partnership.

W

Yeah, yeah.

Paul Tang – Palo Alto Medical Foundation

Partnership still will talk about both access and contribution.

W

Right. Right that's good. Contribution is a good word too.

Paul Tang – Palo Alto Medical Foundation

Because that is clearly a step up from "engagement."

Eva Powell – National Partnership for Women & Families

Right. Right.

W

Yep.

Paul Tang – Palo Alto Medical Foundation

So it's access but contribution. I like how that's put because now we are talking about, there's a word used in project health design observations of daily living and that's part of your contribution as a.

M

So this may be a subset of that and you've talked about this before, Eva, in maybe a different sense or maybe the same. There's sort of patients as proactive sources of information. I know you specifically, at least what I had in my head when you were talking, and maybe you were thinking more broadly, was sort of okay before the visit, you know, do you smoke or not type things but there's clearly the, on an ongoing basis, how are you doing?

Eva Powell, National Partnership for Women and Families

Right.

M

You know a month after your knee replacement are you, you know, is your pain better? Is your functional status better type things and that's a capability that probably is very much a system...capability in the sense of ancillary providers, computer systems, text messaging, and portals, you know, whatever to get that done.

Paul Tang – Palo Alto Medical Foundation

So do we want to focus that health and functional status under patient partnership or is it part of CQM? There's a different, there's a nuance to that, because in fact if you put patient partnership by definition it is coming from and for the patient. If you build it into CQM it gets used mostly on the other side. So, that is a little bit of a nuance that could be important for us to put in one place or another or you could put in it both, that's fine.

W

Well I was going to say, I mean, if you're sort of driving the actual interaction that's, you know, on the more process, but then measuring, you know measuring it is, I mean, I don't know why we wouldn't want to consider possibly both.

Deven McGraw – Center for Democracy & Technology – Director

Right.

W

I mean in actuality, how would you ever validate it happening without being able to measure it in some way, shape, or form anyway.

Paul Tang – Palo Alto Medical Foundation

Okay. Boy isn't that, that's partnering. That's true involvement because now you're applying the data up against the information. Okay, other high level?

Judy Murphy – Aurora Health Care – Vice President Applications

Before we move on from the patient partnership, it's a similar conversation around a patient centric record or I have to call it a record because right away we think of the facility. But does that belong in, you know, the care coordination HIE type stuff or does that belong here too. It's like a similar argument to the one we just had about quality and functional health status, because why am I contributing, you know, what better way for me to know what's going on than me to be contributing and to be part owner of this patient centric record.

W

Can you repeat the question, I'm sorry? Judy?

Judy Murphy – Aurora Health Care – Vice President Applications

The comment you mean?

W

Yeah. Yeah.

Judy Murphy – Aurora Health Care – Vice President Applications

It was more of a comment like we just had this discussion about function in health status and whether its quality or, you know, patient partnership. We can have a similar conversation about a patient centric record and whether that belongs in this care coordination piece or whether it belongs here as well, because the patient contributing and being part of it is what makes it so powerful as being patient centric.

W

Right. Right.

W

Actually any...developed a full set of measures specific to patient engagement that are measures that need to be, that they want them to be part of an EHR that are asked of the patient. So it's not the patient's PAM score but it's a similar set of measures about the, that require the patient to be engaged in their EHR by entering that information that would then influence how the doctor provides the care.

M

I'll just say that Debra Ness and I are co-chairing the, what are we calling it, patient generated information education from the, help me, from the Brookings Institution, the QASC sub-group, quality alliance steering committee. So I think that this is something that we'll be again shooting for down the road. I think that would be a very important thing to put in there. So, patient generated information being incorporated into the electronic health record.

Paul Tang – Palo Alto Medical Foundation

Okay to stimulate further high level goals we'll go through the categories we have, improve quality, safety, efficiency and reduce health care disparities. Any high level goal that has sort of can be captured in.

M

So, there was one item that came up in the discussion this morning with Seth about disparities and there is a desire within the public health community to capture the occupation and industry and that's an area that we are not currently capturing that would help us to define potential disparities.

Paul Tang – Palo Alto Medical Foundation

And that's important. That's a detail, so what's the global.

M

Expand the groups that we're able to identify where disparities exist.

M

Like demographics.

M

Yeah demographics.

M

...discussions with the committee were around more granular demographic data, right?

M

Right.

Paul Tang – Palo Alto Medical Foundation

Okay.

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

There were a number of things that got left, sort of put on the side, granular ethnicity is used; country of origin was another thing that came up. LGBT community responded around collecting gender preference and gender and gender and.

W

Orientation, yeah.

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

Yeah, thanks. And there was another, oh and then the issue about outcomes. We had talked about, you know, being able to look at quality outcomes based upon the characteristics that we were capturing in the demographic fields, being able to parse the quality outcomes.

W

You mean reporting on a, on a stratified level? Is that what you're referring to?

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

Yes, stratified reporting.

Paul Tang – Palo Alto Medical Foundation

Okay, so in the general rubric, sort of more granular demographic information.

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

But also putting it to use right?

Paul Tang – Palo Alto Medical Foundation

So the goal is similar to our original which is reduce health care disparities. Okay, patient engagement I think we just touched, we just sort of re-characterized and I think in a broader way, in a more active way.

W

Can I add just one thing to that?

Paul Tang – Palo Alto Medical Foundation

Yes.

Eva Powell – National Partnership for Women & Families

And I think this may hit on other levels as well. But something that we heard yesterday was the need to foster innovation and I think particularly related to patient engagement there are lots of ways that we can encourage things that people are inclined to do but maybe have put aside or are not getting credit for thus far such as texting or eVisits or ways that you can really meet the needs of patients and therefore engage them, and also make life better for providers by encouraging those kinds of innovative approaches, which admittedly have some of them some strong connection to payment reform, but to the degree we're able to say give a multiple choice option for you must innovate in the use of your health, of your EHR or whatever in one of the following ways. I don't know, that's just an off the record.

Paul Tang – Palo Alto Medical Foundation

I could I capture that as one of our goals is innovation flexibility? Is that sort of the message? And so as we go through these things that's our reminder not to be prescriptive, especially in these out years and to "give credit" for that kind of thing.

Eva Powell – National Partnership for Women & Families

Right. Right.

Paul Tang – Palo Alto Medical Foundation

Okay. Care coordination. We probably could say that's better. We didn't have ACOs, bundled services, etcetera when we first came out with this. What's the more aligned way of saying care coordination? Care plan knowledge that would fall under this. So what's the goal?

M

Is it something.

Paul Tang – Palo Alto Medical Foundation

Not a bad way.

M

Is it something like seamless coordinated care?

Paul Tang – Palo Alto Medical Foundation

Across settings. Be more explicit about how it approaches the settings rather than, you know, it could have been the specialty primary care.

M

Yeah.

W

And provider's types, this is where we can bring in the non-eligible's, because they kept mentioning that there's.

M

Formally an informal providers.

W

...not eligible but that information affects how you coordinate care.

W

Right. Oh yes.

Paul Tang – Palo Alto Medical Foundation

And so would the care case seamless care coordination or...

M

Joe's got the word.

Paul Tang – Palo Alto Medical Foundation

Joe...

Joe

Well, I just, you know, was trying to harmonize across some of the other work groups that are meeting in other realms not just Meaningful Use. I think the map is adopting this concept of a patient centered episode of care of which is a continuum starting from, you know, prevention to acute episodes, to follow up care, or chronic care and that's becoming now part of the parlance

so, you know, supporting a patient centered episode issue. It's just a way to capture the whole thing.

Paul Tang – Palo Alto Medical Foundation

It's a little...to the patient center because it's been abused so much, but I know the concept we mean but it's just become.

Joe

Then you could say supporting the full episode of care.

Judy Faulkner – EPIC Systems Corporation

Doesn't it go beyond an episode of care? I mean don't we want it to go beyond?

Paul Tang – Palo Alto Medical Foundation

Should we go to health? So make the transition to health, so that would fit with the National Quality Strategy.

M

Again, but what they're trying to do is get beyond that episode as defined by when you're admitted or when you're discharged and more to the management of this episode, which the episode may be until you die if you have say type 2 diabetes you know.

W

You know, yeah, I mean, I think it's interesting because I don't think the average public hears or thinks or providers think of episode in that way. So, it's a, when you, if that's what's meant, then I applaud that, but changing the terminology and it's general expectation and understanding of that I think would be a challenge personally but you know.

M

Well, I mean, I think it's more meant to encompass things like the after care, you know, and I think they're actually drawing some temporal limits, so like for chronic disease management they're not really looking beyond, you know, a window of a year or two. But, you know, the seamlessness has to be in essence defined by what it is that you got, you know.

W

Yeah I would say it is a continuance, you know, it's a continuance I think.

W

It also states that with measured grouping, that's what Denni brought up, I'm looking at the notes, she was talking about grouping measures by diagnosis and classes for an episode. So beyond, just, you know chronic disease or long-term, what about patients, what are the kinds of things that you might see through an episode of care that we'd want to track together? So grouping those measures. So if you're tracking for example hip fracture what are the other things you want to think about as you are going through it, depression, you know, mobility, pressure ulcers, you know, putting measures together into categories so that it becomes an episode as opposed to just looking at it in discrete intervals.

W

Well and there's an element, part of what I heard yesterday was the plea to incentivize collaboration between hospitals and physician practices, but I think, while collaboration doesn't get entirely at this concept, there is that element that I think is a little more specific than care coordination, but collaboration among the entities in the community. And every community is going to have a different list of those to meet the needs of the patient. So the hospital and public health, and physician practices, and nursing homes, and social services, and school systems all have to work together, and figure out where are the gaps in the community, and

how do we encourage that kind of collaboration using health information with the obvious limitation that health information is not the only information at play here.

Paul Tang – Palo Alto Medical Foundation

So let me try this phrase out on you. So, seamless support of individual health and care across the continuum and sites, and caregivers, professional and non-professional, it's a mouthful but I think it captured the things that you all were saying. So one is the episode, I mean life is not a series of episodes, life is a life. And so the seamless way of worrying about, of addressing your health, the health of individuals with all of the people who touch it, it could be professional, non-professional, sites of care, it's really across, and continuum also sounds like a care, you know, in a sense our terminology is very care centric. And so to get to the triple aims, the third point, the second one, is if we talk about the seamless report of health, considering all the things it touches. So that's professional, non-professional, living and non-living.

W

Yes.

W

Well and I think an important element of that, and again I recognize that there's a limitation here, but I think we do need to encourage the healthcare system and those in it to reach out to those outside the system that impact health as well. I think your use of the word health gets us part of the way there but we still need to signal that we are not talking about exclusively about traditional healthcare system players, that we are talking about how the healthcare system needs to reach out to other members of the community, and again, with the understanding that the healthcare system is not going to do everything, but there needs to be a linkage there. And given that particularly hospitals but other healthcare providers are often leaders in communities that it's incumbent on them to do the reaching out, that there needs to be that component there. So maybe you can add something health and non-health related. I don't know exactly how to say that.

Paul Tang – Palo Alto Medical Foundation

I will put back in the care. So the seamless support of individual health and care across the continuum with all care givers professional and non-professional.

W

I still think that is exclusively healthcare systems. Like where would you see school systems in that?

Paul Tang – Palo Alto Medical Foundation

Well they're non-professional caregivers.

W

Oh, okay, I see how you're thinking about that. I don't think of a school system as caregiver though.

Paul Tang – Palo Alto Medical Foundation

Yeah. I agree with you. So, let me use this as a...

W

Yeah do some wordsmithing. Yeah, yeah, yeah. I think that's good.

Paul Tang – Palo Alto Medical Foundation

...but that's the concept to get away from being, see patient centric is care centric. So to get away from care centric and to start talking about health and start talking about the social determinate to health.

W
Yeah.

Paul Tang – Palo Alto Medical Foundation

So that's what is supposed to be based into that, which I think is a pretty new category.

W
Yeah, yeah.

Paul Tang – Palo Alto Medical Foundation

And then we'd have to go to...

M
One of the things that I'm worried about with the, and I agree with it all, but on the other hand we're saying we haven't even gotten providers to talk to each other.

W
Yeah.

M
And, you know, I'm sensitive to the fact that, you know, we may not have lots of other levers and tools going down there, so you sort of want to set the trajectory, but I'm really worried about saying something that's like, yeah sure.

M
We all agree...

M
Yeah, well not only do I agree it can't be done, but I feel a tension there with, you know, how to, because it's the right thing to do.

Paul Tang – Palo Alto Medical Foundation

So if we set it as a goal of "future stages" vendors like yours wanted a roadmap and in a sense, it allows them to get "credit" for doing something ahead of its time.

W
Right.

Paul Tang – Palo Alto Medical Foundation

Do you see what I'm saying?

M
Yeah.

Paul Tang – Palo Alto Medical Foundation

You have to say somehow find a way to get more information from out of the care setting before 2017. Well that's just, it's on the roadmap. If we don't put it as a goal it's sort of like, you know, we've got this box.

W
Well and there could be other drivers. There could be community-based drivers that have nothing to do with the healthcare system that force providers in a way that we couldn't do central to the healthcare system.

M
Right.

W

Well if you are going down that route, I would say then going back to some what you said earlier around capturing some of the better known social determinants in health in terms of data capture would, I mean, if we're going that far long down the road.

W

Well and I think the big thing is it allows communities to do exactly what you're saying is identify where are our real health disparities or our health needs and what contributing factors are there and I mean that is something that we could never say on the national level. It's a community specific thing and if there's incentive to get them to actually take that look at what they're doing, which I think there would be, then this will allow for the kind of innovation.

Deven McGraw – Center for Democracy & Technology – Director

It does make me wonder if there's room for discussions of waivers. If a community were to develop a plan for health improvement that involved its providers that there might be a way to sort of weight, you know, allow the providers to take essentially a different track.

W

Right.

Deven McGraw – Center for Democracy & Technology – Director

To meeting Meaningful Use in the later stage that was connected into a community, an organized community program that was essentially approved by CMS through some sort of waiver process. I, you know, I like the community idea. I don't see how we can say all communities must create one.

W

Right.

Deven McGraw – Center for Democracy & Technology – Director

But, if we leave room for the creation of good ones that are aimed at specific issues that are being faced in a community, that are aimed at health disparities, that are aimed at quality improvement and cost reduction in specific areas, and that bring in some of these social determinants that we can't really reach. Then.

W

I like that and not ever community...

Deven McGraw – Center for Democracy & Technology – Director

I mean, I don't know what it looks like, but it just sort of feels like it's almost like we are signaling a way to sort of, if the vendors are looking for a roadmap, you know, we're maybe even if just signaling if you can create these connections in communities like it.

M

So, Deven, if I understood what you're saying, so specify that technology has to support data feeds from barber shops, beauty parlors, pharmacies, grocery stores, those kinds of things to get the data from the community that will then be used in the health care system?

Deven McGraw – Center for Democracy & Technology – Director

Well, but that's why I'm saying.

M

Is that what we're talking about?

Deven McGraw – Center for Democracy & Technology – Director

You don't create that as a certification.

M

No, no I'm just saying, but if you're trying to collect information, I mean we are talking about Meaningful Use of electronic health records, I'm asking, is that what you would envision in terms of a community information, looking at health disparities being part of the clinical record at some point?

Deven McGraw – Center for Democracy & Technology – Director

Well I don't know that it would need to come into the clinical records. I mean, I think it depends on, because I really struggling with where the hair thing comes into clinical records, but having said that I think.

M

Well, but a lot of conversations and, I mean, a lot of social programs go where the people are.

Deven McGraw – Center for Democracy & Technology – Director

Right they go where the people are for outreach.

M

So if we're going to go and view all the professional and non-professionals why not hairdressing?

Deven McGraw – Center for Democracy & Technology – Director

Right. And, you know, Paul and I are working with the Robert Wood Johnson Foundation on their sort of, you know, looking at patient observations of daily living, right, some of which can take place in a hair salon. And when they feed into the clinical record and there is absolutely, you know, they are finding in doing these experiments that in fact some of the information is not really relevant to the clinical aspect of the care, but it is relevant to the overall outcome that gets achieved as a combination of clinical care and patient's health management, and support. And so I guess what I'm envisioning is that, is that if there were a waiver program that you might be able to expand the notion of sort of what we're trying to achieve here that has clinical care as one component, but isn't expecting clinical care to sort of be the driver of achieving all of the outcomes.

W

Right.

M

You know I would like to just add here, it doesn't have to be into the clinical records. There may be another place that this data may be aggregated that serves the population. So while Paul wrote a great line for us to kind of focus on, you could change the word individual to populations here and the aggregation of the data could be an entirely different environment.

W

But I would...

Deven McGraw – Center for Democracy & Technology – Director

...the clinical record.

W

I would say though that there are some things and, I mean, I don't use a medical record, so maybe they're in there and I am naïve, but housing stock, access to, you know, fresh fruits and vegetables, I mean there are things that are very, there are social determinants, you know, violence in the neighborhood, that I think could be and would be appropriate perhaps to put in a medical record especially if there's more of a focus on a patient centered medical home or

someone else that is going to help deal with the whole social environmental aspect of health. So, I mean again, I am not talking immediate, I think this is further down. I think some of those I think are not appropriate to put in a medical record, but I think there are some things more from a social determinants that do play into health and would be important.

Deven McGraw – Center for Democracy & Technology – Director

Yeah, I mean, if the clinician is going to use them then.

M

Not necessarily just the clinical team. You've got to go broader...

Deven McGraw – Center for Democracy & Technology – Director

Right.

W

Right. I was not necessarily saying the physician, I was talking about, because I think in environments where payment reform is going to a more team oriented approach to provide the additional social support that family's need, you know, that families and individuals need, then I think some of that information would be important to capture.

W

Yeah, and one way to talk about that, I think, in the context of what might be included in the record itself, because I agree not all of this needs to be or can be included in the medical record, but the notion of patient strengths and patient needs, and if we phrase it that way and obviously, you know, there's a standards issue, how you standardize that, but the concept of gathering not only goals but what are the patient's strengths and needs relative to those goals, that gets at something that would seem reasonable to capture in the record itself, and then have other data sources that take a more population or community based approach that then gives the provider a sense of what linkages might need to be made or can be made to help support the needs and take advantage of the strengths.

M

Sorry, one more quick comment. I think Art you hit it on, I agree with you myself, but the community context could be something that could be done by the data collection as you described. And I think part of what we ask practices to do is design programs and services to meet the needs of their population, but it's just the folks that comes to see them that they know about, they don't know about everything else going on, so speaking to what you said Amy and what you suggested Art, I think this could be a really, really interesting way of providing that context for the clinical care of individuals based upon the population in the communities in which they live.

M

Can I just say that the ocean response to Deven's suggestion about a waiver, that there may be a different way to achieve local value in exchange in information that doesn't necessarily have to do with trying to get all these data into the clinical record, and that's where I was headed with this.

Paul Tang – Palo Alto Medical Foundation

Let me pick up on your suggestion Art if it is possible, since the fourth category we're going to is public population health, is it possible to combine or it desirable to combine the sentence about the individual and just add population? Would that consolidate the two?

M

Yes.

Paul Tang – Palo Alto Medical Foundation

And in a sense, what you're doing is instead of saying "well here's another public health function" you're saying "it's individual, public and population that happens every time you contact somebody."

M

Right.

Paul Tang – Palo Alto Medical Foundation

How's that sound to folks? It's really combining that. So, not only is it seamless, it's also at the same time recognizing the population affect, the community affect, the effect to the individual. Okay. So, let me re-read these. I think they're really quite nice. So the goals of future stages, 2015 plus, not just Stage 3, is, and not probably in this order, so adverse event detection, detection prevention mitigation and reporting, that's a tool that gives us a way to go fight off these things, alignment and support of future payment models, patient partnership, which is giving them access, allowing them to contribute towards and incorporating their functional status, reducing disparities, a lot of which will have implications on the granular, collection of granular demographic information, innovation and flexibility as one of the overriding goals in how we approach the future.

So we're weaning people off these process prescriptive measures into a way that you know the flowers can bloom. Hopefully that's going to be possible in 2015, and the seamless support of individuals and population's health and care across the continuum with all caregivers, professional and non-professional and that needs to be reworded, but that's the seamless and health and care and professional and non-professional. Okay, so remember this is going to be reworded, but it's the seamless support of individuals and population health and care across the continuum with all care givers professional and nonprofessional. It's not grammatically structured right yet even but.

W

I want to go back to the flexibility and innovation. And it's not that I disagree with that, I struggle with that. I struggle with that because I think there's this tension, and I'm not saying we have to be prescriptive, but there's a real tension. Half the panel yesterday was saying we need specific information; you need to tell us what you want and how you want it for us to do it in the timeframe, right? And the other half were saying let us, you know don't micromanage our process and let us figure it out. And so there's this really clear dichotomy there that I struggle with. And, I, you know, even from, you know, thinking about it from a, you know, public health or a state perspective, you know, again, because there's flexibility in the way EHRs were built, we're built we are having trouble getting measures out, right? So, I mean, I don't know how to resolve it. I just feel this tension and I'm trying to figure out where, you know, what's the right way to go with that. I just need to put it out there.

Paul Tang – Palo Alto Medical Foundation

I think you actually answered the question. In order, so, how people, how people improve the health of their communities is their business, the combination of both the professional side and the community side. But how well you're doing has to be prescribed, that's taking your state point of view. So in a sense, the CQMs need to be prescriptive in the sense of common definitions, data elements, etcetera, but where essentially at this stage of the game we've missed the boat, we have these measures, these specific 44 measures hardwired into systems instead of creating a platform where the communities can add more and more measures that could spit out it in a uniform way. You see what I'm saying? And in a sense, that is one example of where we're going with Stage 3. We don't want to specify with every stage which are the allowed electronically derived CQMs. We want to create a platform where you can have real time reporting and feedback. And we've go to figure out how to describe that, but they can only come out in one way for every measure and that's what wasn't happening here. You see, it is a sort of both, but just do it the right way. George?

George Hripcsak – Columbia University NYC

So under innovation I just want to, because I think it goes there, since we're talking about the future, there may be new ways not just to do health care but to do electronic health records and so one of our goals is not to stifle that, I think it goes under that. So just to give a concrete example would be expertise sharing or crowd sourcing where we start moving towards people seeing, asking like...or in the computer science land, its back overflow, what do I do here and having someone answer. Well I do know whether that works or not, but we don't want to make it so that's impossible to grow if it would have worked.

Another one is case based reasoning which hasn't worked in the past years but now that we have real data and large database connected, maybe that's something that would be a good thing to do. So we don't want to create, I don't think, we're not going to stipulate those things of course, but we don't want to create an EHR structure that there can't be that kind of innovation. And just a comment on the list, I think adverse event is at a different level than most of the other ones and it comes under quality or something like that. So I just wanted to make them more parallel.

Paul Tang – Palo Alto Medical Foundation

In some sense, the bigger rubric is real time, real time surveillance.

M

Knowledge dissemination.

Paul Tang – Palo Alto Medical Foundation

Yeah real time surveillance and reporting and that can feed back into decisions.

W

...talk about notification so it was, it was knowledge transfer. It was real time knowledge, it's sort of 2 things, it's real time knowledge transfer like on the notifications of recalls, which we may have lost in that particular statement.

Paul Tang – Palo Alto Medical Foundation

No there's a prevention.

M

So this is like real-time collection is this half of it and the other one is dissemination.

Paul Tang – Palo Alto Medical Foundation

Yeah. Yeah, so we can reword that, but we'll try to reword it and get it up in more. So how does this sound to you?

M

It sounds good.

Paul Tang – Palo Alto Medical Foundation

All right Neil.

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

No I just, another piece of the measure thing and I brought this up before, I don't know how to deal with this either, but, you know, I am continually concerned that there is actually a conflict between the payment directed measures that keep us focused on the sort of attributed, organized, already in care patient, and the others, and I think it gets to, the reason it triggered in me again was you're talking about, you know, very specific definitions, you can pick a bunch of stuff from a list that's relevant but if you pick one of these measures we're going to define exactly how it's measured, well part of how it's measured is who is in the denominator. And who is in the denominator to me is the most locally important decision that you make, because

it's about whether or not you care about these people or you care about these people. And, you know, we keep talking about population health, but it's a place where really, where the stuff around payment reform, and the need for providers to have this very defined attribution that says I only want to be, I only want you to measure me and be responsible for the people that have been in three times is in direct conflict with our need to stimulate people to do outreach to find the people that are lost to follow up and to do all this stuff. I don't know how we get at that. But I don't want to lose it again.

Paul Tang – Palo Alto Medical Foundation

There's a little bit of, so one of the reasons you have to be seen with x number is because to determine whether you're in the denominator in a claims based method you have to have been seen more than once. So the multiple times could be an artifact of the only way I know you have diabetes is if you had two claims for diabetes because one claim is non-specific. Do you see what I'm saying? If you have people who, you have to have touched them, because otherwise, they're "not in your panel" but we should be looking at the problem list rather than the claims list.

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

There's all kinds of ways to look at the definitions. I mean, there's a dozen different ways to look at the definitions.

Paul Tang – Palo Alto Medical Foundation

But when you are limited only to claims data, which has been the history of our past it created.

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

Right, but we're not there anymore.

Paul Tang – Palo Alto Medical Foundation

That's what I'm saying.

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

Oh, so it's an artifact of the past.

Paul Tang – Palo Alto Medical Foundation

I believe, yes.

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

But our definitions of quality measures from the EHR, for example, NQA measures, you know, you have to have be in two or three times in the last year. But we have those kind of definitions in quality measurement.

Paul Tang – Palo Alto Medical Foundation

Okay, so when we get to CQM.

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

Okay.

Paul Tang – Palo Alto Medical Foundation

We have to change that.

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

Okay.

Paul Tang – Palo Alto Medical Foundation

That would be, we have to be un-tethered from the past. It's the whole looking through the rear view mirror. Okay. So how does this look? I mean honestly?

M

We're certainly on the right track.

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

Like 10 years worth of work.

W

Yeah.

Paul Tang – Palo Alto Medical Foundation

It may be and we will probably work on this for 10 years. Okay, so, yeah Judy?

Judy Murphy – Aurora Health Care – Vice President Applications

...on that last category that we were struggling with, the seamless coordination thing. I'm wondering if we have a way of finding out what's been learned through the beacon communities. Because it seems like that one in particular could really be informed by the lessons learned from that. Josh, do they like write up summaries or something or?

Josh Seidman – Office of the National Coordinator

So they're, around the one year anniversary of it they actually start, they did a series of blog posts, which sort of shared some of the stories, but they will be reporting out periodically.

W

Actually, there's a monthly update that Erin sends out to those who are interested, which highlights three or four beacons each month on what they've been doing in their care center.

W

Oh.

M

Well Judy...3 or 4 hours...all of the good stuff that's happening because it's all in the...just kidding.

Judy Murphy – Aurora Health Care – Vice President Applications

It just seems like they probably learned something that might set our direction again.

Paul Tang – Palo Alto Medical Foundation

Well so I'm, one possible approach to this is, we have it hearing, remember last year we did a hearing on each of the "categories." Maybe we have a hearing on each of the new categories and we can include beacon as one of those participants, because we really have to, this whole strategy thing was to say let's look at things differently, it's not a how do we increment from where we are, we're trying to say, okay now we're going to the future. A lot is stimulated by health reform because now it's possible and now there's a business model that is out there that wasn't before.

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

So can I comment on the hearing thing?

Paul Tang – Palo Alto Medical Foundation

Yeah. Go ahead.

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

So I don't know if other people are in this situation, but these are incredibly time consuming and they're very limited in the amount of input we get and from whom and I would go back to Deven's suggestion. I think we need a different mechanism to get feedback and one that

doesn't require the same, you know, people traveling from all over and giving three minutes to make a presentation in doing this. I think that we should use other types of media to try to get a broader input from folks and stuff that we can look at then more of these kinds of sessions where we can really process and synthesize the information that comes in, because our ratio to like listening to like synthesizing has been out of whack. We spend tons of time getting, you know, getting information but not a lot of time as a group processing it. So I think this is, today's session is really helpful on the way it was juxtaposed with yesterday. But, I also think we need a broader, a way of capturing broader input and more efficiently rather than the hearings.

Deven McGraw – Center for Democracy & Technology – Director

Yeah.

Paul Tang – Palo Alto Medical Foundation

So are you describing that as a supplement or as a replacement?

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

I think we should try it as a replacement once or twice and see whether we get the kind of inputs that we would be looking for and try to, you know, promote it in some sort of way. To say you know here's what we're thinking about such and such, and open it up for public comment for, you know, for a couple of weeks, and, you know whether we do it through the blog or however we promote it, but I think it would be, it would get as a broader range of input and it would give us more to think about. And quite honestly, you know, I would rather have 1,000 minds thinking about stuff and see what kind of ideas they come up with than 15.

Paul Tang – Palo Alto Medical Foundation

I'm not sure it's broader it's different.

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

Yeah.

M

Well let's try it.

M

...

M

You know we definitely did an experiment with some of that with the hearings that we held in 2010 and for some of those hearings we got literally dozens of comments through our federal advisory committee blog which were very valuable and that got incorporated into the public record. And I think that was very helpful. So I think we can kind of try to think of ways to generate more of that kind of input.

Paul Tang – Palo Alto Medical Foundation

So, maybe at the last hour when we talk about, you know, what's next, the next steps, we can figure out how do we want to approach getting information. I definitely agree that, I hate to say it, but a face-to-face is far more productive and it's much more interactive than the call. So we may have, one thought is to piggyback on one of our Policy Committee meetings and add another day to do this kind of stuff.

M

Let me, I just want to, So I agree with Neil, I think we should open up, that's good. I just don't want to denigrate the three-minute limit on what they can say because it's very good to have that person sit there and figure out, be forced to figure out, what's most important so that it fits in 5 minutes because if they just give me the 50 page report and then I have to figure out what's the 5-minute version, I'll never be able to synthesize it. So I don't want that to go away. In fact,

if we go to other mechanisms to put it in I'd like there to just have the analogous 5-minute summary.

M

Well that's what the need is the executive summary.

W

Right.

M

That's what the blogs do in a large sense, you know, people don't do 5 pages usually on a blog, but they do, you know, they often times target.

M

But there's a lot of entries into the blog and so you've got to figure out which, you know.

Deven McGraw – Center for Democracy & Technology – Director

Yeah. That's why Twitter is such a success, you can't make it more than 140 characters, you've got to figure out a way to say it. I mean with all due respect to the AMA, I'm sure it took them a long time to pull this together, but I'm not sure when I'm going to be able to read through all of it.

M

...

M

...

M

Pretty coloring on the pages.

Deven McGraw – Center for Democracy & Technology – Director

What?

M

There's pretty coloring.

Paul Tang – Palo Alto Medical Foundation

Okay.

W

What did we, I don't know if it was caught in the other things but the whole issue of we were talking about real time disease surveillance, real time reporting, real time quality feedback, quality measure reporting, is that captured in our concept do you think? I just want to make sure.

Paul Tang – Palo Alto Medical Foundation

Okay. The next, let me try the next step before lunch, because, so the next step from this process was how we link our new goals, you know, our draft new goals with the lessons learned we got for Stage 1 based on yesterday. And another one is to go look through this list. I think we can actually do that because we'd probably knocked off some of these. So the 10:00 a.m. list which says other topic to be considered is the parking lot issues. The one is outcomes and, well let me knock off the things we've talked about. Innovation, I think we dealt with. Special focus on efficiencies and disparities, we didn't do so much on efficiencies again, so we may need to come back to that. We have not talked about specialists. Let's talk about the first two items which is do our goals for future stages impact the earlier stages, Stage 1 and Stage

2? One thing we talked about, but I think the implications are pretty significant, reduction of any of the criteria, relief from any of the criteria as you progress in stages. It seems like that would be a hard thing to do.

M

Well it's still ambiguous whether people are going to go through Stage 1 to get through Stage N or whether they go straight to Stage N in the future there's an argument that in fact you should have people make sure that they are collecting demographics before they get to Stage N. On the other hand, you could argue well if they're achieving Stage N outcomes goals then why check the demographics. I don't know, is that, Josh, do you have a feeling?

Josh Seidman – Office of the National Coordinator

That's a bad example.

M

That's a bad example?

Josh Seidman – Office of the National Coordinator

Well it's a bad example because Stage N would be doing, being able to, you know, to do reporting by race and ethnicity and if you haven't captured it you can't report on it so you couldn't meet Stage N without capturing the data.

M

Well you'd have to report that there's no disparities.

M

No.

M

Okay, so.

M

You have to report on.

M

We're going to the ultimate outcomes.

M

You have to stratify your measures by race and ethnicity.

M

The question isn't whether, I think that the question isn't whether you need to do it, it's whether you need to sort of report on it, whether you need to check a box and so forth, because one of the things that we certainly hear is sometimes, well, you know, I had to check a lot of boxes, but if you're, you know, reporting on your blood pressure control, do you need to note that you have recorded blood pressure and the vital signs. I think, is that the question that you're talking about?

M

That is one of the ways we looked at it.

M

I mean if you look at certification. Do we need to certify anymore 10 years from now if the person using an EHR achieves it then why check the certification? I mean that's a devil's advocate kind of argument. Do we have to have people go through these processes? Do you have to use a certified EHR if you can achieve the outcomes goals without a certified EHR?

M

That's going to vary by outcome. I think for some things we're going to say yes and for some things we're going to say no.

M

Well, but some would argue that someone who's coming onto an EHR for the first time, I mean maybe not 20 years from now, but for the first time, should go through some process which may not be as extensive as Stage 1, but there are certain things that should be checked off. There's an argument there and I don't know the answer to that.

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

I would suggest we don't think about this in the general but when we're dealing with specific items we ask the questions.

M

Okay.

M

...

Paul Tang – Palo Alto Medical Foundation

So the other one was outcome measure and waivers. This is the thought that if we get to measuring outcomes, then does it really, it's a little bit like do you get a waiver on something, and I think the argument now is sort of, at least the default right now, is no, because otherwise you've created this disparity between people who had to go through it earlier on and I'm not sure it makes any sense. We thought about it. If you achieve, how do you, okay how do you reward high performance and is there a forgiveness on anything, any of the processes that get most people into that position.

W

What if they are high performers because of the patient mix that they have?

Paul Tang – Palo Alto Medical Foundation

The patient what?

W

Because of the patient mix, cherry picking.

Paul Tang – Palo Alto Medical Foundation

I agree. I agree and they do it all on paper. So does that mean you don't, I think society has said we need to have a country that has this capability to acquire and report on data so that we understand and can improve on it. I mean I think that's the statement we made. So I'm not sure waiver makes sense.

W

Well and I think that comes down to the specifics, I mean there may, and I can't think of an example, so I may be proved wrong on this, but there may be examples of outcome measures that we could come up with that do clearly point to use of electronic tools and some of the other things that would mitigate some of the cherry picking and those kinds of things. And if there are those outcome measures that we can employ, for the sake of parsimony, it may make sense to look at the process measures and I don't know about a waiver. I don't know, but, in some way, limit the piling on of more, and more, and more stuff. But I say that with the caveat of it is very dependent of what those outcomes are. And it may be that we just can't come up with it.

Paul Tang – Palo Alto Medical Foundation

When we get to the point...

W

Yeah, but I think it's a fair thing to look at. Because I do worry, what worried me yesterday was to hear, at least I think a couple of people say, you know, I've talk to people and they're like, you know, this is so complex, and I know for myself, we all deal with this everyday of our lives and we all have troubled keeping this straight. Why do we think that any provider, you know, in a small community or any provider could keep this straight? But, it's so complex that I really will just take the ding. I can't expend the time and energy to understand. So, that really concerns me. So I don't know how we balance those things.

Paul Tang – Palo Alto Medical Foundation

So, I mean maybe that's another one of our high level goals. We still have to go back and honor the parsimony because as we add on, we just cannot, especially when we're making major..., we just cannot keep adding a whole lot of stuff.

W

Right. Right.

Paul Tang – Palo Alto Medical Foundation

Let's figure out, so it's good that we only have whatever it is four, let's stick with these four, figure out, it might be that we actually have four to six more period, not keep growing.

M

Paul, what do we have four of?

Paul Tang – Palo Alto Medical Foundation

Four goals.

M

Oh, oh.

Paul Tang – Palo Alto Medical Foundation

Let's not have another 12 objectives on top of those goals.

M

Paul, I like the way it's going, but I think one of the top parts that we can do to educate folks is here's what we're measuring, these are the prerequisites you must have. You're not going to get this once you have this, maybe not necessarily make them check everything, but the foundational items you were talking about earlier are prerequisites for many of the kinds of measures, not all of them, some of them don't have those kinds of prerequisites, but I think we can make that cookie crumb trail so folks could see they need these before they get to that, and when we're measuring that we don't have to measure all of those other things they had to get to do before they got there.

Paul Tang – Palo Alto Medical Foundation

It's sort of like once we're at 80% percent of something, let's not make it 90, because let's just drop it, because there's just, let's just try to drop the burden every time we want do something. Be very sensitive to, we don't want to add burden, we're just trying to set a good rhythm.

M

Well we could say we don't add anything unless we take something off and let that be the algorithm. You know think about every time you add something you have to think about what is the least important thing on there.

M

...

Paul Tang – Palo Alto Medical Foundation

NQS has this top down criteria and once you're topped out there's no sense to keep pushing on it. So, I mean, once you're at 80%, there's no sense to keep measuring, you know, that kind of thing. All right. So, I think we've covered it. The only thing that we haven't covered and it's an important thing and we have trouble dealing with it so I'm going to make a proposal.

Specialists. We've had hearings, we've had input. We don't have a good solution. One of the reasons is the products are not as mature in the specialty care area, that's one, and neither are the CQMs. So we have, we are missing some of the tools we have had for primary care. The suggestion I have, Josh, see if this makes sense. Is if staff could go through all of the criteria and sort of see, and maybe you already did this, and we just how it applies or doesn't apply, where are our problems, where are our gaps, and try to address these gaps and find some action plan for fulfilling this.

Josh Seidman – Office of the National Coordinator

I mean, the medical side is one of the things that was given to us yesterday was that analysis done by the society....I have looked at some of this in the past. I haven't looked at, I don't know if this document is new. I don't know if it's.

Paul Tang – Palo Alto Medical Foundation

But in a sense, it's some of the discussion that you and I had about for the non-contact physicians, anesthesiology, well, not anesthesiology, pathology, radiology, what do we do with those folks? And let's see actually how do they make it through this criteria? That kind of thing, you know, as you said, there may be three clusters of folks, procedural lists and non-procedural lists, and how do they go through this? And so we have the gaps right in front of us and we can understand globally what we need to do to address this. Neil?

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

So, I think, the mistake we made is we thought that they would, somehow we could fit them into the same trajectory as everybody else. And I think that was fundamentally flawed, you know, that their measures are different, their processes are different, the way they practice is different, some of them don't even have offices, you know, that they work in hospital settings. We just, you know, I think we just kind of figured, oh well, they're an orthopedist so they do the same thing we do they just do it in a limited fashion. So the problem with it is we lost them. And, yeah, I know that we saw the graph with 2% or 3% or whatever that is, but I think those are probably large organized practices that have the capabilities of practically meeting any requirement you throw out there, you know, they have the financial resources and other resources.

So here's what I would focus on. I want all of the specialists in our community on electronic health care records. And the two things that are important to me about that, and I would give them Meaningful Use dollars if they could meet both of these criteria period, end of story. One of them is that they participate in the regional exchanges and they can exchange information. And the second is that they can participate in some way, participate in the direct exchange of information with referring providers so they get information back and forth, and that their information is available in the regional exchanges. And I can tell you that those are, those two things would get everyone on the trajectory, and I don't really care about today.

Like, if we are going to lose them, if we're going to lose that stuff because we can't figure out what quality measure to put on them that to me is ridiculous, because that's, the big quality problem is that they're not participating in exchanges and they're not available to exchange information electronically with the primary care providers who are getting on the systems you know more and more. And so why don't we create a different trajectory for that group that enables them to get systems, communicate with the people that they need to be communicating with and make sure their information is available in the exchanges that are

developing? And say that's enough for Meaningful, I mean that is enough for Meaningful Use right now. Stage 1 for specialists or Stage 3, A, B, or whatever.

Paul Tang – Palo Alto Medical Foundation

It's 3. Marc?

Marc Overhage – Siemens Healthcare

Just, and I don't want to, if there's a turnaround, Neil...it occurs to me that one of things that we're seeing a lot with the specialists and cardiovascular has kind of led the way as really trying to head toward the sort of learning healthcare system sort of notion, which we really didn't, we talked a lot about quality measures and we talked a lot about data capture, but we didn't really talk about too much as we talked about phase 3 and they're related, but as sort of think about, talk about specialist it just reminded me about that sort of thing and is that something as we look towards phase 3 we want to signal towards maybe it's in that further out kind of thinking, but for the specialist I think, you know, one of the things that, at least from a professional society perspective, you know, they're really working hard...got a new initiative to go down this road and others, somehow marrying that in might be a way to help both leverage the energy they're already putting in and create an additional value to achieve the kinds of things that Neil was talking about, because I think at the end of the day it's the same work in the practice.

Paul Tang – Palo Alto Medical Foundation

So I think in common with the two suggestions is a separate track for specialists and so for example I think Marc added registry to your two requirements, and there probably is.

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

Yeah, there's other stuff, but I mean the critical things, I think that would get them, that would lead to the greatest quality improvement at a national level would be to have them communicating with the rest of the system, and right now we're keeping them out of the system or at least not using the same incentives for them because so many of them are not participating.

Paul Tang – Palo Alto Medical Foundation

Right. Art?

Arthur Davidson – Denver Public Health Department

Yes, I agree with what both Neil and Marc have said, but yesterday the comment that I heard from Kevin Weiss was that there are these maintenance of licensure and competencies activities, the OPPE, the FPPE that they are measuring. It seems like we should get ourselves lined up with that. We should figure, I totally agree with what you are saying. They need to start exchanging, but they also probably have needs inside their practices that report on their quality for their competency back to their boards.

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

And those things are developing.

M

So I just want to make sure to Neil's point, because I think obviously the exchange is a big part of this. One of the things, you know, when we look at all the specialties that are actually getting dollars I think you might've made the point that they might've been part of big groups and the issue, the opportunity for specialist in big groups is that if they are drawing from a centralized system they have that data because the requirement in Meaningful Use is not that you input the vital signs or blood pressure, but that you have access to it. So once we have, so I think there are two questions, one is where are we now and what do we need to do in the next two years, and then there might be a second set of questions about skating to where the puck is going to be and if we have robust exchange and that kind of infrastructure than that data could be there.

And then in a sense, by participating in the exchange then they can get all that data in their record and they can contribute the relevant data.

Paul Tang – Palo Alto Medical Foundation

Well, so interestingly, that would, that would be one of the answers to fulfilling the existing possibly.

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

Except what we're saying to them you've got to do all of this stuff first but it's really not relevant or helping the quality of care in America at the moment, because not only aren't they doing it, but they're not in and they're not exchanging it. So Phase 1 is you do it and then Phase 2 is then you can start saying well, you know, we think you should be checking blood pressures because wherever people touch the system we want their blood pressures recorded so when the primary care provider sees it instead of seeing the last blood pressure from a year ago they see all the blood pressures when they went to the dentist, when they went to the other folks, and it's all available through the exchange, but I think by doing it, but we started it kind of backwards.

M

Right.

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

We kind of set the requirements in place first and then.

M

Right and so that's what I'm saying it's a set of near term issues instead of long term issues.

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

Yeah. Yeah, I totally agree. I think they're compatible.

W

Yeah.

Paul Tang – Palo Alto Medical Foundation

Eva?

Eva Powell – National Partnership for Women & Families

Just that I would agree with Neil's thought that there could be a second separate track for specialist, but I think we do need to have probably a separate and more detailed conversation about what specifically that looks like, because what worries me, well I agree, that the key is exchange, I agree with that. What worries me is that just the reality of today is that many, many patients do not have a primary care doctor. They have specialists for all of their care whatever care that might be that they're receiving and so in many cases, if we only have exchange, as part of the equation for specialists, we'll lose the whole patient engagement component.

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

No we shouldn't lose that.

Erin Poetter – Office of the National Coordinator

And so we need to talk very carefully and specifically about what that looks like because there are specialists that maybe don't have interaction with patients typically. And so we need to account for that as well, but by and large, specialists do have interaction with their patients face to face and we need to make sure that we retain those patient engagement components that are not inherently in exchange.

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

I agree with that.

M

So instead of creating a track, another alternative to that, since we're also talking about reducing Stage 1 being parsimonious, I wouldn't mind figuring out what would be the bare minimum that would cover specialists and primary care providers and reduce Stage 1 to that size so that whatever we would have given to specialists we also give to primary care providers and anything that gets left out because we went that way goes into the quality measures because we're moving towards outcomes. So not have the separate track. So if it comes down to just you do HIE and med rec or, you know, care coordination and your done that applies to everyone, you know, three years from now when we're doing Meaningful Use, that's all that the Stage 1 version is, and we don't, as you said earlier, you don't have to check the demographics because the outcomes measures imply you had to have collected it.

W

I have a question, I just wanted to follow-up from what Eva was saying, which is beyond just having, you know, the basics which is information exchange...only see specialists and the burden may be on someone else if we don't have some certain criteria for them. So, you know, I agree its exchange but if they're just exchanging information and they're doing bad practices, and then even if they have a primary care doctor, well is the primary care doctor accountable for those outcomes that, you know, the specialist did bad care. So, I almost want to go back to the bread crumb analogy, I think there's some bread crumbs we have to leave in there beyond exchange, I don't think that we have to set the measures as high or have as many measures for specialist, but I do think that there's some expectations that if we're going to ask primary care doctors to meet we would need to ask a specialist as well.

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

So just...is one thing. I think if we would reduce some of those things that what I'm suggesting is to add back has to be just exchanging information with two or three people should not qualify. If your taking away some of the stuff what we really need is the specialist information accessible to the larger community, because that's really where there's a huge gap in communication right now. And so I'm willing to take away some stuff to say, but what you have to do is participate in, you know, the community exchanges of information and be able to do direct with anybody that can do that.

Paul Tang – Palo Alto Medical Foundation

Is there, as a strategy for how to make progress on this, is there a small group of us that actually this, Josh, do you think we can get this AMA table in electronic form?

Josh Seidman – Office of the National Coordinator

Yeah that would be good.

Paul Tang – Palo Alto Medical Foundation

I'm sure we can, but it's very helpful. So I'm wondering if a small group of us can digest this and try to propose the, I think what we are consenting around is a different track, and maybe just one track, but a different track, and how can we make this most useful, but also equitable with all those primary care folks who are doing all this work, but it's a compliment.

M

Paul?

Paul Tang – Palo Alto Medical Foundation

Does that make sense? Yes.

M

Before we get anchored on the track I kind of like what George, if I understood what George was saying, it's sort of a subset of the same track.

Paul Tang – Palo Alto Medical Foundation

I mean, that's fine.

M

If we're on the same train I think it's important we don't kind of do sub-specialists, specialists goes here, and primary care goes here, I think there's a core feature, there are core features that we want subspecialists and specialist to really focus on. I think as long as.

Paul Tang – Palo Alto Medical Foundation

It's a variance.

M

Yeah, but the track...track, I mean we're all doing this together, you have different requirements because you practice differently. We have different requirements we practice, but we're all on the same track...

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

But, that's what failed the last time. We failed at that the last time. We failed at that the last time by calling it the same thing and it's not.

M

But you can have different requirements within the same setting.

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

Yeah, but we can use the same broad categories. We can use the same broad categories but anyway, well we can, I think a subgroup is a good idea to digest this stuff.

Paul Tang – Palo Alto Medical Foundation

Okay. So who would like to be a part of that subgroup? Mike? Okay good, so there's at least three. Any others takers? Okay. Okay so the goal of that, does that group, we have a call I believe on October the 18th, does that group think they can bounce some ideas off of us by then? Between now and then? That's two weeks, right? I mean that's up to you guys if you. Yes? Okay I saw a Neil, yes.

M

Who knows?

Paul Tang – Palo Alto Medical Foundation

Because I really do you want to make progress on this and it's been hard. It's not because we haven't wanted to it's just, it's been hard.

Judy Murphy – Aurora Health Care – Vice President Applications

Where you including radiology and anesthesiology in that?

Paul Tang – Palo Alto Medical Foundation

Yeah.

Judy Murphy – Aurora Health Care – Vice President Applications

Okay.

M

What about pathology?

Paul Tang – Palo Alto Medical Foundation

Yes.

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

What about what?

M

Pathology?

Paul Tang – Palo Alto Medical Foundation

Yeah.

M

...

Paul Tang – Palo Alto Medical Foundation

Yeah, this is the EP, the non-primary EP. We need to figure out how to do this better.

M

Sort of a tracks within tracks with the pathologist.

Paul Tang – Palo Alto Medical Foundation

Okay, the next thing we have to do is try to bridge the gap between sort of our new goals for future stages and the feedback we heard. I have two approaches. We can break for lunch and then do this in a better fed state or we can plow through? I'm going to suggest that we need a better fed state. Okay. So could we adjourn for an hour? Or maybe even 45 minutes, so that would be 12:30PM.

All

Yes.

Paul Tang – Palo Alto Medical Foundation

Great. Thank you.

Paul Tang – Palo Alto Medical Foundation

Before some people have to start leaving, one, I think we'll try to wrap up in the next, before 2:00. Let's plan out so we have a call on the 18th, so we have a policy meeting next week then we have a call on the 18th. So we'll continue our discussion on the 18th. One of the agenda items will be the report from the smaller group on you know some thoughts about how to approach this alternative, this alternative track or whatever the small group comes up with in dealing with specialists which the non-contact specialty is a subset, the radiologists, pathologists.

So right now I think we'll try to bridge and it's a way of checking our work, bridge between the issues we heard about with Stage 1 and the goals we set for ourselves for future stages. And see what work we need to do in order to bridge that. Let's see a series of more information gathering however we choose to do that, that's another think we need to reflect on before we leave is, is it scheduling another hearing or is it completely relying on blogs?

Okay. So the biggest issue that we've talked about at the beginning is CQM. So how, what's the role of CQM in the new goals we have for Stage 3? Stage 3 goals were adverse event detection, prevention, mitigation, and reporting, and we said that that might be a little bit off in terms of the levels compared to direct. The alignment and support of future payment models, and that bridges everything from care coordination to transitions, etcetera. The partnership with the patient, active contribution, functional status, reduce disparities, and seamless support of individual and population health across the continuum with professional and non-professional

stakeholders. And keeping in mind innovation and flexibility in all of those. So what role does CQM, is it a driver? Is it a metric? Is it the goal for these new kinds of goals?

I guess it fits mostly in the last group in terms of the seamless across the continuum kind of thing. Now, one thing we have to figure out is how to address all these challenges that were mentioned, untested, errors, ambiguous specification, change in workflows, who's the owner of it, who maintains it, the heavy use of exclusions, which means you have to get back into the medical record. So is this something that this workgroup wants to deal with or is it and I'm sorry David Lansky is not here, is it something for the quality measure workgroup? Now they've been focused not so much on these though, they've been focused more on the concepts. So in a sense we either have to form another workgroup that concentrates on this or we deal with it at the workgroup level.

W

Paul, it seems, maybe this is just my own constant, not confusion but having to think in two separate ways. There's the functional measures which I think primarily this workgroup is about, however, one function obviously is to be able to generate quality measures and the specific quality measures, it sounds like from our conversation, is not an issue for this group. That the ability to generate those is an issue for this group, but it sounds like from our conversation earlier today that getting into the weeds of what measures should we require to be reported in all of that is really either secondary or not really for us to decide, that we need to focus on the capability and so in that regard, it seems to me like kind of the functional part of the CQM is what we should be focusing on. But is that correct?

Paul Tang – Palo Alto Medical Foundation

I think that's correct. So initially for Stage 1 this group in its entirety did include working on the quality measures, which measures. Since trying to get on a fast-track to get eMeasures and newer measures there was a formation of this quality measure workgroup as a subset of this workgroup. So that's why that group is focused more on the content.

W

Right.

Paul Tang – Palo Alto Medical Foundation

So I think you're correct that we're still worried about the functional capabilities of an EHR to generate that and actually most of these criticisms have to do with that piece.

W

Right.

Paul Tang – Palo Alto Medical Foundation

And I think it actually has to do with the certification and what needs to be certified and then how does that relate to what gets reported.

W

Right.

Paul Tang – Palo Alto Medical Foundation

So In a sense, one of the recommendations this group can make is recommending to the Standards Committee who recommends to ONC about the certification process how to address some of these issues. Am I correct?

M

Yes.

Paul Tang – Palo Alto Medical Foundation

Okay. So, you know, using tested measures, what gets certified and what can you use to spit out the measure, that kind of stuff. I think they're policy recommendations we can make to the Standards Committee who can go on and recommend the changes, recommended changes to the certification process.

W

Yes.

Paul Tang – Palo Alto Medical Foundation

So maybe that's basically, again it probably would be useful for a smaller group to just start the draft and I think then it can be discussed in the full committee and probably get closure pretty quickly.

W

Well and one thing, and this may be on your list, I'm sorry, I can't see all of the details of what we've already discussed, but it seems like a part of the functionality element of this is some of what there was a good bit of discussion around yesterday with both the need to capture all of, make sure that in the EHR we are capturing all of the elements that could potentially be needed to comprise a quality measure, that's an issue for this group, but the actual quality measures is something else, but capturing the information is something for this group, but then also this push/pull of the workflow issues and not requiring, what I heard a lot of people say was do not require any additional documentation. And yet there was push back at the end by, I forget the gentleman's name, names aren't my strong point, but who said, but if we only rely on what we currently are capturing in electronic health records we are limiting ourselves tremendously in terms of what isn't our purview as the quality measurement.

So it seems like there needs to be a component of what we do discuss in this regard maybe for a separate workgroup of how do we encourage the capture of information necessary for quality measures now and in the future without getting down into the what are the actual measures, but what kinds of information are important and that's a tough task because we're predicting the future, but I think we've got, I don't know, if that is already on there forgive me for taking extra time, but that to me seems to be a really strong tension and is kind of a frustration in a quality measurement workgroup of we're in this kind of vicious cycle of we can't advance quality measurement because we don't have the means to collect the information, and yet we are the means to collect that information. And yet we don't want to add to people's workflow so how do we reconcile those things?

Paul Tang – Palo Alto Medical Foundation

There might be sort of three statements to make out of this. One is what does a good eSpecified CQM look like? It is primarily electronically captured in standard term. It is, has minimal, if any exclusions that require manual audits of the medical record. It is already in the workflow of the clinician and it has been tested. I mean, I'm just, I mean those are attributes of a good ECQM and I think we could come up with that list and pass it on to the Standards Committee and ONC, and CMS who could then pass it onto their contractors. Say, hey look we're looking for eMeasures, they need to have these properties, don't give us more things that you've just sort of reformulated, but not tested, even for mistakes.

W

Sorry, on this issue of testing, I agree that things need to be tested. The question is how do they get tested if one of the requirements to put them in the electronic format in the first place is that they be tested. So, again it seems like we're in this vicious cycle and I'm just wondering, and this may be a very bad idea, but I'm going to throw it out there since this is a strategic discussion, is there a role within Meaningful Use to be part of that testing? That if you were a meaningful user of technology for CQM then you are constantly, it's a learning healthcare system, you're constantly testing measurement and new ways to measure things, but along the lines of what we've already said that the information is collected as part of your workflow, I just

worry that, I feel like we're setting ourselves up for not making any progress because where's the testing going to come from is the question.

Paul Tang – Palo Alto Medical Foundation

Part of the NQF endorsement criteria includes testing so they do field testing.

W

But is it field testing in an electronic climate?

Paul Tang – Palo Alto Medical Foundation

And ONC happens to have a bunch of people they pay to do this, beacon communities.

M

...part of the measure development process requires a lot of testing and validation and as Paul said its part of the NQF process is to actually test and validate it. We also have other procedures in place for the certification process to make sure that there are data sets that you can test against that we, you know, for example we know that the outcome should be x percentage. And we'll run you're numbers through this, you will use your calculator to calculate this and if it is off, we know there's a problem so we can continue to test and validate that.

W

Okay, but my question is, because I think part of what we heard yesterday was that it's at least, thus far in certification that these things are not being tested in the real world. So my question is, I know this is part of the NQF process, but the NQF is still making the transition to eMeasures so is this electronic? That's the question.

M

So the big push right now is we don't want to come out with measures that aren't eSpecified.

W

Right. Right.

M

And so that would be part of the eSpecification process is to test it and validate it and make sure that the data is, coming from EHR is clean and put in the correct spots to be able to calculate that.

W

Okay. Okay.

M

But the issue yesterday was not so much that, but rather when you get into the field these things aren't practical, right, wasn't that what they were getting at?

W

Yeah. So the question is what does the testing involve? Is it just spitting something out or is part of the testing that's already in place being, actually being used with real EHRs that are on the market today and being purchased by providers?

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

In other words, are they are doing usability testing or are they just testing to see if the stuff spits out?

M

Well, I don't think it's under the sort of our umbrella to test usability. We don't to, you know, user interface is one thing, user ability is one thing, but being able to spit out calculations.

W

But that's not what I heard them saying.

M

Well they said that the...methods had included a 45 day period of something like that where they had a cycle. So, I don't know that it's all about total usability,

W

Right.

M

It's just, you know, how will it really work in a practice was the complaint.

M

And so I think stuff like that is maybe something maybe you could recommend to the policy or the Standards Committee to include it in their certification process.

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

But now can't you work with some beacon communities that could actually try some of these?

M

In some cases we are. So for example in the area of patient reported outcome measures, where those are certainly, there are a few beacon committees that are very interested in testing those out in a real world setting and so we will certainly be doing that with them.

Paul Tang – Palo Alto Medical Foundation

So, I think they have access to folks who have EHRs that could do this and if our recommendation is that it does get tested in real EHRs in a practice, that could be one way they execute that, but I think that was one of the important lessons learned. So I think is there anybody that wants to work on just, I think it's really just listing, reframing this as attributes of a good ECQM.

Judy Murphy – Aurora Health Care – Vice President Applications

Before we go there I want to go back to this thing we were talking about earlier about not really doing specified traditional CQMs, but you know we were talking about the problem list or, you know, I'll throw in there allergy list, a good med list, the things that were more indicative of quality of care as it would relate to having the right information to make good decisions as compared to disease specific clinical quality measures. And I really like that conversation because I think you're the one who said there's other people that are going to be specifying these other things or other initiatives. Why don't we focus on the things that are unique to what would help quality in the electronic health record?

Paul Tang – Palo Alto Medical Foundation

I think they're both good points. So, one is nobody is covering the up to date accurate problems in meds, but this thing actually can take sort of a leading role in the sense of we know better potentially than some of the consumers of the CQM, what's possible in an EHR or what can be possible? So, I think we have a role to play of giving more exemplars of things. Now the exemplars could turn out to be used in the program and I think, I think CMS would like to have those things.

Judy Murphy – Aurora Health Care – Vice President Applications

You know in your harmonization effort Rob, and I know we're not going to be submitting what is it, in 2012 right? So 2013 is the first time CMS would actually be able to accept the quality measures, right?

Robert Anthony – Centers for Medicare & Medicaid

Well there's a pilot program that would go in.

Judy Murphy – Aurora Health Care – Vice President Applications

In 12?

Robert Anthony – Centers for Medicare & Medicaid

In 2012 yeah.

Judy Murphy – Aurora Health Care – Vice President Applications

So there's already some beginning specification? I just knew there were some action, I just didn't know how much it was.

Paul Tang – Palo Alto Medical Foundation

So, actually let me, so the final rule said that we would attest in 2011 then we would expect to submit electronically to CMS in 2012, is that still true?

Judy Murphy – Aurora Health Care – Vice President Applications

No.

Robert Anthony – Centers for Medicare & Medicaid

In our, the ePrescribing rule that went out not too long ago we outlined sort of a pilot process for accepting it electronically in 2012 using our group reporting tool the G-Pro tool. So that is, whether that becomes ultimately the final way in which that will be everything will be submitted or whether that's sort of a interim point for us we're not sure at this point, but that's what we're using in 2012.

Paul Tang – Palo Alto Medical Foundation

Okay.

Judy Murphy – Aurora Health Care – Vice President Applications

But just to be clear, I believe the majority of the organizations who attested in 2010, excuse me 2011, will be attesting in 2012 for the clinical quality measures, not, they have to measure the whole year but they'll be attesting not electronically submitting, correct?

Robert Anthony – Centers for Medicare & Medicaid

Do we expect the majority of people in 2012 to be submitting electronically, is that what you are asking?

Judy Murphy – Aurora Health Care – Vice President Applications

I thought you guys gave some clarification and said that you were not going to be willing or able to accept the full years worth of clinical quality measures or other measures, for that matter, the functional measures as well, in 2012 and it would still be attestation, but the attestation has to be for the whole year, not for 90 days, if you started the journey in 2011.

Robert Anthony – Centers for Medicare & Medicaid

And I don't know all of the details about how this is submitted. You'll have to excuse me. I don't work on the G-Pro Tool, but I actually think it's the other way around.

Judy Murphy – Aurora Health Care – Vice President Applications

Okay.

Robert Anthony – Centers for Medicare & Medicaid

That if you submit that it may have to be for an entire year and not for a 90 day period because G-Pro doesn't work that way. And if you agree to submit clinical quality measures through that

pilot program it could potentially delay you're payment if you are, 2012 is you're first year and it's is 90 day application...

Judy Murphy – Aurora Health Care – Vice President Applications

If you are part of the pilot, but if you're not choosing to be part of the pilot.

Robert Anthony – Centers for Medicare & Medicaid

But if you're not then it wouldn't right.

Judy Murphy – Aurora Health Care – Vice President Applications

Yeah. Whereas originally I believe everybody thought we were going to be, everybody was electronically submitting in 2012.

Robert Anthony – Centers for Medicare & Medicaid

And I think that's sort of where we're hoping to end up, but there just weren't the resources to put together just for 2012.

Judy Murphy – Aurora Health Care – Vice President Applications

Right. Right. Okay.

M

Paul?

Judy Murphy – Aurora Health Care – Vice President Applications

Anyway, back to the question, yeah.

Paul Tang – Palo Alto Medical Foundation

Okay, so on CQM, right?

Judy Murphy – Aurora Health Care – Vice President Applications

Yes.

Paul Tang – Palo Alto Medical Foundation

So I think it's both.

Judy Murphy – Aurora Health Care – Vice President Applications

Oh, you know what there was another question for Rob. I apologize. I think the question was in your plan to harmonize your different efforts, now I understand what you're planning to do in 2012 for the Meaningful Use program. What are you planning to do for your other quality measures submissions? The other ones that you require for payment?

Robert Anthony – Centers for Medicare & Medicaid

You are asking the wrong person.

Judy Murphy – Aurora Health Care – Vice President Applications

Okay. I'm so sorry.

Robert Anthony – Centers for Medicare & Medicaid

I think that's sort of an ongoing discussion and part of it is not just a, for CMS an operational question, although that's obviously a component of it, you know, ultimately I think, and I'm sort of speaking for Patrick, but I've sort of heard him speak to this, so I hope I'm paraphrasing him correctly, but certainly ultimately I think where they would like to get to is a point where, as everybody wants, you submit once and it counts for everything. There are a lot of bells and whistles and things that people much smarter than me would have to iron out, but then of course there's the question of harmonization actually across the individual measures, and that is also part of what's going to have to be ironed out to get to the point where we do the

operation side of it. So I don't think we're at the point of the overall harmonization solution. It is however, on the radar and is the goal that they're driving towards.

Judy Murphy – Aurora Health Care – Vice President Applications

So that's where I was going to go. Understanding that that's on some trajectory, yes we could help inform this because it's going to make sense and we're, you know, probably smart in this area, but there's going to be a time when we can lay back on the typical quality measures because other programs are going to be requiring them anyway and we can focus on the ones that are unique, yeah.

Robert Anthony – Centers for Medicare & Medicaid

Yep.

Paul Tang – Palo Alto Medical Foundation

Okay. Michael?

Michael Barr – American College of Physicians

Yeah, Paul, just an observation, yesterday many of the comments were about CQM and all the challenges but also I saw the people, some of the positives that this actually drove change, and was very positive stuff, and here we started our session today talking about CQMs, came up with a really wonderful list of things that need to be improved. It just occurs to me, and we also talked about being parsimonious and trying to build the foundations and maybe measure the outcomes. If we focus on the CQMs, everything else should likely fall in place. I mean, that's just an observation because you can't get to some of the things we'd like to measure unless you have those fundamental pieces and it goes across all the categories you've just listed for the day, adverse event prevention and so on. All those things are actually measures. So if we can align, specify all the things that are up on there and start pushing that out as where the puck's going to be, you can't get out there without all these other building blocks. So, I just the way I think we should be focusing our efforts.

Paul Tang – Palo Alto Medical Foundation

So it's important we get this right, certainly get it better because the whole taking 75% of the effort is just not where we need it to be. So what is it that we can do, what policies, what standards can we put in place that would make that cost much less than 75% of the effort? Volunteers for a small group to work on that side?

M

Could you please restate that?

Paul Tang – Palo Alto Medical Foundation

So it's really, what kind of recommendations, which might include attributes of a good ECQM can we make to help improve the ability of this program to stimulate EHRs that can produce CQM with greater efficiency.

M

Who gets the attributes?

M

We were creating an attribute list that we publish like we published the other attribute list with CDS.

Paul Tang – Palo Alto Medical Foundation

So, it's the attributes of a good electronically specified CQM would be the following. It includes its standard elements, harmonized with other programs, a minimum number of exclusions, trying to avoid exclusions that require manual chart reviews that are field-tested, that kind of thing.

M

I mean I would think that David Lansky would certainly want to be involved.

Paul Tang – Palo Alto Medical Foundation

Right and I'm happy to work on this too.

M

Yeah.

M

Paul, can I, and I'd be happy to work on it or volunteer Charlene to work on it either way. But, I guess I'm struggling a little bit on because there's a role of how do the measures look and behave that's the important part of this and then there's a part of what the EMRs and I'm just sort of trying to think about what the recommendations you could create that look like that would fit sort of within our scope and would shape how measures, I guess there could be sort of a pragmatic sort of approach that says okay here's what's realistic to do with EHRs, therefore measures that are going to be usable need to look like, maybe that's the angle.

Paul Tang – Palo Alto Medical Foundation

I think that would be a useful to say, because I think one it's something this group should be knowledgeable about. It can be embedded in a program that is meaningful and, you know, people get incentives to comply with and it can be used by other folks who have an interest in this like CMS, like NQF, like measure developers. So I think it is a useful exercise. Am I on the right track there?

M

Yeah, I think that, I was struggling for minute but as I started to say that made sense.

Paul Tang – Palo Alto Medical Foundation

Yeah it made sense, yeah. How's that ring with you, Rob? If we came up with this list of the attributes of a good electronically specified CQM, would that be of value to CMS?

Robert Anthony – Centers for Medicare & Medicaid

Again, you're asking the wrong person. Potentially, in regard to the things that we can develop and that we use with ONC we contract to be developed, yes. We are obviously not the repository of all electronic CQMs and that's where the challenge sort of comes in.

Paul Tang – Palo Alto Medical Foundation

Well there's two avenues that you mention. One is you can contract, you can work with other members, CMS and ONC have contracts with measure developers. This can be part of that RFP for example or that contract. Two, when you're looking to incorporate quality measures for the various programs that CMS has you can turn to this list and say hey you know these are considerations on which measures should we choose for access the performance of people on various programs, that seems like a.

W

Yeah, sorry, I'm not sure how to pull all of this together because I think you're right part of this is what are the attributes of an eQuality measure. There's already been some work done on that though by NQF in the form of the quality data set or what are we calling it now? The quality.

W

QDM.

W

QDM, yeah, Quality Data Model. So I wouldn't want to repeat that and obviously we need to be consistent with that. But in my mind there's a step beyond that, that's kind of taking a step toward defining measures a little bit and it's a right step I think for this group to take, but there's also the component of is the tool, the EMR, capable of calculating that eQuality measure? So, and I'm just looking at the national, the recent report of the National Quality Strategy and the measure concepts that they have put out and there are things like access to healthy food, access to recreational facilities, use of tobacco products, all of these things that are dependent upon lots of information that isn't in an electronic record now and I think there's a piece of this issue, that's the conversation that we had before, that not everything needs to be in the EMR but there needs to be a capability for an EMR to somehow link with other databases to then have a measure calculated.

So, I don't know, maybe I am bringing up a bigger issue. If we're focused only on clinical quality measures and the way that we think of them today that may not be such an issue, but I feel like there's a component that we need to advance this beyond our current, as Judy was saying, beyond our current concept of quality measures, but that there may be other measures that perhaps are more in line with the National Quality Strategy that are of an even different sort that are dependent on multiple data sources and I don't know what to do with that, but again, in my mind it's critical to somehow ensure that that capability of making the link from the electronic health record, because that obviously will be a major data source, to whatever else we may come up with in the future.

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

Making a link for who access, for the patient themselves to access or for who to access?

W

That's a good question.

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

I mean if we are linking it, we have to think about who's on the other end of it.

W

Right.

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

Yeah, I'm not sure that you want the other people on the end of it to be accessing this as much as we want maybe the primary care provider to be accessing information on housing and other things. You don't necessarily want the housing people to be accessing information on people's clinical records, I mean it's a lot of.

W

Right, well and I, yeah that's a good point as to who the measures are designed to administer.

Paul Tang – Palo Alto Medical Foundation

We have one, two at least three, oh, Joe?

Joe

So, I'm a measurement guy in my day job rather than an informatics person and I can tell you it is extremely hard to do good measurement. Even with specifications that come from, you know, the QDM or groups. And I'm wondering whether this discussion is around the concept of like, you know, similar to the info button. Do we have a, you know, a CQM button on the EHR that makes it really easy? I don't see that happening. And I see, frankly, if you were to enable eMeasurement, I think the best thing you can do is provide some not terribly prescriptive guidance on the data architecture in essence, the guts of the EHR that facilitate the kind of work that a savvy, you know, analysts or biostatistician can do that will of necessity involve some data linkages, some data cleanup. Even the best designed data systems have issues

that you've got take, you have to take the data files and look at them it's not the same as abstracting medical records or pulling things by hand, but you know, there's columns and fields that won't align, you'll have patients with the same, duplicate patient identifiers, you'll have null values. You just, it's, so those are the kind of things that we just don't want to get into, but I think there are probably some principles you can articulate about what system enables the kind of back office work rather than trying to specify that we have that measure button on you know the front end.

W

Yeah, so from what you said, would the second question, the first question being what does an ideal eQuality measure look like. And then the second question might be how do we enable eMeasurement? Which is what I heard you say. Would that be a question for this group? And it may be just identifying hey we need to figure out X and so that's for someone else.

M

Right. Yeah. I think the most we can say, there are certain designs within an EHR system that can enable performance measurement, but I still think there's a lot of work to be done even with the correct specification to get the measurement right, you know, and frankly, you know, from the clinical practice perspective, you know, maybe I'm defining measurement different, I think you want more panel management. You want to be able to bring up a screen of patients that, you know, meet certain attributes and from those attributes to see whether certain recommended practices are there or not or certain intermediate outcomes are where they need to be. And, you know, that's a capability that can be in the system, but that's a little different than measurement.

W

Yeah. Yeah. Well and I think that gets at what's been mentioned earlier too is that we need to both enable measurement for reporting and for improvement and what you just said is for the latter, and it's the value case I think for providers.

Paul Tang – Palo Alto Medical Foundation

So, why don't we have a small group, so far Marc and David got volunteered and I volunteered, and anybody else want to join, Art? So we'll, so Josh, you have those names and maybe you can help us get together.

M

Yes. Since, I already admitted I was a measurement guy.

Paul Tang – Palo Alto Medical Foundation

Sure.

M

I'm sorry I did that now.

Paul Tang – Palo Alto Medical Foundation

Okay. So, we'll work on, and bring that again back at the October 18th call. Okay the next topic; we're just checking our work so it would be the alignment side. I think we have that covered because we had the alignment, where's that...the goals.

M

Yeah, the goals.

Paul Tang – Palo Alto Medical Foundation

So alignment is probably, alignment was set up in the context of CQM actually. So we can make sure that we've covered the alignment in our CQM discussion. So the case definitions, that's a definition issue, I suppose that still can be captured in the CQM. Patient engagement,

we had a complete goal dedicated to that. EHR certification, again has to do a lot, there's two aspects, I think one was CQM and the other was the module. How you have to buy one module, you have to get the work done and you also have to have the module in hand. And I think we can, so that's where, so one of the cases involved in CQM is people typically have a reporting database probably not in their EHR it's separate, that does not qualify per se. What's the work around if the, I mean could we make a policy recommendation that said as long as you can attest to the accuracy of the algorithm you used to produce the report, if you are willing to do that, you can do it without having it come out of the certified EHR. Is that fair game for us? Josh is saying no.

Josh Seidman – Office of the National Coordinator

I think that would create a degree of flexibility that again allows people, you know, you may buy an EHR but it doesn't have the best platform to be doing database management.

Paul Tang – Palo Alto Medical Foundation

Right and most of them don't. Let's see that's and ONC or CMS, that's an ONC right, because it's certification?

Robert Anthony – Centers for Medicare & Medicaid

It's an ONC it has a CMS audit impact and that's honestly when you say that that's immediately the way I think of it and I know exactly the situations that you're addressing, we have it come up with hospitals all the time who are feeding multiple systems into one database area and want to be able to feed out of that.

Paul Tang – Palo Alto Medical Foundation

Right.

Josh Seidman – Office of the National Coordinator

And the only thing for us is that potentially sets up an audit impact where, you know, if you attest to this and we discover that your algorithm does not correctly populate that or does not translate those values over, it puts the provider in a situation where, you know, they're potentially remitting that payment back.

Paul Tang – Palo Alto Medical Foundation

But alternatively, I think a large number.

Robert Anthony – Centers for Medicare & Medicaid

That's the value of certification that you know everything is tested to provide an x-line.

Judy Murphy – Aurora Health Care – Vice President Applications

Weren't they just certifying their data warehouse then though, I mean.

Robert Anthony – Centers for Medicare & Medicaid

And that's the process that people were going through is actually getting certification for that data warehouse or that server.

Paul Tang – Palo Alto Medical Foundation

And that may be preferable because I think a lot of the 75% cost is the rework of your work flow just to do this and to make sure you do that rather than actually getting the data out to report. So that trade-off, seems like we could offer, we could recommend to offer that kind of flexibility. As long as you're willing to go attest or get your database certified, that fits the usual operational pattern much closer. Okay. So that's another, that's we should put that on our list somewhere.

Michael Barr – American College of Physicians

Paul, the one, I don't disagree, I just, for, we talked mostly about eligible hospitals, at least at this point, but I just want to make sure we don't lose the push to have at least some of this functionality in records for the ambulatory physicians right? We want to have the same sort of choice for them.

Paul Tang – Palo Alto Medical Foundation

Correct. Correct.

Michael Barr – American College of Physicians

Okay, I just wanted to make sure.

Paul Tang – Palo Alto Medical Foundation

Yeah. And we talked about, actually, I think that's it for what we covered. Oh, HIE. HIE and public health reporting. So HIE, have we covered it, we've covered it in our seamless care goal. And, I'm trying to think, how can we improve upon the HIE situation. How can the policy group improve upon the HIE situation? Will the, is it an NPRM or final rule for NHIN governance?

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

Is it a question of the timing?

Paul Tang – Palo Alto Medical Foundation

Yeah.

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

The final rule we hope will be out by the end of next year.

Paul Tang – Palo Alto Medical Foundation

End of next year?

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

The final rule.

Paul Tang – Palo Alto Medical Foundation

So when will the NPRM come out?

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

I can't actually give you a specific date in this context.

Paul Tang – Palo Alto Medical Foundation

But within this year?

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

You should expect to see something this year.

Paul Tang – Palo Alto Medical Foundation

This year, Okay. I don't know, I think the biggest challenge for HIE, the organizations has been the business model. Now I don't know that we have a policy except for, well I mean it can be done through payment. It can be done through, at least we're giving people the capability to participate.

M

Is there a...because one of the, and there's many issues, I was just kind of thinking about what could we address that might help. One of the things clearly is the cost of integration that virtually every system has to bear. I mean, there's sort of the organizational issues of privacy and, you know, whose going to steal my data and all that, but, if you can get past those and you are confronted with the "my vendor wants \$15,000 to connect me" and I think many people when we started down this road of Meaningful Use hoped, envisioned that systems would be certified and at some level you could just say okay, as a minimum component of the system to be certified it must be able to send and receive data in the following format with the following codes and do something sensible with it when it gets it, and that is, and we obviously can't say how the pricing models of vendors work, but we could make that a requirement of a certified system with maybe certain levels of transparent, because I'm thinking out loud here, transparent configuration, you know, sort of the you shouldn't have to get the vendors consultants to come in for 3 weeks to set the IP address that you're going to send the data to, or something like that, you know, is there a level of, can you remove that barrier through the process?

Paul Tang – Palo Alto Medical Foundation

I'm not sure how.

M

So the capability could certainly be part of a certified EHR.

Paul Tang – Palo Alto Medical Foundation

Yeah.

M

And we took baby steps with phase 1 in that direction.

M

So we already put in the use case that props the Standards Committee to do exactly that and then it's just a matter whether it's feasible and they have to decide what to do, but that's, so normally the Standards Committee would be doing that half as long as we put in the policy thing, which is that there's a use case that says you need HIE and that's what we tried to do in Stage 1 through testing and 2 through actual examples.

M

And then the vehicle though would be sort of to make sure it actually works without tons of work, it would be sort of like, I mean you could imagine something in certification that ONC could specify that said, you know, the certifier, not the vendor, needs to be able to in less than half an hour with, you know, somebody holding their hand, do this or something, I mean.

M

We could make a suggestion to the Standards Committee that this might be a path to pursue or something.

M

Right.

Paul Tang – Palo Alto Medical Foundation

Okay so that's on our parking lot. Okay. And public health. I'm not sure what, we're doing quite a lot and then Seth was reporting that the public health infrastructure has been also working pretty feverishly to try to receive this stuff. Anything other suggestions we can do?

M

Well, again, I think what Seth was saying this morning was that there is an attempt to harmonize some of these messages, the content, the vocabulary, the secure messaging, the transport protocol all of that across multiple types of messages that would go to public health. I mean if we could achieve that in Stage 3 that would be a boon to public health, that we were able to recycle the efforts going on now to multiple other situations, you know, the cancer, birth defects, even some of the chronic disease things that we discussed earlier today. So, that's, I mean that would be an ideal goal. And I'll say it once again, in terms of disparities, this occupation and industry, if there were a way for us to actually have patients report what occupation they have, you know, they could contribute. We talked about this earlier about contributing information. And they probably know better than a, you know, a clerk what occupation they're in and would be able to triage through that if the tools are there and were not, they're there now, but people are working on that.

Paul Tang – Palo Alto Medical Foundation

Okay.

Judy Murphy – Aurora Health Care – Vice President Applications

And, Paul, this is Judy, at Stage 2, didn't we keep it kind of generic? You just have to be submitting data? And the only other thing is at Stage 3 is to get more specific and I'm not sure this group would do that, but to suggest that there be more specificity about the surveillance data that is provided? For example, is it just lab or should we be looking at some other physical attributes like temperature and medication lists. I know, you know, CDC for example through...accepts all three of those right now, and I know we're submitting that, but I don't know if those are the most valuable ones, but we could certainly ask for what's the minimum data set and get more granular about what we'd be expecting at Stage 3 for surveillance.

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

Is there another head on the arrow between public health and providers so that it's not just, you know, you need directional in terms of us providing information to public health? Are people thinking about the way in which public health alerts can be addressed to providers in electronic health records?

Arthur Davidson – Denver Public Health Department

Absolutely.

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

Where is that, what's the state of that Art?

Arthur Davidson – Denver Public Health Department

So, we discussed that in our deliberations around Stage 2 that bidirectional, there was a mention of that for Stage 3, I think Neil you know very well what was going on in New York about how Farzad and company were able to send messages to you. I think there's a much simpler use case which is forecasting, you know, what a child should get in an immunization based on the current immunization record that could be stored at a public health or someplace in a knowledge management system so that the EHR does not need to keep building in these rules everywhere in the country. You know, it could be that there are differences by state or by region and we could work that out, but that would be the bidirectional. I can send you my immunization records and you could tell me what that child should receive. Just a simple standard use case to bidirectionality.

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

So, I guess my question is, is there anything that's ready even to be put in that says if the other side can do this, we should be able to receive it? Is there anything in that stage of readiness yet in the country from public health?

Arthur Davidson – Denver Public Health Department

I think that, I mean in my state.

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

Immunizations?

Arthur Davidson – Denver Public Health Department

Immunization Registry is doing that.

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

So the receipt and integration of immunization registry getting back into the electronic health record.

Arthur Davidson – Denver Public Health Department

Yes.

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

Nothing around public health alerts or anything like that.

Arthur Davidson – Denver Public Health Department

Well, as I said, in New York, you know, had that.

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

Well but we don't really accept those electronically.

Arthur Davidson – Denver Public Health Department

Yeah, and I don't know whether there'd be alert fatigue or whether that's something.

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

But there's no national system where people are thinking about standardizing how alerts could be sent back from public health to providers about outbreaks in the community or anything like that.

M

We should perhaps get some other input from some folks, but there is the Health Alert Network or HAN which is the way that the health departments themselves share those and some people have leveraged those to communicate to providers and then even localized it further. So yeah, there are people doing that and there are some standards for that and, you know, they're simple, but they work.

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

So for those alerts, is there possibility for those alerts, I mean, because we have a health alert network and we participate but you have to log into it separately which nobody ever does unless something.

M

Right, no, but they are transmitted as a formatted message that you can get.

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

So that would be used, you know, I'm thinking about ways that we can make the health department communication useful to providers, that would be a way to do it, would be able to, in places where maybe you can help me Marc, you know, in places where the system is implemented that electronic health records would be able to input those and provide them, make them available to providers at the point of care.

M

Yes. No I think that's a realistic goal and, you know, the related thing is, you know, there's, well there's a whole variety of dimensions, but yeah, yeah.

Paul Tang – Palo Alto Medical Foundation

Okay.

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

I want to put that on the list.

Paul Tang – Palo Alto Medical Foundation

Pardon me?

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

I want to put that on the list for our future consideration.

Paul Tang – Palo Alto Medical Foundation

So that feeds right into, so here's a suggestion for how we do our call on the 18th. Do we have two hours Mary Jo on the 18th? Okay, so I think we'll have an update from the CQM, small group, an update from the specialist's small group, a reconfirmation and we'll put a draft out, a redrafting of the goals that we set, a reconfirmation of those goals for future stages, and then probably start going into smaller groups according to those goals. So we have, it'll probably be similar to our category 1-2-3-4, you know, there'll be a category that includes the seamless interaction with the public, with you know public health and population and that's where, you know, fleshing out that kind of objective would go. And I would see us being very cognizant of where we've been, that we haven't changed everything and being very judicious on what we ask and see that as another step along this road map that we're painting. How does that sound as far as a work process? So it's sort of, reconfirm what we did in terms of our goals, hear the updates from the 2 smaller groups, the CQM and the specialists, and then start drilling down on the objectives under those goals that we have.

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

One additional comment that sort of came up in our lunch time discussion. You know when we were talking about Stage 1 we were able to constantly refer to things that we were putting off to 2 and 3, you see where I'm getting with this. So, now we are talking about 3, but we don't, unless we start actually creating a parking lot for 4, we're not going to really have a place to sort of park these things that we don't think might be ready for Stage 3. So I would suggest that we, even though there isn't one now, that we at least have some way of parking some future things, because those are the signals that even though they don't get built into the stages create a lot of momentum in some of these areas to say, hey at least we're thinking about these things.

Paul Tang – Palo Alto Medical Foundation

I think that's partially why I have been referring to this for future stages. And clearly, the goals we've outlined are pretty hairy and are not likely to be done by 2015 or whatever. Just a side note on the timeline, if you do the math, you come up with a few conclusions. So, one of the goals was to give vendors and I guess its vendors and providers 18 months from the final rule to get things accomplished. And we know that it takes one year to go through the rule making process, that's 2.5 years from January 1, 2015, that means we would have to submit our final recommendations, June of 2012. Also, the implications of our recommendations that we push out Stage 2 for the early attestors means they're not coming in until 2014, which means by definition we won't have Stage 2 feedback going into Stage 3. So, either that's true what I just said or something's got to give. And I don't know whether CMS or ONC can help us understand what the current thinking that's public.

Robert Anthony – Centers for Medicare & Medicaid

No, I think you accurately kind of grabbed it, that's sort of our concern as we are talking about Stage 2 is that we don't have a wealth of Stage 1 information at this point to inform that. Obviously there's a period of time between the NPRM and the final rule where we can solicit public comment if we're going to have a period of time to gather more of that data. And I think something similar with recommendations would be true as well, is that we would have time to start to implement that and see some of those changes, but are we going to have a complete picture of both of those by then, that is a challenge.

Paul Tang – Palo Alto Medical Foundation

So that, I mean, this is a consequence, I mean we just have to accept it. The consequence both from the vendors request, the provider request that this is, I mean this is, in order to try to honor those, I mean that's where we are headed.

Judy Murphy – Aurora Health Care – Vice President Applications

So, let me add a Standards Committee request.

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

Add another year.

Judy Murphy – Aurora Health Care – Vice President Applications

We need an...I know that we talked when we're evolving Stage 2 how important it was to give some context. And the letter that was created kind of said why do we think this is important and there was that column on the right you know. That was really helpful except we missed some, I think, what might be considered to be big issues around policy. So for example, we had this long discussion about what do you think the Policy Committee meant when they said longitudinal because of course there's no standard definition right, so we had to try to come up with something. There's no standard we could point to. And it felt more like a policy issue than a standard issue. And I know, you know, we use that word a lot, longitudinal, but to be honest, you know, it was like this conversation we were having before is that, you know, the longitude of an episode or is that life you know?

Paul Tang – Palo Alto Medical Foundation

Yeah.

Judy Murphy – Aurora Health Care – Vice President Applications

So we just keep that stuff in mind I think as we go forward and there are some lessons learned that I think we could from the Standards Committee get back just in terms of specificity of the criteria that might be helping.

Paul Tang – Palo Alto Medical Foundation

No specificity was clearly up there.

Judy Murphy – Aurora Health Care – Vice President Applications

Yeah.

Paul Tang – Palo Alto Medical Foundation

I heard it loud and clear from Patrick, as well. He took special emphasis on that. So, I mean, we only had so much time, but we should try to build in if we're going to specify some of these things, and actually that'll be on the list of attributes. Are they good ECQMs. I mean we will just be as careful as we can.

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

Did we find a place to put the efficiency stuff? The considerations.

Paul Tang – Palo Alto Medical Foundation

No.

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

Those are still being put off for another.

Paul Tang – Palo Alto Medical Foundation

No, that's a really good point. We really, I think we really have to do something.

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

I think we just set, there needs to be another goal.

Paul Tang – Palo Alto Medical Foundation

Yeah. Is that goal under one of the existing? Well it would be under alignment support of future payment models.

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

Yeah.

Judy Murphy – Aurora Health Care – Vice President Applications

And under HIE.

Paul Tang – Palo Alto Medical Foundation

Yeah. Okay. All right. So, any other further comments, agenda before we break until our October 18th call? I'm sorry, and then we'll have public comment. And then is there anybody not assigned to a small group that somehow escaped that?

M

Fess up.

Paul Tang – Palo Alto Medical Foundation

Fess up and join one. We just need to have the work force to get this stuff cranked out.

M

Paul...CQM.

Paul Tang – Palo Alto Medical Foundation

Okay. Good. Alrighty. Okay, so let's open it up to public comment please? Did you just say you wanted CQM?

M

CQM.

Paul Tang – Palo Alto Medical Foundation

CQM, okay, great.

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

And by the way, Paul, you do have two hours 10:00 to 12:00 on the 18th.

Paul Tang – Palo Alto Medical Foundation

Thank you.

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

Are we ready for public comment?

Paul Tang – Palo Alto Medical Foundation

So we're ready for public comment now.

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

Okay, we now have time for public comment. If there's anyone in the room who would like to make public comment, please come forward and sit at the table and in the meantime operator, if you would prepare for the public to dial in. If you're on the phone please dial 1-877-705-2976 and then press 1 to speak. Thank you.

Carol Bickford – American Nurses Association

Carol Bickford, American Nurses Association. I want to thank the group that raised the conversation about clinicians, not just physicians as being partners on the healthcare team, conversations in relation to plan of care being important and then a longitudinal record across all settings, and the full life spectrum. So thank you for the conversations related to that today, but please keep that in your thinking as you move forward in your conversations on the next call and the next call, and the next call.

...Peters – American College of Radiology

Hi I'm...Peters, American College of Radiology, first of all, thanks for putting together this small subgroup to talk about specialist issues. What we'd really like to see is some quick movement on that so that the agencies can at least signal that they're looking at these issues in the NPRM. I know it's pretty late in the process, that's probably out the door already, but to the extent that we can get some of this stuff in Stage 2 that'd be fantastic. Also, there is the challenge of the regulatory definition for certified EHR technology that even if you are a specialist and you are excluded from a lot of the things that you don't do, for example, ePrescribing, you're still required to have an ePrescribing module which is a huge barrier for a lot of folks in our community that seek compliance via the modular pathway because they might use a risk that has certification for a number of the criteria but not all. So that's what I'd like to say.

Jason Byrd – American Society of Anesthesiologist

Hi, I'm Jason Byrd I'm with the American Society of Anesthesiologist and also want to thank you for the discussion these last 2 days and particularly the discussion today around the specialist's criteria. I know there's been a lot of conversation here around the table of not only of needing to hear from folks who are wanting to participate and are struggling, and wanting to identify those barriers and we would welcome that conversation. We think we have a good story to tell and have tried to tell that story and would continue to welcome to telling that story. In that regard with this subgroup, I think some of us were talking and maybe one recommendation is whether that subgroup can look like a Tiger Team and whether there can be folks from the specialist community that could be involved in that or at least be invited to participate in those conversations. I think a lot of us have different sort of apples and oranges types of issues but there are some similarities, but some careful nuances and specifics that we may be able to lend to the conversation and help illuminate some of those barriers for all of you.

I would also like to reiterate my colleague's discussion around getting something in writing. I know my members have been become increasingly nervous about will I be able to participate, you know, we know we're eligible, but the criteria doesn't apply. What do we do? And I keep doing this tap dance of well we're working on it and we'll get it fixed for you but in the meantime they're getting increasingly nervous about what they should do and with that nervousness, over couple of years, comes a lot of frustration. And so getting something in writing, even if it was to the point of we acknowledge there's concerns with specialists criteria, we're working on it, we invite comments or something along those lines I think would go a long way for the specialists community to show those that can't participate here and hear the conversations, if there was something in writing that's tangible that they could see, okay they get it. I think that could go a long way.

And then also something for this group. Just a humble recommendation that we were also discussing was, whether there should be, rather than public comment at the end when everyone's has had a very long meeting and were trying to catch airplanes, if, after some of these sections, if there were short areas for public comment that are more close to the conversation or issue, it might help with the conversation here and may be able to help the people connect some dots from some of the folks that are here in the audience for all of you and give you additional perspectives. So, I appreciate the opportunity to comment.

Paul Tang – Palo Alto Medical Foundation

Whether there's already an FAQ dealing with specialists to sort of give that communication, no?

W

Not at this point.

M

Yeah, we haven't.

Robert Anthony – Centers for Medicare & Medicaid

As far as clarifying requirements for specialists, I know a lot of people have, radiologist, anesthesiology, chiropractors a number of different specialists have come back and asked, you know, if something isn't applicable to our workflow are we allowed to exclude it and just verifying that you have to actually be able to claim that exclusion. I think we have spoken to a number of specialty organizations independently and we've certainly heard those concerns in regard to Meaningful Use and are thinking about some of these issues as we work on Stage 2.

Julie Canter-Weinberg – College of American Pathologists

And I'm Julie Canter-Weinberg with the College of American Pathologist and we too thank you for getting to the discussion of specialist, but we're a bit impatient. We've have had discussions with CMS and ONC and, you know, you're getting to Stage 2 and our members don't know what to do about Stage 1, even our members that work full-time in hospitals don't meet the definitions of hospital base. And if you're having a workgroup like Tiger Team working on specialist I think it's incumbent that you reach out to the specialty societies and get them involved in your work because who better knows that work than the specialist themselves. And obviously laboratories and pathologist contributed about 70% of the data in EHRs yet there is no way for us to participate, we don't get any credit. One barrier is the certification requirements, because you have to use either a complete EHR, all of the modules, or all of the modules have to be certified. Our members don't use EHRs, but use LISs, APISs and blood banking software in some of the bigger institutions, they do, but they have no choice over that and all the surveys and the 5 year HHS, HIT plans talk primarily about primary care physicians and secondarily about office based physicians, so our members are eligible but don't meet those categories, but yet Meaningful Use will fail if you don't have the data that our members oversee.

The other point I want to make is none of the clinical quality measures apply to us, there are only two PQRS measures that apply to us, there's three more in development, but even if you had all of those you wouldn't cover it because it's sub-specialization the entire field of pathology and things that are supposedly universal measures like BMI, but if you don't see a patient we may be able to weigh a specimen, but we can't get a BMI of a person.

And lastly, there's exchange of data every day between an LIS an EHR but we have concerns, and we testified at these back in May, on some of the problems and data that is lost and corrupted in that process that can in some cases lead to actual patient safety and even potentially harm.

And lastly, as you look to the future you have had absolutely no discussion as to the coming revolution in genomics, pathologist are central to that. I commend your attention to a Brookings

study released last January on that subject. There is some recognition of the topic of genomics in the 5 year HHS, HIT plan, but if you're thinking about far out stages and are not including that aspect of personalized medicine I think you'd be remit. Thank you.

Paul Tang – Palo Alto Medical Foundation

Thank you. Anybody on the phone?

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

No one on the phone at this time. Thank you.

Paul Tang – Palo Alto Medical Foundation

And just for the specialties' that spoke, you consumed a lot of our lunch time discussion so it's not that you're ignored, we're trying to figure out what it is what you do, I mean we're working with our HHS colleagues to try to figure out what to do here. All right. There's no further agenda items, we're adjourned and see you next month and hear you on a call in a couple of weeks.