

Meaningful Use Workgroup Transcript July 18, 2012

Presentation

Operator

All lines are now bridged.

MacKenzie Robertson – Office of the National Coordinator

Thank you. Good morning, everyone. This is MacKenzie Robertson and- with the National Coordinator. This is a meeting of the HIT Policy Committee's Meaningful Use Workgroup. This is a public call and there will be time for public comment at the end, and the call's also being transcribed, so, please make sure you identify yourself before speaking.

I'll now take roll. Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Paul. George Oestreich?

George Oestreich – G.L.O. & Associates

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, George. Michael Barr? David Bates? Christine Bechtel? Gail Cowman? Tim Cromwell? Art Davidson?

Arthur Davidson – Denver Public Health Department

Here.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Art. Marty Fattig? Joe Francis? Leslie Kelly Hall?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Here.

MacKenzie Robertson – Office of the National Coordinator

Hi. Thanks, Leslie. Yael Harris? David Lansky?

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Here.

MacKenzie Robertson – Office of the National Coordinator

Deven ... thanks, David. Deven McGraw? Greg Pace? Latanya Sweeney? Robert Tagalicod? Charlene Underwood? I know Charlene's on the line; she just may be on mute. And Amy Zimmerman? Are there any staff on the line?

Mary Jo Deering – Office of the National Coordinator – Senior Policy Advisor

Mary Jo Deering.

MacKenzie Robertson – Office of the National Coordinator

Thanks, Mary Jo. Okay, Paul, I'll turn it back over to you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, thanks, MacKenzie. Um, hopefully there'll be other members joining as well a bit later on the call. Um, but you-

Christine Bechtel – National Partnership for Women & Families

Hi, Paul. It's Christine Bechtel. Just to let you know, I think there was some confusion on the line number.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, great. Thank you, Christine. Um, and uh, the reason for ... we wanted to get started on time is because we have a very full agenda, remind us that, um, we're presenting on August the 1st. Uh, so, we'll be presenting for the first time on preliminary recommendations, eh, in prepara- to get feedback from the group and then we'll take that back and then in October, um, come back with the recommendations we would like to present in the request for comments that's due to go out early November. So, that's what's keeping us on schedule as far as getting our draft recommendations in- in good form, both for the initial viewing, as well as, um, in preparation for the RFC.

And all that is to make, uh, the milestone of- of having our final recommendations to ONC and CMS by May of 2013. And of course, the driver for that is so that we give people, uh, people, the- the broader community, that's the healthcare organizations and the vendors, uh, sufficient time to prepare for Stage 3. So, we've been promising more advance notice because each time there's a new stage there's a whole- it kicks in motion a whole set of activities that has to happen. The- the vendors have to develop new functionalities, they have to test it. The healthcare organizations have to upgrade their systems yet again and, um, go through and train everybody, etc.

So, the March is—the time table is- is every two years and that's quite aggressive in and of it. The first stage got delayed because of this timing glitch in terms of some of the earliest adopters, you get an extra year, but in general, the intent is for each of the stages to march along at two-year intervals knowing that Stage 3 isn't the last stage.

Um, so, we're here today to finish up, um, Subgroup 4. Uh, there's some- been some changes in Subgroup 3. We- we left some homework for them at the end of the last call and then we wanna start going through the impact, uh, analysis. Um, we wanna find—we're trying to, uh, find an objective measure so that we can help ourselves get through a parsimonious set. Um, it's because of the stresses on the system, and it really is an entire system, this healthcare, uh, delivery system an- and putting out new requirements every two years is- is very stressful.

And so, it's not only trying to meet what objectives, um, that- that a Meaningful Use program and all the other CMS programs set out, um, they have, they, pro- providers have some other things on their plate as well. So, there's always an opportunity cost. There's a fine balance between the two. So, that's why we—that's why parsimony is so important.

Okay. So, why don't—with that, any changes to this agenda? Comments?

Michael Barr – American College of Physicians

Paul, this is Michael Barr. I just wanted to let you know I joined.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Thanks, Michael.

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

And Charlene Underwood's on.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Great.

Yael Harris – Office of the National Coordinator

And Yael Harris, thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Thank you, Yael. All right. Why don't we get—

Christine Bechtel – National Partnership for Women & Families

Paul, this is Christine. I have another quick question—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, please.

Christine Bechtel – National Partnership for Women & Families

...which is I think, you know, in looking at it there is still some work to do, um, to address some of the overlap between CAP subgroups and also some of the areas where—you know, I know in looking through the chart, people were referring things to Subgroup 2, which is the group that I am on, but I don't have enough information to understand what they're referring to us. So, at what point do- are we kind of going back and doing- addressing those issues?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It's a really good question, Christine. Um, so, we have one more call, which is cutting it close I think, um, on the 28th and- and as you know, our meeting is on the 1st. So, I think we're gonna have—by the end of today, we need to agree the- you know, I guess the- the refer- the refer- the people—the subgroup receiving the referral needs to, uh, a- agree that they'll- they'll take that and- and then maybe offline there's a discussion between the- the referring, uh, group and the ref- the accepting group, does that make sense, in- in anticipation for the July 28th call. So, by the 20—

MacKenzie Robertson – Office of the National Coordinator

Sorry, Paul, this MacKenzie. The call is Friday, July 27th.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Sorry, July 27th. So, by the 27th call, we need to have reconciled all of these hand-offs. We should also hopefully have received some information from HIT Standards Workgroup in response to this and, um- which is really fast, um, and deal with our parsimony.

The better we have our- our preliminary recommendations, uh, in shape for our presentation August the 1st I think the more productive the conversation will be.

Christine Bechtel – National Partnership for Women & Families

Okay and then I think we should maybe use the same process to identify areas where there's overlap or redundancy, um, 'cause I think there are a couple of those. Um, but, so, you mentioned the Standards Workgroup, and I'm sorry if I missed that, but their- when we went through their- at least when I did the parsimony exercise, there were a number of areas where I said, "I don't know about the Standards...." So, is the- so is Standards Workgroup advising on- on all of those ...?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

We're- we're gonna try. Um, so, the way it's indicated on the matrix are the yellows and presumably, those are coded based on us- on our conversation saying we wanna refer this to Standards and the notion was it would go into Standards subgroup, um, that's- that's a- that's relevant. Uh, so, John Halamka committed to trying to- to organize that- their response back in- in a timely way and understanding that it's probably gonna be their best guess at this point and- an- since they only have a couple of weeks to- to work with it or less.

Christine Bechtel – National Partnership for Women & Families

Okay, 'cause there were a number of areas that I just don't know the answers—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

Christine Bechtel – National Partnership for Women & Families

—that are not coded yellow though.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. We'll- we'll point that out. So, in our- in our less section, and hopefully we'll have more than a half hour to do this, we wanna cover those referrals, um, that- that Christine spoke about, the- whether there's any missing yellow coding for things that need to go over to HIT Standards Workgroups and understand, um, and have any questions about the impact criteria so that we can be fully prepared for the 27th. So, thanks for asking that question, Christine.

Okay, Art, I think we're ready for you to present Subgroup 4's, um, uh, preliminary recommendations for discussion by the full workgroup.

Arthur Davidson – Denver Public Health Department

Okay, thank you, Paul. So, I'm starting on line 16 in the spreadsheet that, uh, uh, I think MacKenzie or Michelle sent out by that ONC, um, mailing this morning. So, uh, this is the one, uh, where we're talking about immunizations, this line and, uh, the first point there is that the ongoing submission of, uh, immunization data has not changed. So, that- that remains as it was, uh, proposed in Stage 2 meaningful use rules.

We have added, however, two other items related to immunizations. The first is this capability to receive and review a patient's immunization history from a registry and the second one is the capability to receive or generate a- a set of recommendations for what immunizations should be given. So, there are two listed in this box. This is the only one that I'll be presenting where there are two items in the same box.

And, um, uh, in this, uh, example here, we have the- the desire for people to have a comprehensive history before giving a shot. That's, uh, important to care and it's, uh, part of our national priorities you can see, um, and this is- probably will be applicable to many different specialties.

The desire is that- the- the measurement, rather, would be that there's documentation of timely and successful electronic receipt and review by the, uh, EHR of the vaccine history from a, uh, immunization registry or immunization information system, IIS. And we have suggested that we- we set this, this is something we can certainly discuss, but we set this at- for a subset of all patients who receive an immunization in that practice or that- by that eligible provider or at the hospital and we set that at about 30% knowing that not, uh, all people will, uh, have a shot where there will be a review, but for- for kids in particular, this is very important. Adults, someone may say, "Well, did you get your flu shot this year" and- and they may just proceed with a shot rather than going out to check to see if there was anything in the immunization registry already.

So, um, that's the first one and the second one says, "Should you be giving, uh, a particular shot?" This is the, uh, ability to receive from some source, and this is something that I think we- we would like to see happen in several areas in this population of public health. How can we receive information, knowledge from a source and use it in the electronic health record?

In this instance, it is "What is the immunization schedule?" It's a flu shot every year. It's three hepatitis B vaccines in the first year; whatever it is and these may come from the, uh, Advisory Committee on Immunization Practices, uh, that's, uh, FOIA at CDC. That would be posted.

So, you know, here's something where the Feds have to step up and say we're going to allow EHRs to retrieve immunization schedules from a Web site, uh, as a Web service and that will then be received by the EHR. There may be certain special reasons for not following that ACIP recommendation and there would be the opportunity for local or state override on that, but basically it says if you have an EHR, you're able to receive a standard set of recommendations that most of the country is following right now. That's the recommendations from CDC.

This could be, this one could be a, uh, clinical decision support. It- it could be one of the, uh, CDS measures that we propose. I'm not saying that this has to be, but that's one of the ways that we could use this. Um, and, uh, if we were to—I'm just trying to get this full view here. Just a second. Um, sorry. Um, just a minute. I just need to move my document here.

Um, okay. Um, so, the- the EHR needs to be able to consume this stand- standard set of- of data from- from an external source such as the CDC if they were to have this website, uh, made available. And I understand there is also a national vaccine program, which is, uh, uh, from a different place in HHS and they may contribute to that as well.

So, maybe I'll just stop there and see if there are any questions about this. This is the only instance—I'll- one more comment. This is the only instance where- where even though we- we seek a lot- many more opportunities for bidirectional communication, this is the only one where we are actually, uh, making that a- a piece of the, um- of the, um, meaningful use measure here. You know, that you rec- you are able to, uh, send information to an immunization registry and you're able to receive information from that immunization registry with the full, uh, uh, immunization history.

So, that's- that's this roundtrip that, uh, we have been seeking, uh, and this is the only one where we actually push this along in the population public health measures.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Thank you, Art. Uh, it was an excellent presentation and it gives the rationale and also the- this last statement you made gives a heads up that this is the only one of the- of the, um, public health measures where we're- we're excising the roundtrip. Can I ask a clarifying question before we open up for discussion? So, you have a- a- an X in each box except for "Not market driven?" Um, is that implying that you think the market would drive this functionality?

Arthur Davidson – Denver Public Health Department

Um, no. You know, I don't know why that's blank, um, and I actually am not exactly su—maybe you could describe to me exactly what you mean by "market driven." So, that- that means that- that the market itself would have made this happen?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Correct.

Arthur Davidson – Denver Public Health Department

Oh, then there should be a, uh, an X in that box.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Arthur Davidson – Denver Public Health Department

Yeah, yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And you are saying that there are mature standards available that- that would—

Arthur Davidson – Denver Public Health Department

Yes, absolutely. Uh, this- the immunization HL7 specification, the implementation guide has been around for, uh, close to a decade, uh, 2.31 and most recently 2.51. And we're not trying to make them change anything that they have done so far in the immunization registry world. We're trying to take advantage of what they have, including they have the ability within the HL7 specification to send recommendations.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Arthur Davidson – Denver Public Health Department

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Great. Okay. Open up for comments please.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

Well, Art, it's Dave Lansky.

Arthur Davidson – Denver Public Health Department

Yes.

David Lansky – Pacific Business Group on Health – President & Chief Executive Officer

I'm just wondering; is- in what way does this—you mentioned—is this a special case of the general clinical decision support, uh, direction that we have been discussing and to what degree do the standards that are available to support the ... um, mirror or implement the standards that would be used for a general clinical decision support, uh, infrastructure plug-and-play system? Do you know?

Arthur Davidson – Denver Public Health Department

N- you know, so that's a great question. I was hoping that, you know, there would be more of a, um, of a—this is not something that, uh—the- the sending of the recommendation is something that's already embedded in the HL7 message, but the incorporation of this- this- this schedule is not something that we have figured out yet and that's not something that the, uh- that I'm aware, the, uh, immunization practices group at CDC has really thought through.

I- I think at some point in our meaningful use discussions, and- and I- I was hoping that your- your group would- would come forth with a framework for saying how does someone go out and acquire knowledge and then bring it into an EHR, but that part has not been, um, uh, standardized yet.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Uh, this is Leslie and I just would like to include a space saver for the future, uh, for patient participation in that shared decision making because this is one of the areas where, um, knowledge, uh, is- is so powerful for public health practices, as well as an individual patient's decision and consider the controversy. But allowing for that roundtrip eventually, uh, that includes the patient in that decision making I think will be a- a good- good plan, but, um, out of scope for- for at the moment, but something to keep in mind.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, I know Michelle is not on the call right now. First of all, is there someone on staff that is taking notes?

Emma Potter – Office of the National Coordinator

Yeah, hi, this is Emma Potter from ONC ... for Michelle.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, thank you. And then I know Michelle is going to listen to the recording afterward. So, the suggestion from Leslie is- is a placeholder for a future stage in terms of involving patients in the- in the immunization decisions.

Arthur Davidson – Denver Public Health Department

Yeah. That- that's an excellent point. We did discuss, and as we'll get down to patient generated data that there's an opportunity there for the patient to contribute to the immunization record, although we'd certainly wanna be keeping track of the prominence of the data and- and—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

Arthur Davidson – Denver Public Health Department

—making sure, but indeed that was something we discussed, Leslie.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Great, thank you.

Arthur Davidson – Denver Public Health Department

Thank you for reminding us, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, I think as Art mentioned, this is one of our, um- uh, part of our vision and part of our dream as far as this by- uh, this, um, roundtrip nature of- of communicating information to public health and receiving recommendations. As you mentioned, Art, it- some of these schedules are really complicated and we- we don't actually know how to represent them, but- but, um, and that's how it could be most useful, of course, back to the EHR.

So, you might wanna take that into con—so, I think the- the- these- these- this pair of- of objectives is certainly something we've talked about and the question is timing probably. Should we take one of each one separately? Do we think, um, the time is right for accessing the patient's immunization history across the, uh, continuum and enterprise and community? What are people's thoughts?

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

Is- Paul, this- this is Charlene. Is this the capability to embed it, or—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Uh, well, I would guess so. Art, is that- was that your—

Arthur Davidson – Denver Public Health Department

Well, I thought your question was whether you should- could access the immunization, uh, information about a patient, and I'd say that the timing for that is- is appropriate. Now, I think that not all immunization registries are there yet, but I believe that there are registries. I know in my state there- there's a registry that does this work. Um, so- so that's- and that's not something that happens in my institution, but in other institutions it happens automatically. So, that forecasting, what they call that recommend function, uh, coming from- from looking at the full history is currently available in many states, not all. They'd have to work toward it.

The second piece about putting in the- the schedule; right now, most states do that manually. They- they input it into the EHR rather than going to a knowledge base that electronically transmits it to either the IIS or into the EHR. So, this is- this is something that is not currently available to my knowledge, that- knowing ... is electronically posted for someone to retrieve.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Uh, this is Leslie. It- it seems that this could be harmonized in the future with ... initiatives as a ... patient-specific, uh, query. ... is that something that's in the test?

Arthur Davidson – Denver Public Health Department

Well, the patient-specific query is the first one, really. It's retrieving all the information about their, uh, vaccine history.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, let me, um, try to separate these two so we can focus our discussion. So, right now, let's talk about the first new objective, which is to be able to, um, access essentially the patient's immunization history in some- some, uh, public healthy registry. And then the second question that Charlene introduced is does that mean view and access, or does that mean incorporate in an understandable way in the HER? So, Art, what- what did you mean, what did your group- subgroup mean in terms of question number two?

Arthur Davidson – Denver Public Health Department

Well, I- well, I don't know whether they need to incorporate it. I think what needs to happen is—I mean ideally that information would be stored. You retrieve some information about a patient and you store that as the information you had on that day in your EHR from some external source. That would be the ideal piece.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Is that your intent for the objective and measure that you're proposing?

Arthur Davidson – Denver Public Health Department

Right, but- but the—you know, that data lives still in the IIS and it may be that the workflow for- for this, um, use case might be I have made it available and it has been surfaced to the- the, uh, provider and if they want to use it- if they want to review that they can see that again on another query. So, does it have to persist is, I think, the question that, um, uh, Charlene is asking.

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

Yeah.

Arthur Davidson – Denver Public Health Department

And I don't know that I wanna dictate what the workflow should be because- someone- someone- because in some instances, they may consider the IIS their extension of their EHR.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, let me, um, make an analogy to, um, accessing prescription- prescription refills through, for example, Surescripts. If people are making that acceptable, but we have not required that they make- they incorporate that in their EHR and particularly incorporate it in a, um, structured way, you would like that in the future, but that's just not where we are. Might you consider something like that in- in this objective, that is, right now, it's access to the immunization registry so that a human can view this and take that in account in decision making, but in future stages, we start thinking about, um, uh, storing that in a structured, uh, format.

Arthur Davidson – Denver Public Health Department

I think that's a good analogy, Paul, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. How do people feel about that?

George Oestreich – G.L.O. & Associates

Wait, what exactly, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, this would be access to the public health immunization registry so that a human can see, "Oh,"- can make- can incorporate that information in their decision making, but at this point not requiring that EHRs, um, consume that in a structured way even though that's where we wanna head, I mean, so we can be talking about that as a placeholder and- and a good signal.

George Oestreich – G.L.O. & Associates

Well, uh, my only point would be 2016. You know, we- once we cut it back, we can't go forward. So, is that where you wanna end up maybe in January of 2013—I mean that- is that where we wanna come to that decision six months from now? If we make a decision now then we're cutting it back. Like what if it turns out it's more feasible than we think?

When we do our public comment, public, you know, request for comment, I don't wanna throttle it down too much too early.

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

Yeah, and to that end, Paul, I know the discussions with some of our standards folks; this is one of those candidates that they're evaluating. Again, it's really tricky space, but that would kind of support what George is saying at this point in time is, that we get the current status- standards and its potential to do that.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Um, other comments.

George Oestreich – G.L.O. & Associates

And of course, by the way, if we did throttle it back then we'd probably have to get rid of the second one 'cause the second one is about using the structured information to draw conclusions. If we're not gonna do the structured information then we're not going to be doing a reasonable decision support.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Uh, I don't know—

Arthur Davidson – Denver Public Health Department

So, again, George, I think that that could—all of this could be through Web services. You don't have to incorporate it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

Arthur Davidson – Denver Public Health Department

You just kind of feed what you receive to the Web services, say, "Give me a recommendation."

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah. Yeah.

George Oestreich – G.L.O. & Associates

Okay. Okay. I see what you're saying. I mean you're just saying that as long as the health- the central agency has all the information there's no reason for them to present it to me in structured format to give me those recommendations.

Arthur Davidson – Denver Public Health Department

Well, they could present it to you in structured format, but you don't have to store it.

George Oestreich – G.L.O. & Associates

The, um- the only problem is the patients giving me additional information in real time and I ... this patient. So the- the- the city say, "We'll recommend you do this next" and the patient says, "Well, actually, this is true" and I can't put those two together anymore, but, you know, those are details that we have to figure out; not on this call.

Arthur Davidson – Denver Public Health Department

Right. Right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, so back to question one. Um, the- the latest I heard from Charlene, which is to propose that it would be, um, acceptable in a structured format and the condition is we- we ask HITSC, uh, about the- the- one, the existence and maturity of the standards and, two, the adoption of that standard. Is that, uh, fair? Is that agreeable to folks?

Arthur Davidson – Denver Public Health Department

I think so.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Okay, let's deal with number two then. We'll have the same question. Is this access to the latest, essentially information, in the context of a record? You can always- you can always go to the Internet and search CDC, but you would love to say, "Okay, I do have this pediatric person in this age group. Uh, tell me what's the latest recommendation." Part A would be, "Let me view that." Part B is "Even give me the recommendations appropriate for this individual." Now, we did mention that. That's hard, period, let alone trying to do in a standard nationwide way, but let's talk about A. Is this- is the timing correct- uh, the- is the timing appropriate to require this, um, for 2016?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Uh, this is Leslie. I think yes and I also think the mechanisms are in place now to do, uh, external queries using patient context.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, that means the public health systems have this capability and are following the standards?

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

So, if- if they are following the standards for any sort of patient-specific ... uh, physicians could ... query, um, often the contextually aware query, then yes, they would have that capability. So, the- the- the services, um, are there. It's just whether or not, um, public health is using them, but standards are there.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah, but there's lots of standards that are present just in general. Um—

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

But, NI- NIH uses it, for instance.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

But, George- I mean, um, Art, were you gonna say as far as the- the level of adoption in public health and their- their capabilities right now?

Arthur Davidson – Denver Public Health Department

So, I- I don't- I don't know the answer to this question and- and I'm sure I can get that from the- from ... national, uh- uh, immunization.... But- but, I think—

George Oestreich – G.L.O. & Associates

Art, I think just generally there are several states doing that actually.

Arthur Davidson – Denver Public Health Department

Yeah, but there are several states doing that and- and my state is one of them. I did check with them on this, that they- they can give patient-specific, uh, information around all shots and they can give patient-specific recommendations about what shots should be given. That's- once again, that's called forecasting in that domain.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And is that basically the only ... they're probably using is age. Is that correct?

Arthur Davidson – Denver Public Health Department

Well, they're going through the entire schedule. Um, you know, there's- based on age and prior immunization history.

George Oestreich – G.L.O. & Associates

And contraindications.

Arthur Davidson – Denver Public Health Department

And contraindications, correct. Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

How would they- how would they know that?

Arthur Davidson – Denver Public Health Department

Well, they store some of that in the registry, in some of the registries.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, but so- but- but it's not—okay. I- I think we can- they can only go so far. One is immensely due to incomplete information, but also the, their ability to process certain information. So, contraindications may or may not be known, submitted to the public health department. Other things like, uh, other chronic diseases, um, may- are probably not known by public health services. They may not know some of the risk factors that may- may affect the- the recommendations.

Arthur Davidson – Denver Public Health Department

Absolutely and- and, you know, I don't think we're trying to get that deep in this.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

Arthur Davidson – Denver Public Health Department

Uh, we're- you know, that- that is probably stage four.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Or, or later.

Arthur Davidson – Denver Public Health Department

Yeah, right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, so, let's start—

George Oestreich – G.L.O. & Associates

...simply, um, given this pat- this pediatric patient, 'cause those are the ones very complex, immunization history that we know of, here's what you would do. So then, you have to apply those recommendations to your patient, taking everything else into account. It's still useful information.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, but that's- that's coming back as unstructured—

George Oestreich – G.L.O. & Associates

Yeah, yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah, that—so, I think—let's start there and see what people feel. So, the ability to receive—in fact we might- we might want to and need to be more precise. Let's say age specific rather than patient specific because it's pretty hard to know what the public health system would know. What about receiving age-specific recommendations, uh, for immunization, and- and this in unstructured text at this moment.

Arthur Davidson – Denver Public Health Department

Well, I think we want patient-specific data as Leslie was, uh, uh, pointing out. I don't think it's at the age. It's- the prior experience of the patient really makes a difference about what you want to present them. If it's just the age, they'll say- people will just ignore it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

But- but my concern, Art, is- is to call something patient specific when- when it's unlikely that the- the public health registry knows a lot of the

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And then—this is Leslie. ...don't know, can be ignored in a query? So, from starting with the patient specific, you can always submit what you know. You don't have to You just simply respond with what you know.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Leslie, I- you probably know this, but you're- you've got a lot of background noise going on. Um, so, where are people falling in terms of- of, uh—well, let's start with this patient specific then. I guess my concern is labeling something patient specific is- is probably not gonna be, uh, accurate in- in the majority of cases.

Arthur Davidson – Denver Public Health Department

I would, uh, tend to disagree with that. I think that the immunization registries are trying very hard to unduplicate patients, to merge data. They spend a lot of effort on that and, uh, the intent is to have a patient specific, uh, uh, recommendation. Indeed, there may be some information that isn't in there and that may, uh, prompt a provider to collect that information and put it into the immunization- immunization, uh, information system.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, Art, my- my- my, um, uh, challenge is not that the public health department isn't providing information in the context of information, uh, data that they know. It's that there's a lot of things that are not submitted that may shape the recommendations for this individual patient and just labeling it "patient specific" may be misleading.

George Oestreich – G.L.O. & Associates

So, can we change it to, uh, specific to the patient's age, gender, and immunization history, 'cause that's really what we mean?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, again, immunization history as far as the registry knows.

George Oestreich – G.L.O. & Associates

Well, but that's true of the EHR. I don't know that everything I have will necessarily—you know, I think it's—well, once you're- you're giving up on the registry having the immunizations then we don't need to have any of these objectives, 'cause what's the point of the thing if we know it's gonna be wrong most of the time. I think—

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And building on the patient specific allows us to add more if we need it and not limit the request initially because of our fears of folks not having it. There's no query that's gonna fail because all the information isn't there. It will just give what it has and then the provider will have some or the public service agency will have some ability or some burdens to retrieve information or ask for more information if needed, but I don't think they should limit the request.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, I think what George proposed is- is enumerating what things have been taken into account is, um— that- that makes a lot of sense to me. How- how do other people feel? So, you said age- age immunization history and there was one more.

Arthur Davidson – Denver Public Health Department

Gender.

George Oestreich – G.L.O. & Associates

Gender, yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Gender, yeah.

George Oestreich – G.L.O. & Associates

For certain immunizations.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right. Right.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

Um, this is Leslie again. I guess I could push back and say vendors are already creating queries that are patient specific that have age, gender, chief complaint, all the rest of the things. Uh, they use the same standard and then only ignore information that isn't- isn't needed rather than creating two separate structures.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

How do other people feel about George's suggestion? Art, does that- does that, uh, make sense to you?

Arthur Davidson – Denver Public Health Department

Yeah, I think that's cor- I think- I- I agree with George's suggestion that we make it age, gender—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

...and immunization specific.

Arthur Davidson – Denver Public Health Department

Yeah, and immunization specific, right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, and then do think this is, uh, an appropriate time? Is this- is this an appropriate objective for 2016?

Arthur Davidson – Denver Public Health Department

I- I think we're ready. I think the immunization world feels it's ready.

George Oestreich – G.L.O. & Associates

Encouraging.

Arthur Davidson – Denver Public Health Department

And- and- and Jim, do you think otherwise? Jim Daniel, I think, is on the phone as well.

James Daniel – Medical College of Wisconsin

Oh, no, they're- they're definitely ready and a couple of them are doing it now as you can- as you mentioned.

Arthur Davidson – Denver Public Health Department

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. How does the group feel about that? So, it's sort of this amended with George's specificity - age, gender, immunization history as known by the registry. Okay, um, do we need to ask HIT Standards anything or is this already known?

Arthur Davidson – Denver Public Health Department

Uh, let me just look at my discussion here. I don't think- the Standards Committee would determine the feas—um, so, one of the things, um—no, I think this one is- is okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Arthur Davidson – Denver Public Health Department

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, we'll have to move on and, uh, you promised this was the only that had two new- new objectives.

Arthur Davidson – Denver Public Health Department

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, the next one.

Arthur Davidson – Denver Public Health Department

This is the only one that had two new objectives.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Okay.

Arthur Davidson – Denver Public Health Department

Yeah. Okay. The next one is, uh, line 61. Um, this electronic lab reporting from the- from the hospitals to, uh, the state health departments has not changed.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Arthur Davidson – Denver Public Health Department

But, we have added, uh, for eligible providers the capability to receive and incorporate external data from the jurisdiction, um, specific—again, we're talking about receiving knowledge from ex- from an external site that would then drive case reporting from the EHR to, uh, the local health department. So, there are many, many cases of diseases that are never reported.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Mmm. Mm-hmm.

Arthur Davidson – Denver Public Health Department

And it's- it is an obligation in virtually, I think it is every jurisdiction in the country to report some number. Sometimes it's 58; sometimes it's 62. Diseases or conditions and, um, um, I can tell you as a- a public health practitioner that I rarely get a report from a doctor and I- I'm, uh, I have been at fault in this myself. I did not always fill out the cards to send to the state.

And most of the time, health departments rely on case reports from positive lab reports and not every, uh, reportable disease has an associated lab report - toxic shock, varicella post-vaccination. They don't always have a- a, uh, a positive test. So, these are a couple of examples of reasons—for instance, for varicella, we'd like to know that the vaccine isn't working.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yep.

Arthur Davidson – Denver Public Health Department

So- so, we're suggesting that a knowledge base exists. The EHR consumes that and then, uh, allows the, uh, record to then be sent to a- uh, a state, a local health department that receives it.

We are also asking—this is one where we would need to have the- the Standards Committee weigh in on this. We're talking, uh, in- in- intensely right now in the Standards in, um, in and the S&I Framework is- is to see whether we can use the consolidated CDA as a method to send the initial case report. We're not trying to solve all of surveillance problems right now, just trying to get an initial case report in. And, um, that might include a dozen, maybe two dozen variables and we're hoping that using the consolidated CDA, which will be used hopefully in many different instances in meaningful use, we could use this as well as the format for sending data to local or state health departments.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. So, you- is- is- are standards, are- are there mature adopted standards available in this case?

Arthur Davidson – Denver Public Health Department

No, there are not and that's- and that's where—if we're talking about pushing a standard in other priority areas, and my colleagues hopefully will describe that. I think I heard that from- from, uh, Subgroup 3. The, uh, transition to care document is proposed to be a consolidated CDA. We wanna use that same one. We're not trying to create a new one. We wanna leverage the one that would be developed for Stage 3 for one of the other priority areas for population public health.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. So, um, I think we need to—is there's something you wanna ad—is there something in development, or you're proposing this?

Arthur Davidson – Denver Public Health Department

I'm proposing that and I think if we have a transition to care document in 2016 that uses the consolidated CDA, I'm proposing that we use that to report the public health as well, and that's what the Standards and Interoperability Framework is considering now, that—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

All right, so- but I'm reading this new objective to say, receive the knowledge of- of what would constitute- that this is reportable; not that this would be reported using the consolidated CDA. Am I reading it in correctly?

Arthur Davidson – Denver Public Health Department

I think so. So again, we're talking about how do you consume external knowledge. That's- that's Web service that an EHR—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Correct.

Arthur Davidson – Denver Public Health Department

You know, that's the same thing that David hopefully is gonna present something related to, um, quality metrics. I mean I assume that- that we're- we're talking about some knowledge that would be—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Where does- where does it say, "Send back the case report" in your- in your objective?

Arthur Davidson – Denver Public Health Department

Um.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

What I'm reading is, "Receive and incorporate from case reporting knowledge base."

Arthur Davidson – Denver Public Health Department

Right, and you know what? I think I have a- a- a bad copy I- I put in here. I tried to combine these two into one and I didn't do a good job. I'll- I'll fix this, but—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, but probably you ought to separate it 'cause they are two new things, um—

Arthur Davidson – Denver Public Health Department

No, I—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—almost like your one before.

Arthur Davidson – Denver Public Health Department

Right. There- there were two. In the last meeting we had, the subgroup suggested combining them and I didn't do a good job. I will work on that. But- but the- the- the point is that you consume some knowledge and then based on that knowledge, the EHR decides whether it should send a report.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right. Yeah. Okay. So, um, folks, what do you think about this?

George Oestreich – G.L.O. & Associates

Why is the second one new, Art? Isn't the second one the old one? We're just sending in capability that's been made electronic—

Arthur Davidson – Denver Public Health Department

This is for an EP though.

George Oestreich – G.L.O. & Associates

Oh, it's new for an EP.

Arthur Davidson – Denver Public Health Department

Yeah.

George Oestreich – G.L.O. & Associates

All right, sorry.

Arthur Davidson – Denver Public Health Department

Yeah. I will fix that, Paul, and get that to—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Sure. So- so, just for folks—so, just, uh, uh, like the previous one, there are two new objectives for EPs, both receiving the knowledge and then the transmission of the case report. How do people feel about it in 2016?

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

Um, this is Charlene. I think, again, the challenge has been the knowledge, you know, because case reporting varies by even local jurisdiction, and we also know there's huge gaps in this reporting. So, clearly, it's an area that needs attention. At a minimum, it seems like it needs to be signaled and some mechanism like this which makes the knowledge available is going to be critical, I think, to even having any success in this space.

So, I'm not sure it can be there by 2016, but certainly the signal needs to be sent and the framework needs to be set. So, if we're setting it up under an infrastructure, for instance, in meaningful use- I'm- I'm sorry, immunizations to do that, you know, we would hope to like maybe use the same kind of framework.

Arthur Davidson – Denver Public Health Department

Ri- right. So- so, let me just point to that. I thank you for bringing that up, Charlene. So, there is a concerted effort between CDC and the Council of State and Territorial Epidemiologists to create this knowledge base, this reportable disease condition knowledge base and- and they're working on it right now. And I was at a meeting last month where I think there's been the commitment from CSTE, that's the State and Terri- Territorial Epidemiologists, and CDC to create this electronic knowledge base. This is what I understood in a- in a meeting we had about a month ago. And- and, uh, we're still talking about that. There seems to be a lot of enthusiasm for that, um, the- from both organizations.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, um, Charlene, I wonder if you have an opinion on—so, it's clear that we would like to get there. It's clear that this is probably not market driven and—

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

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—what is the best way to signal this to vendors. We have a couple of options, um, you know, that we've got- used before. One is to make a menu for- for a particular stage; let's say Stage 3. The other is to put it in a placeholder for Stage 4. Now, both of the—so, one is a stronger, uh, signal, but actually it's not even a signal. For vendors, a menu means it's gotta be done.

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

Yeah. It's tough.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, do you think that this is in the menu, gotta be done Stage 3 or the Stage 4 placeholder in public?

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

Um, my take because of where we're—unless what Arts says is gonna happen, it's gonna probably have to—'cause I mean different vendors are all over the place in doing some of this kind of reporting, but it's clearly not there. Um, so, it would strike me that it's more the Stage 4, but it needs that concerted effort to even get us there for st- you know, Stage 4.

Arthur Davidson – Denver Public Health Department

Right- right and I- I agree. I mean we may have some time here where, where CDC and CSTE actually do some rapid prototyping of this and, you know, between the time that we, um, make our first presentation to the Policy Committee on August 1st and when we get back the, uh, uh, request for comment, hopefully CDC actually will have made some progress in this area.

George Oestreich – G.L.O. & Associates

So, for Stage- so, for Stage 3, we would suggest the EP version of the EH objective and for Stage 4, we suggest the, um, consuming knowledge.

Arthur Davidson – Denver Public Health Department

Maybe that- maybe that might be.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Uh, how do you feel about that, Charlene?

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

Say it again. The EP—

Arthur Davidson – Denver Public Health Department

Just, you know—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Who's rep- basically reporting.

Arthur Davidson – Denver Public Health Department

That we'd have reporting. Just like EH has reporting, EPs would have reporting for Stage 3. Remember, we're still going go through public comment and everything.

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

Yeah.

Arthur Davidson – Denver Public Health Department

But then, the actually consuming knowledge to automatically find these cases, that would be Stage 4.

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

Well, I- I think we should put it out there and get some feedback, you know. I- I don't know if it's dependent on the knowledge to actually be able to do it, but at least you're getting that reporting framework into place, you know?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

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

I'm sure there's gonna be a lot of feedback on this one.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That makes sense. Okay. Are people comfortable with just going- going with what George just said? Okay, um, the other thing we may wanna put in our com- RFC is- is a preamble that talks about our intent. When we put something in a- as a visible placeholder for—

Arthur Davidson – Denver Public Health Department

Yep.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—Stage 4, it- we're trying to signal everyone - um, vendors and the healthcare providers - that this is our intent, um, and we should get good comments on that.

Okay, trying to move along. Then the next one you said—

Arthur Davidson – Denver Public Health Department

This will be a fast one. The syndromic surveillance remains unchanged. It still pertains only to hospitals.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Arthur Davidson – Denver Public Health Department

So, we can move on to the one beneath that. We're now up to line, uh, row 63, which is, hold on a second here. Uh, this is the capability to electronically participate and send standardized, uh, commonly formatted reports to a registry. We did put in Stage 2, and- and I think that's in the meaningful use, uh, uh, measures currently for Stage 2 in the rule, opposed rule. It says "cancer," but I think there's been some discussion about whether cancer—first of all, is cancer reportable in all jurisdictions? I found out no. There are very few, but there are some that do not have a cancer mandate.

And then the other thing is that there'll be some practices for which cancer is really not that relevant. It's- it's a rare event. There may be many other things that are much more relevant and meaningful to those providers; things like the, uh, early hearing detection/intervention in a pediatric practice where cancer is- is pretty unlikely and then, uh, children with special needs. So, we- all we did was suggest that we will have an opportunity—we're gonna see in this- in the next, uh, um, uh, objective that there are opportunities to participate in several registries.

Some of them will be mandated, such as, uh, cancer in some jurisdictions or early hearing, um, uh, detection and intervention. Those are mandated in some states. Again, doctors don't necessarily report very often, um, but that we would have a mandated, uh, registry event and then we would have objective rather, and in the sub- subsequent one, we have a jurisdictional or professional registry as we talk about these specialized registries. So, I'm just trying to set you up for this and the next one.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, Art, um, where- where we had come down in our comments on the NPRM for Stage 2 in- in re- re- in regard to registries, both cancer and specialty, is, um, the lack of standards about the registry data elements. Most of the time they are a number in the high tens or maybe more. Uh, that has been one of the things that we- we've, uh, had- had an issue in the others - um, some of the cost involved in participating. Does this address either of those two issues?

Arthur Davidson – Denver Public Health Department

So, the cancer actually is leading the way. They've done a- a fair amount of work in this and they have, uh, uh, established as- as we now know because they—I think basically with their efforts, they were able to reverse, uh, our concern about that and convince ONC- uh, CMS to add that back into the, uh, proposed rule, uh, for Stage 2. They've got a standard.

Now, all the others don't necessarily have a standard, but we'd hope that if there's one out there that people can use and model after that we encourage that. We don't need EHRs to have standards for all different registries. We might want to propose for efficiency and for parsimony a standard for communicating with registries.

George Oestreich – G.L.O. & Associates

Does this exist, "A standard for communicating with registries"?

Arthur Davidson – Denver Public Health Department

I think that's where we're trying to transform this. Does it exist? There's a standard for one registry, but can we—how- how many different methods will we set up for structured messaging to be sending from an EHR to each of the different entities with which we wanna have lots of exchange?

George Oestreich – G.L.O. & Associates

Right.

Arthur Davidson – Denver Public Health Department

I think we need to kind of consolidate that.

Leslie Kelly Hall – Healthwise – Senior Vice President for Policy

And then this is- this is Leslie and where there aren't standards, uh, is it possible to think of things beyond messaging where we're looking at just Web services, um, or, uh, several different options so that we don't continue to since we, uh, endorse the- the di- the transaction methods?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, um, both Emma and Michelle, we'll need to add this, the- the question of is there a standard or is there, uh, something that could be used as a standard way of communicating between EHRs and registries.

Emma Potter – Office of the National Coordinator

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Um, the other question then is what about the data, the relevant data standards? Art, are you just saying, well, pick something that's important to you or mandated in your state and try to use this communications standard, um, to submit your data?

Arthur Davidson – Denver Public Health Department

We- we are suggesting that there would be—in addition, you know, we're- we're- I think we need to lead with some suggestions about how this can happen. I think our problem is that each of the silos has gone off and done their own thing.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Arthur Davidson – Denver Public Health Department

That is- that is part of our public health, uh, dilemma.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, I think we can lead with the transmissions. I don't know what we do about the data and presumably—well, it would be nice if the public health departments who are mandating these would lead with the specification of the data standards to do so.

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

You know, Paul, and I think—this is Charlene. The signal that we wanna send, I think, across all of these—you know, every single vendor has to embed the same logic into their system—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

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

—across the board. It's like if there is a way to get some parsimony structurally so that public health provides the knowledge as well as consistent reporting mechanism—and Marty's not on the call, but he said, "You know what? As soon as you make that infrastructure available, we'll use it 100% because its re-reporting is so onerous right now."

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

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

There's huge value in like looking across these and signaling that, you know—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

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

—they need to come together and we can use these as an asset. So, that was kind of why I was in support of even like the adverse event reporting, just as long as we don't look at these pieces independently. You know what I'm saying?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah. So, uh, Art, would you mind sort of tightening this up and being more precise about what you're asking for because I think we've honed in on let's find a common way for us to transmit data in support of registry and that's sort of what this objective is all about versus any specific registry - cancer or otherwise - because hopefully if we make—as Charlene said, if we make the infrastructure available, we'll get public health services- uh, departments to start specifying the data they need to consume in a standardized way.

But, I guess what we're doing is trying to put the capabilities into EHR. If you would describe it a little bit more precisely and say, "What is it we're asking from EHR," then we'll get comment on the appropriate, um, concept.

Arthur Davidson – Denver Public Health Department

Right. I mean in- in some ways, this is just another example of could you use a consolidated CDA?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah. Yeah.

Arthur Davidson – Denver Public Health Department

Yeah. Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, that's good. That's good. Okay.

Arthur Davidson – Denver Public Health Department

Okay. So, we're- uh, we're now on, um, line 64, which is- is similar, but now it's- it- it's saying you- you could do one that's mandated and here's another one that may or may not be mandated, but you have a particular interest in. And this- this gets back to the specialties, the specialty registries where someone maybe, you know, uh, has a device that they're implanting or- or using and they like to follow along with others around the country, um, as we heard from- from, uh, various specialties and- and testimony.

So, this is, um, adding yet another registry activity that's of interest to that provider where they hopefully would be getting some information back from the registry and- and we don't expect that is gonna to be happening in Stage 3. As- as I said, there's only one, uh, roundtrip. That's the immunization. But here, we're thinking that this could support many activities of particular interest.

Um, the- the- the one thing that I think here we—you know, we talked about how do things relate to the Million Hearts Campaign and I'll give you an example. We're trying to build a hypertension registry for the city and county of Denver. Uh, we're trying to build one for hypercholesterolemia and for smoking as well. Those are registries that are not mandated, but have particular public and population health benefit, and it's something that I could send a message back to a practice to say your rate of control is better than the average in the city, or your rate is lower than, and we could provide information that might change behavior in the practice over time.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, Art, is- is there a possibility of combining the one we just talked about with this and instead of saying, um, "Participate with something of interest"—I mean there's so many things that has to go into that, um, and it's hard to make that a requirement. Could it- could our maj- major contribution be deciding on the standard way of submitting data to registries, which is what we talked about in the previous one?

Arthur Davidson – Denver Public Health Department

Yeah, but, um, you know, if cancer gets approved in Stage 2, it would hard for us to pull it out in Stage 3 as- or what would we do? Would we make it a menu?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, no, no. You're- you're- uh, we- we- we already know we have to be subject to reconcile with the final rule and this could change this discussion. So, it's exactly what you're pointing out. But if- let's say if, um, they take our- our comments about the two registries they propose and, um, maybe they'll- they'll use something like—maybe they're gonna propose something like this.

Anyway, if- if- if, um, if cancer is not—if they do not specify something that's required, um, in the final rule then would you be willing to make this- this infrastructure piece?

Arthur Davidson – Denver Public Health Department

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. So, I think this is one of the things we'll have to revisit once we see the final rule and see where we can make a contribution.

Arthur Davidson – Denver Public Health Department

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And if we do add something, I think we have to be a little more precise though.

Arthur Davidson – Denver Public Health Department

Okay. I'll- I'll try to be more precise.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah, it's the clarity thing. Okay, you wanna finish up with, uh—

Arthur Davidson – Denver Public Health Department

Yeah. Yeah. So, um, Stage number- line 65 is just, um, reiterating our desire to have some patient-generated data. Um, uh, Leslie pointed to this earlier and we have had this discussion, uh, previously regarding adding, um, occupation and industry, uh, as a demographic variable, but there's not a meaningful use, uh, objective or measure that we're specifically adding here. It would be available through that earlier, uh, addition, uh, in priority area one.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Arthur Davidson – Denver Public Health Department

Okay. Um, and then, uh, line 66 is, uh, we had a- a- a nice presentation about heal- healthcare associated infections that are reported to the National Healthcare Safety Network and, um, there's a- a CDA measure for this. There are, um, something less than 1,000 facilities now reporting. It lines up with, uh, JCAHO requirements. Um, we think that, uh, this can be spread easily to, uh, hospitals. They have to do this.

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

Yep.

Arthur Davidson – Denver Public Health Department

Um, so, this is not that hard and, you know, the HIT Standards Committee could evaluate that CDA standard, but, um, I've been told by my public health colleagues that this is uh, pretty functional now, uh, that- that- that- that some EHRs are reporting, um, um, this, uh, event to this National Safety Health- uh, National Healthcare Safety Network.

There's also a Web-based entry form. So, not all of it is going that way, but, um, a fair portion is currently using that CDA standard.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, so, Emma, this is another one where the discussion is that they'd like to have HITSC, um, assessment of readiness.

Arthur Davidson – Denver Public Health Department

Right.

George Oestreich – G.L.O. & Associates

Is this one-

Emma Potter – Office of the National Coordinator

Okay.

George Oestreich – G.L.O. & Associates

Is this one market-driven?

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

That's a good question.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's a really good question since, like you say, it's required.

Arthur Davidson – Denver Public Health Department

Well, it's- it's—so, is

M

The- the reporting is required, but the electronic version of reporting is not required.

George Oestreich – G.L.O. & Associates

Yeah, but still, it's more market-driven than many of our other ones.

Arthur Davidson – Denver Public Health Department

So, if it's market-driven, we would say that this is not something that, uh, we're en- encouraging?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, we're not—we can encourage 1,000 things and people accuse us of doing that. Um, so, it- it- it's basically sort of the Marty Fattig comment. If we put into place a consolidated CDA and make sure that it is, um, used for these various reporting requirements then I think, you know, the ... old compound thing.

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

Absolutely.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, I think your biggest bang for your buck is to have created, um, the focus on consolidated CDA as the mechanism of fulfilling a reporting requirement and making it easy to do in EHRs. So, for example, the other thing you had was the automated trigger. If I detect, i.e. the EHR system detects that you- you have just diagnosed a reportable illness, let's make it really easy for the physician to do that reporting.

That sort of- now, that- that's, uh, infrastructure and that's enabling and that's an exemplar. I don't know that even though there— there are a lot of national priorities as well. Just because national priorities- we- we don't wanna embed every one of these into the, um, um, the meaningful use program, we're trying to put in the infrastructure to make all those things happen more efficiently, effectively, more completely. So, I think you've done that job actually with your- your- the- the, uh, objectives you had higher up.

Arthur Davidson – Denver Public Health Department

Uh-huh. Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Does that make sense?

Arthur Davidson – Denver Public Health Department

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I mean we're- we're really—I'd love to have what Marty suggested have- come true. If we build this then they will take advantage of it. So, this- it was a smart thing to do.

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

Absolutely.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And then- and then we would also be pointing the vendors in the right direction. Here's the capability and the way we wanna automate this to have to, you know, happen. That's where they can do the innovation.

Arthur Davidson – Denver Public Health Department

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And then they'll take advantage of this. Okay.

Arthur Davidson – Denver Public Health Department

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Is that still okay with everybody else? Okay. Your final one?

Arthur Davidson – Denver Public Health Department

Uh, I'll move to the next one, which is, um, uh, capability to, uh, electronically send adverse event reports, uh, to- you know, for a variety of different things to either the FDA or the CDC and, um, you know, we're- we're trying to find a way for this to happen, um, easily and, again th- you know, this may be an infrastructure thing is to say, "How can you easily prepare a report to send to the- to one of these, uh, national agencies that are monitoring?"

And, uh, we heard a- a presentation by Becky Kush from CDISC and, you know, we've- we've talked about that public health button, um, but we don't really know what that would be or we haven't yet established what that would be and it- it- it- this may be a good case for us to think about using the button to bring up a—uh, it's called a retrieve form for data, uh, an RFD that CDISC has where you- you, uh, bring a form onto the screen, you populate it with data from your record. This is the way that they do lots of the, uh, pharmacy trials, uh, the- the drug companies, the- pharma does this. And then, you fill in a few other elements and then ship it off.

Now again, this is, uh- this is an infrastructure that exists for a different reason, not in the- in the, um, uh, uh- other than research world, uh, at least what I understand from Becky, but, um, this is something I think—and Becky is on the Standards Committee. It would be something for us to evaluate as a method to make that public health button do- uh, do a function that's needed to support population public health reporting adverse events.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

You know, another example could be reporting EHR adverse events or EHR events.

Arthur Davidson – Denver Public Health Department

Yeah. Yeah. We- we could add that to this. Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, does this sound like another participant in your- in your, um, infrastructure for common reporting?

Arthur Davidson – Denver Public Health Department

So, the- the- the ones that are case-based where you're adding to a registry, it's- it's pretty clear or at least the minimum elements that you need to go to that registry are pretty well defined.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I see. Got it.

Arthur Davidson – Denver Public Health Department

The vaccines, EHR, devices - those are all over the map.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

Arthur Davidson – Denver Public Health Department

And- and it may be harder for- for us to use that consolidated CDA here.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, good. I see how this is a different category.

Arthur Davidson – Denver Public Health Department

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Other comments?

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

Um, this is Charlene. Again, um, because one of our focuses is safety, it felt like we at least needed to signal this area—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Mm-hmm.

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

—as an important place to get some consolidation around. So again, um, hopefully as the national infrastructure becomes more harmonized and there becomes less places to report the same thing, we can start to do it in a standardized way. So actually, that was kind of why I supported it. I think it's a really important signal now.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Mm-hmm. Okay, so what I'm hearing from essentially, um, most of the discussion in this area, you're—you're, um, suggesting that there is a standardized way, um, format to report things to registries and a standardized way of, even though we don't under- uh, the fields may be, um, varying, there's a standardized way of reporting essentially adverse events or risks,—

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

Yep.

Arthur Davidson – Denver Public Health Department

Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—i.e. safety- safety events. Let's call it safety events, um, or safety risks - events or risks. And third, that there is, um, and this is where innovation can occur at the vendors, there are ways to detect, um, detect things that should be or could be reported. So, that could be either reportable, um, uh, like HAI or let's say in the adverse events, they detect, um—uh, so, there's common ways of detecting adverse drug events. So, it may detect the possibility of an adverse event and prompt you to fill out the form or, you know, say whether this—

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

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—is in fact true. So, there's three things—report- report to registry, report at adverse- uh, safety event or risk and a- and a way of supporting that. In a sense, it could be decision support to help detect these things and remind you.

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

Yeah. Paul, the other aspect of this, though, that would be really helpful is just the knowledge of what to report, right?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes, correct and that—

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

What do we report because once they know what to report, building- building, and, again, as there's more standardization maybe around detecting it, but that's really our—maybe those two are the same thing, you know, the—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, I think that's the thing that, um, Art had in his first, um, objective.

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

Yeah.

Arthur Davidson – Denver Public Health Department

That's correct.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, that's actually like number five, uh, four I guess.

Arthur Davidson – Denver Public Health Department

Yes. Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, you—yeah. So, there's been- some very important principles here that I think would- that- that are not market-driven that would raise the- the- the tide and would create the infrastructure to use in many other ways.

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

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

A- and that's really nice.

Arthur Davidson – Denver Public Health Department

Well, I- I like the way that you've kind of summarized here, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Maybe we can put a little bit more precision and specificity around those things, but those are nice, um, infrastructure tools that are en- enabling.

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

Mm-hmm.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Uh, okay and we do need some Standards, uh, HIT Standards advice on some of these things and- but I think Art has covered those things in his discussion.

Emma Potter – Office of the National Coordinator

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Great. Thank you.

Arthur Davidson – Denver Public Health Department

Thank you.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, so the final one, I think, and we don't have time to discuss, but it's, I guess, the question of, Art, does this fit in your—you've, again, referred some things. Does this fit in your, um, subgroup to look at it? It doesn't mean you have to do all these things, but to look at these things?

Arthur Davidson – Denver Public Health Department

I see some of these that I feel fit right away.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

Arthur Davidson – Denver Public Health Department

Some of them are a little more difficult, but, um, you know, this, uh, individual care plan—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

Arthur Davidson – Denver Public Health Department

—how- how, um, public health gets involved in that is a- a little bit harder for me to understand or—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah, I would actually look at that and say it doesn't belong here.

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

Yeah.

Arthur Davidson – Denver Public Health Department

But- but—

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

That's- that's kind of what - this is Charlene - we kind of evolved to that collaborative care plan from these object—when we got to these requirements that's what took us to that other level, you know, but the one that we didn't know what to do with was kind of that first one was, okay, when you're in a care setting and you identify patients at risk for either readmission or, you know, managing those populations.

So, this could be in the context of—it could fall under—remember, we've got that requirement in quality under Creating the Patient List. So, is it that? We discussed evolving that to be a registry, right? So, it was just kind of confusing where to best position this one and it's really helping healthcare providers managing their populations too.

Arthur Davidson – Denver Public Health Department

So, I think that this is one that I believe fits in that area about those registries for—it could be for people with a condition that they're at risk for readmission and that could go to an ACO. From the EHR, a consolidated CDA is shipped to an ACO or an HIE or whatever and there is an effort to manage that patient. I don't think this is far from the intent of using registries to support population health. This first bullet just seems consistent with that.

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

Okay. So, it's really more that one that—

Arthur Davidson – Denver Public Health Department

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Okay, let's move—thank you, Art. Um, I think this also has been a good discussion and I think there is a way to— to sort of, um, consolidate the underlying, uh, requests that you've had.

Okay, so, I— all right. Let's move on. Charlene, you had some updates from Subgroup 3 you wanted to cover.

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

So, um—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

We need to do it very quickly of course.

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

Back to 51, um, on- in the worksheet, um, we took the input from the worksheet and our workgroup had lots of discussion and- and we stepped back for a moment. Um, in the document itself, we've really put a lot of our information relative to, um, kind of that preamble in the other worksheet, you know, and I'll just highlight one or two points.

Last time, um, the workgroup kind of stepped back and said on a broad scale, in Stage 3, we'd like to start to be positioning with efficient standards and capability to ultimately move to this collaborative care capability that transcends venues to support managing patients across a continuum. Um, we recognize that's a big stretch for Stage 3 because those projects are lit- products are just literally emerging now in some form. And, in addition, um, the standards, in some cases, are, again, being worked on very aggressively, but they're not road tested yet. So, we- we get that.

Um, so, in light of that, what we looked at Stage 3 being is kind of the transition to that, um, platform and maybe enabling that platform if you will. So, that's kind of how we focused on our Stage 3 efforts. Um, last time we were asked, um, had great input from the group to....

So, we framed in under this—as you look at care coordination as a process, again, very consistently, we heard three major themes or functional areas. Number one, um, the ability to communicate; number two, the ability to be able to kind of track and record, you know, things that are in the care plan or in the coordination area, and number three, um, the ability to be able to have a pretty robust reconciliation process. We're making the assumption, and that's a bit of a leap, but that by Stage 3, and, um, that's given in Stage 2, a lot of the exchange infrastructure will be in place such that, um, we'll have a higher number of, for instance, transition to care summaries, um, populating the respective EHRs and when they get it, they're gonna have to know what to do with it to be able to make that data useful. So, we're kind of making those assumptions.

So, to that extent, um, we consolidated, um, the objectives into three and so that's what, um, I'll present. Um, and so, if you look at 61, actually- or row 53, um, what we did there was, uh, we looked at, um, the reconciliation process and with pretty strong, um, input from the group was the need that we need to enable a reconciliation process, again, that vendors can make smarter and more intuitive over time, but we looked at, um, starting to reconcile, um, a list of information and it becomes reconcilable, if you will, as that information becomes standardized.

So, for instance, um, to date, we're reconciling medications. We suggested, um, again, um, adding into that medication allergies, intolerances and contraindications and I put a note in there that, again, con- I defined contraindications, but again, there may be some standard underpinnings required for that and then the last item was problems. And again, um, in Stage 2 problems will be coded in SNOMED. So, that will be the basis for the reconciliation.

A note to that: We do recognize concurrently we're trying to evolve to the concept, um, if you will and we don't know what this is, Paul - a longitudinal problem list that's a little bit more higher level. We don't know how to frame that. So, we started with just the base of, um, you know, of problems that are coded in SNOMED. Um, and again, there's an increasing number of those problems that are gonna be added to that language is our expectation.

Then we also flagged, um, that, um, there is—and again, we made this applicable to, um, both EPs and EHs, um, and we left- and we made the percentages higher. We- I left 50%, but we could go to 55%. Again, we're waiting for what comes out of Stage 2 and the experience. We know the experience is gonna make a difference, and we left it for 20% for the new data elements, but what we wanted to propose is some flexibility, you know, in those reconciliation processes. Again, um, it's my assumption that if you're gonna reconcile medications, most likely you'll reconcile, um, allergies and intolerances and contraindications in a similar process 'cause you're doing this the same time, but we didn't make that jump yet.

Um, the other thing that we identified here as we reco- we wanted to highlight, um, it's gonna be important to reconcile elements, um, from the care plan and those, um, we expect to become increasingly defined and standard over the course- over the work that's happening now. So again, it could be can—I know the, um, the long-term care, post-acute care community is advocating that we reconcile them in Stage 3. We just listed them at this point as future reconciliation candidates just to lay out a roadmap.

So, um, now I'll walk through the other two objectives. Do you want me to do 'em all at once or just—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Uh, we probably should talk about them.

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

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, comments on this? So, how would you—what- do you have a- an idea on how you would propose, you would recognize that reconciliation has taken place other than it being a check off?

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

Um, again, from a systems perspective you do the reconciliation, right? I mean we have to know- we are gonna to have to know it's a transition of care and the process of reconciliation being completed is something the system would capture. So, that's how we would, um- we would know and then we'd use the same- same date base as the denominator.

So, we're kind of—in Stage 2—the reason I'm proposing this, in Stage 2 certification, um, we're being required to do certifica- or reconciliation for problems. So, the capability will be in the system.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Did you say problems or meds?

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

Meds. Well, for Stage 2, we're being required to do reconciliation for medication allergies, intol- in the certification piece—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

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

—not meaningful use, just certification. Medication, allergies and intolerances and problems. So, the vendors will have the infrastructure in place to do this in- in Stage 2.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, I guess I'm not seeing that. So, for- for line 53, the ... is for reconciliation of medication.

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

Right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I don't remember us having problems there.

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

No, no, no, but the certification requirements have that included as a requirement.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

How does that fit there?

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

Um, there- the certification, um, is pushing out a—like remember in orders last time we had to be certified to do medications, lab and radiology? So, we had to certify we could do all three of those. So, that's the same case.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Oh.

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

We're- they're pushing the vendors further, um, than the meaningful use agenda.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's interesting.

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

So—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

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

—I'm- I'm trying to like—I'm trying not to push the—you know, they've asked for other stuff, but I'm not trying to push the window on, um, the other elements yet because the vendors won't be ready.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And the 20%, where did you get that 'cause that- that- that wasn't—

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

Um, I just made it—we- actually, what we talked about was just harder for me to do. You know, um, we thought maybe for each of the kind of data elements we could put a percentage on- you know, as we're starting to do this. That's kind of open to what the best approach would be, but that got pretty complex to keep track of. But again, once you do the reconciliation of it, when you do that process, the system will know that and we can count those things. We just kept it lower 'cause it was new.

So, we expect most people to be doing med reqs, um, and then perhaps more people will be taking on the reconciliation of these other capabilities in Stage 3.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, just trying to read the- the language you have here- here. The- the EP- the- the provider must do reconciliation for medication for more than 50% of transitions of care and for more than 20%—what's the difference between the 50% and the 20%? At least reading the words it's hard to tell.

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

Okay. It's medication, the med req function for more than 50% and 20% for the other two data elements.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Got it. I'm sorry.

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

Okay. That was- maybe there's a better way to—I didn't change so much the text of it 'cause I was trying not to.

M

But, it's just that the latter two are new, so they're 20%.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

M

We can argue what it should be, and 50% is med req since we're already doing it.

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

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Got it.

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

In my original copy, I had it marked in red so you could have seen it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right, okay.

M

I mean we don't know if problems will stay in there forever, but this is the time to introduce it and get public comments on whether it's possible. It seems like allergies should follow meds. So, uh, uh, that one's more straightforward.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

M

So- and this is, I think, the right way to lump it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And- and so, we've introduced a number of new things; allergies, not only allergies though, but intolerance and this new thing we've created - contraindications.

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

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That's- that's quite a bit. So, I- I wonder if 20% is- is, um, high—

M

Maybe.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—'cause we've used 10% when we're starting something brand new and I mean the- the- it really is. This- this notion of, um, contraindications is brand new.

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

And I mean maybe just ... those candidates for, you know, a menu. We really—it's important to get going on the problems one 'cause it's gonna be really important ultimately for the care plan.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Mm-hmm.

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

That was why we thought we needed to get this- that on the table.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, what do people think about the new additions? And there's some background conversation going on. Can you mute your phone please? Comments on the 20%- on- on the new- the new reconciliations?

M

Do you think that number's too small, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think it's too high for new.

M

Oh. Right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

'Cause- 'cause these- these are brand new workflows. I mean those are always hard to—you- you have to ramp up.

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

Right. I mean maybe the better approach would be—you know, typically, once you ramp up, you're gonna do it for a higher percentage.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

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

Maybe the better approach would be to make a menu, you know what I'm saying, because once you start, you're gonna probably do that, right—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

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

—across the board. You're not gonna just say, "I'm only going to do this for a small percentage of my patients."

Christine Bechtel – National Partnership for Women & Families

So the difference, it's Christine, is- is the- the current measure is- um, on med req is 50% transitions of care. You're just adding more, and it's menu, but you're adding more types of reconciliation to the list, right?

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

Yeah. Yeah. So, when I reconcile, I reconcile my- my—you know, my med list comes in; I reconcile that. I've got to reconcile my allergies, you know.

Christine Bechtel – National Partnership for Women & Families

Right.

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

Um, and then, I've got to reconcile my problems and our expectation over time is more and more in- like more and more information is transferred. There'll be more elements that can get reconciled as that data—

Christine Bechtel – National Partnership for Women & Families

Right. No, no, no, I got it, but I guess my question or I'm trying to understand Paul's concern. If it's already at 50% but it's menu, are you just wor—I mean this looks like it's going to 20% and core.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, no. Uh, 50% is- is, uh, med. We have brand new things, things that haven't even been defined, things that are not in the workflow even on paper at times, contraindications. Um—

Christine Bechtel – National Partnership for Women & Families

Ah, okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—we're- we're- we're introducing new concepts and a new workflow and I—

Christine Bechtel – National Partnership for Women & Families

Yeah, I got a new concept here.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah. So, I- I think we need to be very careful and- and stage it either using a very low threshold or menu as is being suggested. So, I might even suggest both - a 10% so that people—you want people to be, uh, induced to- to use the menu. It's not just there to- to be- to be there, um, so, I would almost suggest 10% as- and all of this as a menu.

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

Okay, so I'll put like—we'll put just “menu” next to ‘em, you know, um—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, how other people agree with that?

M

So, you're saying menu and 10%.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

M- men- menu and 10%, correct, correct, correct.

M

Good.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Good start. It's- it's something we're going—we're basically making these extremely important things for every patient, um, more accurate and more complete as we go.

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

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

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

All right. Um, 50—wait, am I—wait, I gotta back up.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Fifty-four.

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

Fifty-four, okay. So, um, this actually—we think this probably is a starter requirement for us. This is the whole- the whole thing about communication. So, we, um, followed a similar pattern in that and we were—first of all, um, to provide the summary care for each transition is exactly the same except we claim—we- the important statement, again, that we wanted to include in that was inclusive of a concise narrative in support of, um, care transitions, free text.

So, no one wants to lose that. So, we just carved that out—that's a- it's not a huge change, but a change in, um, you know, those- that little short statement a physician says that sums it up. We would like to really capture that. So, that's really important to, um, the communication.

And then, uh, we would like to, um, as a second element of that, and perhaps this is menu, provide updates to a core set of information relevant to a patient's care plan and I list those and I included in that, um, who the current cor, um, care team members were, the related information. So, for instances, if you're. you know, discharged from the hospital, your discharging physician and perhaps your social worker or something. So, there's some update relative 'cause we said last time it should be the primary care team. So, we restricted it to be, "Just give us an update of the people who are relevant to that transition." So, it's not everyone on the care team, but just to help it so if they have to call somebody, they can call them, which would be really helpful.

Um, then we're listing a couple elements, um, and again, these were important relative to, um, patient goals/problems and again, what we wanna be here- clear on here, and I think, um, Neil said that at your broader hearing, is let's not let the standards get in the way of getting something- getting something available. So, if it has to be narrative, we're okay with that.

Um, current status of activities to meet goals; um, and again, I have to take some of these, and then we listed specifically the patient assessment content because these are—as part of the CDA, there are standards now in place for these different elements - cognitive, functional status, pressure ulcer content. And the other one, um, we listed which was important was an advanced directive.

So again, um, to some extent, this is contingent. That- those particular data elements are contingent on, um, the work that's being done on the CDA to capture this information. So, it's really a next level of CDA. Um, but again, what the workgroup recommends is that, um, we need to get started in this area with Stage 3. So, that was kind of our, um, direction here.

Christine Bechtel – National Partnership for Women & Families

So, Charlene, I- I like this a lot. Um, I have two questions. One is in terms of providing updates, um, to the core set of information, and I think you've listed the right category I worry about making that a menu item because we saw such, you know, low uptake of this piece in Stage 1 and we just don't know how it's gonna play out in Stage 2.

So, I- I almost was thinking about what if the kind of menu approach was more like, you know, that- that there is a requirement to provide updates, but that the update, you know, must have sort of the first two bullets, right - care team members, which is already Stage 1, but it's just a little bit more- got more detail in it, which is great, and then the second bullet is care goals, problems and interventions. But that, um- but that the current status of activities to meet the goals, the patient assessment and maybe I don't know about advanced directives, um, maybe that, just that part of the content is sort of either extra credit or it's optional or they- they're encouraged to include that- those things, but you just worry about making this whole piece, um, a menu item given the low uptake and given how critical it is to support new models of care and national priorities and- and its applicability to a range of specialties.

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

Yeah, and even on advanced directives, sometimes they just wanna know it's present.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

You know, so, it's not—they do wanna know what it says sometimes, and so they wanna know its contents, but, you know, the first phase is just that it's, you know, present.

Christine Bechtel – National Partnership for Women & Families

Yeah.

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

So, um, clearly, that coincides, Christine, with what we're hearing in terms of those first two bullet points. Even just, you know, a narrative in terms of what's on that care plan, you know, just make that available.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, um, I- I think these are all laudable goals. Um, I don't- I think there's so much here that is new and added to- to the, uh, providers', um, demands on their time that I'm not sure it's feasible for- to- to throw all this at- uh, at them at once.

Christine Bechtel – National Partnership for Women & Families

Well, Paul, but what if you just take the first two bullets where you—you know. I mean current care team members you already have the groundwork for in Stage 2 most likely.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Well, we said, uh, minimum of PCP. Most- most people will not—there's almost nobody on the care team or the patients that will know this information. And so, yes, it would be important to have, but who are we placing the burden of getting all this information on?

Christine Bechtel – National Partnership for Women & Families

Well, most likely it's gonna fall to the patient. The patient certainly knows who's on their care team.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Uh, I don't know. I think that was one of our challenges.

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

I mean, you know, the current—

Christine Bechtel – National Partnership for Women & Families

I know who I go to—I mean I know who I see and I self-define my care team. I mean all- all of our, you know, research that we did a couple of years ago was very clear that people self-define their care team. So, I mean I don't think there's a requirement that, you know, every single person. It's just sort of who's the most important people. You know, right now, I know I have a cardiologist and I see a physical therapist.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, that- so that's where we need precision, um—

Christine Bechtel – National Partnership for Women & Families

Yep.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—I don't- I don't think standing- standing with these words, um, people would even understand what's meant and people would be concerned. There's a lot of people, as you—as everybody knows, in the hospital, you see lots and lots of people. Um, so, if you can come up with a precise definition and- on what's the- the minimum then I think, uh, and- and a way to- to carry across enterprises, that's part of the trick, and a—

Christine Bechtel – National Partnership for Women & Families

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—way to identify them. So, I think there's a lot of things here that would have to be thought out before you make this requirement.

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

So, the- the fact there, Paul, was, and maybe I need put in this, it was kind of update on this summary of care document, um, that field and when you do a transition of care, again, they're—you know, even though there's been a lot of caregivers when you're in the hospital, we don't want that. We just wanted like who the discharging physician was—you know, those people - the discharging physician and the social worker; just those relevant people to the transition of care. Does that make sense?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah, so could you enumerate those please and then people would—

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

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—at least have a better, uh, idea of how to comment on this.

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

Yes, yes because I don't want everyone that took care of the patient while they were either—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Correct.

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

That will never happen, but it's just relevant to the transition. So, if you have to get clarity on the transition you know who to call. That was it.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. So, if- if you could enumerate that then it'll save a lot of discussion—

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

Yeah, because then you do that as a process when you're discharging and you just—you pick a couple of them and you put—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

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

— ‘em on there, okay?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Good. Okay.

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

No- so I was trying to minimize that, but again, it’s so important to knowing- for that communication.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, uh, same probably are- are- is true of the other bullets. So, first, event directive I think we have in a separate objective. So, I’m not sure I would, um, include—it can be on the report, but—oh, I see what you did. Okay.

Christine Bechtel – National Partnership for Women & Families

Yeah, I think Charlene’s just saying ... yes or no and I think that’s important here.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, um, so the individual care goals, problems, interventions; all of these things need to be defined otherwise, uh, it’s gonna be hard to know whether it’s taken place or, you know, what kind of functions have to be in place. And- and activities to meet goals - that’s sort of—what I’m describing here, these sound like good things, but you have to get very precise in what they mean, otherwise people don’t even know how to interpret them.

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

Yeah, so, Paul, I was struggling a little because the reason—and you’re- and I put that in my- some of my text someplace, probably in the introduction. I was really clear in the introduction ‘cause we- I populated that preamble with all this stuff.

Um, the- the Standards work now is going through the definition, uh, for this longitudinal care plan and will come out with the definition. So, I’m trying to as best as I can to stay aligned with their nomenclature. So, I’m trying not to ... things that they’re probably working on, so—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, but you’re- you’re gonna have to be—so, remember, we’re gonna put this in front of people who have not seen this or not been a part of the sessions—

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

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—and they’re gonna have—uh, I mean this will just bog us down with what does this mean.

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

Okay. All right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Uh, another example is the “Patient assessment ... including.” This is a huge thing that’s not done right now - the kind of status function. These are all good things, but to require them is a massive change and adding to time and changing the workflow. We just have to be sensitive to this.

M

The- the key thing, I think, is distinguishing what you want, what we want to be documented, you know, implemented in the record so a provider can put it in versus what we’re checking that the provider didn’t put in.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Exactly.

M

If we’re talking about pediatricians having every patient to say pressure ulcer is not relevant, you know, functional status is a little bit different than the pediatric—it’s a different kind of functional status, I guess, for a three-year-old. So, there’s what we want the EHR to be able to support, say, functional status versus what we’re gonna check that every provider use- does on every transition.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Correct.

Christine Bechtel – National Partnership for Women & Families

So, this is Christine—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, what you described here is a meaningful use- what the provider’s gonna be, um, audited for and ... it has to be far more precise and probably not as- as prescriptive.

Christine Bechtel – National Partnership for Women & Families

So, I would just suggest, it’s Christine, that, you know, one of the ways we could approach this is, um, after we’ve done kind of- after we’re done coming through the whole chart is to look at what we’re already collecting in the EHR. Like communication preferences, for example, would be good to have on there. It’s probably already being collected in Stage 2. Um, you know, the problem list is, you know, already being collected, what- look at what’s in the after visit summary at least on the EP side, what’s in the discharge, um, summary from the hospital side, you know, so that we can build on what’s already being collected as the core set and I- although I would add one or two new things in there that, you know, are defined clearly and I think care goal is- is probably, um, one of the key pieces.

But then again, you know, having this idea that there are other, um, elements that people could also put on there more as an option or a menu, uh, just so that we can create the capacity in the EHR to do that and then let people who can accommodate the workflow change make those changes and get credit.

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

Yeah, so I mean I- and- and Christine, like at a minimum, like the patient assessment content, those are kinds of things that we’d want to signal at a minimum for certification in that stage.

Christine Bechtel – National Partnership for Women & Families

Right, as long as it’s defined and- which I agree with Paul on that, but, yeah, I- I think that’s absolutely right.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, so, um, Charlene, I think we need to move onto the last part of our agenda, but I think looking through your- your recommendations and trying to be precise, you have to say how would someone coming on press, which is what's gonna August 1st—

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

Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—interpret this and if it cannot be interpreted and we- and we- we'll generate five questions on what does this mean, that's not going to be very productive in terms of moving us forward. So, uh, I think some- Christine's suggestion's good. What do we already have and what you're saying, create the capability that- to accumulate all this information and other things that- that, um, may or may not be present, but don't require the "meaningful user" to do all these things 'cause it's not relevant a- across most- many of the providers.

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

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Um—

Emma Potter – Office of the National Coordinator

Um, this is Emma. I just have a quick question.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes.

Emma Potter – Office of the National Coordinator

For, um, the current care team members, we didn't make any definitive decisions on how to define that, correct?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Uh, Charlene needs to come back with how to define that I think.

Emma Potter – Office of the National Coordinator

Okay, 'cause I mean I heard the sort of term "discharge physician/social workers are not," but I wanted to just make sure.

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

We'll come back and clarify that in terms—

Emma Potter – Office of the National Coordinator

Okay, great.

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

—put it in context because—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

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

—you know, it's- it's those that are important to a transition.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

And then- and then test it against the- the- our- our impact criteria; uh, so broad applicability, some of the things that George mentioned. So, not everybody needs to- to apply pressure ulcer content, um, or cognitive status even.

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

Yep. Exactly.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Be- be careful with what—and then also, the mature standards. Okay. Um, so let's transition over to the impact criteria. We need to find ways to help us get to a parsimonious step and recall that what we're- we're not doing- we're not saying what is an important- is not important in healthcare delivery. That's not our job. We're trying to—we've been using the exemplar approach to, and I think the population discussion was a good example of this, to put in place infrastructure that includes the EHR and in the population health, um, example, the broader community, the HIE, um, uh, infrastructure that would allow people to enter in important data and transmit, um, important data to- to registries that are relevant to them.

So, it's really the exemplar that would drive creation of the infrastructure that people could take advantage of. That's sort of our- our main goal. What we'd like to do is select an exemplar that supports the new care model, it is, um, supportive of national health priorities as determined by HHS, and is broadly applicable. So, we're finding the exemplar that sort of manifests these other, um, uh, attributes and that's how we'll drive the whole system.

So, that's, um, the goal of having- of- of using impact criteria to guide us in pruning some of our list and looking for parsimony. I'll just ask, uh, up front; did- did these criteria- was it fairly easy to apply these criteria to your thinking to say, "Huh, how does this particular objective stack up against those- those impact criteria?" Was that, um, easy to do?

Christine Bechtel – National Partnership for Women & Families

Paul, it's Christine. I mean I would say it- it was and it wasn't. Um, I did not have the brilliance to do the high, medium, low and probably would have been a good idea, but there were just some pieces I didn't know, as I mentioned earlier, particularly around standards.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

Christine Bechtel – National Partnership for Women & Families

So, you know, I think- I think that is, you know—there are sort of clear "yes" winners and then there are some question marks and then there are some ones that probably come out. Um, so it was- it was, I think, a good exercise in that respect.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Christine Bechtel – National Partnership for Women & Families

But it was a little suggestive.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah, and what we're trying to do is, uh, get our collective subjective, um, opinion to try to start- start pruning this and make sure that we're not, uh, over prescribing things.

Christine Bechtel – National Partnership for Women & Families

But Paul, I would say I'm- I'm hoping that where things are on the margin, we're- we're not recommending these straight to CMS. So, I think, you know, what we were told in the subgroups was that this was a process that we would go through where we would get input from the Standards Committee—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Correct.

Christine Bechtel – National Partnership for Women & Families

—then we'd get input from the public. So, I wanna be, you know, judicious about what we prune, but I also don't wanna over prune at this stage.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, that's fair. And the next question that Christine raised was there's some cross referring of- of- of, um, certain proposed objectives. Have the- the subgroup leads looked at those things and is that a fair question to ask? And again, it doesn't mean, "Oh, you must do this." It is, "Would you mind considering this as- as a, uh- as an objective in your subgroup area?"

Christine Bechtel – National Partnership for Women & Families

Well, we had two, Paul, but I couldn't understand either one of them. So, I- I mean I just didn't—there was just not enough information and I noted it and it's in the new charts that were sent out this morning, but, you know, there was a referral for the- for us to discuss patient preference for communication. Okay. Well, I- what about that? No idea.

But, I think, you know, more importantly with respect to our parsimony attempts, having just listened to Charlene and really gotten a better understanding of what's in care coordination, depending on how that section moves forward, there are probably pieces that can come out of patient family engagement because they're being built into, you know, other elements like the care plan. So, that's- I- I think there actually are quite a few areas where if we just added this piece over here we can take it out over there kind of a thing.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

That would be lovely. Um—

Christine Bechtel – National Partnership for Women & Families

Right, but we'll need some time and I think some one-on-one time with, you know, the other chairs to do that, and Charlene's on my subgroup too. So, that- you know, that will work out, but I think we have to have some focus time to do that quickly.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, how should we do that between now and the 27th?

Christine Bechtel – National Partnership for Women & Families

Well, I think you've mentioned it before, which is I think we've got to do it offline—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

Christine Bechtel – National Partnership for Women & Families

—and just see if Charlene and I and, you know, Eva who's on that group as well, can get on the phone, and probably Leslie Kelly Hall 'cause she's on the subgroup, and just say, you know, or maybe anybody from the subgroups, "Here's the date and time we're coming together and let's talk."

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah.

Christine Bechtel – National Partnership for Women & Families

I think in terms of the—we're not going—everybody has real busy schedules. So, I think in terms of blending, we should do that, but in terms of talking about things from other groups, at least where I've flagged that I think what would be most helpful is if the staff could go back to the subgroup lead and say, "What did—" you know, "What did you mean" and give more information and context 'cause that can probably be done via e-mail, um, as well.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. No, that's a good suggestion. Uh, how do we even—so, in your case, is where you said, "More information is needed staff could help," um, pose that, uh, question to the subgroup lead and give you back the answer?

Christine Bechtel – National Partnership for Women & Families

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Do the other subgroups leads have similar questions of like, "What did you mean here?"

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

Well, we were—we- a lot of our overlap - this is Charlene - was as Christine noted, were things we felt like we either touched on because of the way we approached it or, um, it would embed some of the, um, patient engagement capabilities as part of ours. So—

Christine Bechtel – National Partnership for Women & Families

Right, but in terms of the referrals, I couldn't tell if people just took them because what I have is—so, if you looked at like line 30, which is around advanced directives, we asked Subgroup 1 to take- you know, to take what we were thinking and I think what's in there is literally what we- what we wrote. And so, I- I don't know if it just sort of made it in, or if the groups talked about it 'cause if there's no change in what we wrote.

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

So, on the referral end, and Paul, this is a really good example, um, we asked for the- this whole concept of automating the eReferral process like ePrescribing. So, what we've put in, and actually, we missed that objective. On my page it's- it's- it was follow the yellow. We actually put in the tracking of referrals for an EHR capability and receipts of documents 'cause you can start to- to see people tracking. Well, did I send something out and if so, did I get the report back and what's the capability there?

But, you could also see patients self-referring and you could see the system telling a patient they had a referral and did they show up. So, there's a lot of process around that, which we put in care coordination, um, and that kind of completes the other side of sending the eReferral out. So- and then, I actually sent Christine a patient might want to self-refer, right, and does that capability- is that capability relevant. Now, maybe that's not for Stage 3, but getting the infrastructure, I think, for eReferrals into Stage 3 might be important and the standards exist to do that.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay, um, can I—I think we need some offline work done, but it- maybe as Christine mentioned, if we could organize, um, some calls of the subgroup leads, uh, to- to try to do some consolidation. It would be lovely if there could be a- a bit of a consolidation. Like Christine mentioned, well, some of this would actually fit well with, say, care coordination—

Christine Bechtel – National Partnership for Women & Families

Yeah. Yeah.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

—or with, uh, advanced directive in- in, um, Subgroup 1. That would be lovely because we want to get as tight a, um, a document as possible for August the 1st. As- as we find out—the more we spend time discussing things that really are born out of- of uncertainty and vagueness, the less time we- we have to do- to deal with the subsequent issues. So, we need to, one, use some of these attributes of a good objective description that appears at the top of the matrix, clear and unambiguous, um, that people won't have the question, "Well, what did you mean by such-and-such," uh, and that ideally for the measure that it could be automatically calculated in the EHR - less of the check off measures, less of the, um- certainly less of the reading the chart kind of thing.

So, those are pretty good operational tests as well. May- one way to help direct our attention then, um, as far as some of these signals and probably gives you a better bucket to put things in is, um, for Emma, if we could create another couple columns. One is for menu and one is for Stage 4. So, that at least gives us the ability to put things that we- we- is so important we know that it's going to be infrastructure enabling and so on and so forth, but just 2016 is not a time, uh, where- when we're ready.

Remember, the readiness deals- deals with the technology, the standards. It's also the ability for this health ... that's under so much change to be able to deal with, um, this additional, uh, request that we're making.

Christine Bechtel – National Partnership for Women & Families

So, Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, if we have placeholders for- for menu or Stage 4, those could be a way of- of us keeping them on the parking lot and finding a way to signal about their importance in- in the future, but not- but offloading Stage 3.

Emma Potter – Office of the National Coordinator

Okay. I'll talk to Michelle about adding those in there.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay.

Christine Bechtel – National Partnership for Women & Families

Hey, Paul, it's Christine.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yep.

Christine Bechtel – National Partnership for Women & Families

The other thing is, you know, I- I don't know how we're gonna frame our discussion on August 1st for the full committee, but I think there's a lot- a high degree of variability within this matrix around, you know— what- what we did, for example, in the- in the Engage Patients and Families Subgroup was really focus on the objectives, but we don't have measures. I think Care Coordination does, but I think there are a fair number of other areas that don't have measures. Do we need to be down to the measures level by the first?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Um, I think it would be useful to go through the exercise because it'll stimulate your thinking about, "Well, gosh, how would we prove it without doing either a check off or a, um, uh, chart review?" And what'll happen is it'll help you say, "Well, gosh, it's a really nice objective, but how would we actually show this and how would people incorporate it in the workflow?" So, it's really a nice check and balance in terms of have I been either specific enough or is it can you- can you- can you ascertain whether this process as intended happened?

Christine Bechtel – National Partnership for Women & Families

Yeah. So, we- we can try to do that. It's just that it may have to be offline since we don't at least have a workgroup- subgroup meeting scheduled between now and August 1st.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Right.

Christine Bechtel – National Partnership for Women & Families

And I don't know if there's an issue with that because then the public doesn't have a chance to weigh in or hear the discussions.

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

I- I think- thought you had one, Christine.

Christine Bechtel – National Partnership for Women & Families

I think it's in August. I don't know. I'm gonna take a peek. But anyway, um—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

The way- the way to, um—

Christine Bechtel – National Partnership for Women & Families

Oh, I think I- I think we might be okay actually.

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

I think you have one Friday, don't you, or something?

Christine Bechtel – National Partnership for Women & Families

Oh, goodness gracious.

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

What subgroup are you, Christine?

Christine Bechtel – National Partnership for Women & Families

Yeah, 2. So, I think actually—for some reason, I thought it was August 20th and I think it's actually July. That's gonna help us. We're smarter than we thought.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, you may- you don't- you don't have to come up with the precise definition 'cause it- but thinking through, just asking yourself the question, "How would we measure this" would perhaps help- help you shape either how to write the objective or whether that's really an objective you could measure.

Christine Bechtel – National Partnership for Women & Families

Okay, great. That's helpful.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. So, we have a lot of work, I think, before we- we get a tightened up version. So, please, um, one, communicate about the consolidation to really test your assumption of whether this is something for- is it ready for- for Stage 3 or no, we've given you some other options - you know, menu or Stage 4. Remember, "menu" is the same thing as "required" from a vendor point of view.

Arthur Davidson – Denver Public Health Department

Paul?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yes.

Arthur Davidson – Denver Public Health Department

You know, "Is it ready" is different than "Is it high enough priority."

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Correct.

Arthur Davidson – Denver Public Health Department

So, there's two dimensions and I wonder—uh, it's hard on your own work, but if we could prioritize within subgroups. You know, even if it's kind of ready, but it's lower priority, we need to know that.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

It's a good point and that's ess- essentially what this impact criteria is supposed to help you—

Arthur Davidson – Denver Public Health Department

I know. So, we have to turn that into one dimension though.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Yeah. Um—

Arthur Davidson – Denver Public Health Department

Are you saying we do that as a group or—

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

No, I think the subgroup leads should do that independently. So, if we could organize—um, if we could prioritize what's in your list that would be really helpful. And I think giving you the additional slot of- of Stage 4 would be helpful for that process. So, it's not denying it's important, but is it ready and important to- to really ask people to do in 20- by 2016? That's a good question. We can't have people falling off. We- we've got to invite people on this escalator and we can't have people falling off. Remember, we're working at two-year intervals, which is really, uh, pretty short.

Christine Bechtel – National Partnership for Women & Families

So, Paul, how will we handle—I mean we've- we've got checkboxes here for the purp- the purpose of parsimony. You know, there are some that have one or two, you know, checkmarks and some that have- are completely full. I mean what's the plan for dealing with those?

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

I think you can try to use that to- to prioritize within your subgroup. So, I think—uh, and you prioritize to say, "Look, actually, if- if they were doing this in even Subgroup 1 already, do we really need to add another objective" or two, "Is this still part of the infrastructure, essential, etc. and meets all the impact criteria, but we're just not- but we could postpone this to Stage 4?" That's another out you have.

Christine Bechtel – National Partnership for Women & Families

Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

So, it's really we need to start—the more you come up with- with the pruning before the conversation on the 27th either by consolidating with other- other, um, objectives in other subgroups, or by postponing, uh, that would be great or just taking a second look at it and saying, "Well, you know what? It actually is covered," sort of like what we did with, uh, population health today. There's another way to look at accomplishing the same objective that's actually simpler, clearer and accom- it accomplishes our exemplar infrastructure objective.

Thanks. I know- I know this is- this is a lot work. Um, we're trying to keep up with the time line because that's what's required by the community really, the- um, the system. If there's nothing else, uh, could we open to public comment please?

MacKenzie Robertson – Office of the National Coordinator

Sure. Operator, can you please open the line for public comment?

Public Comment

Operator

If you'd like to make a public comment and you are listening via your computer speakers, please dial 1-877-705-2976 and press *1; or if you are listening via your telephone, you may press *1 at this time to be entered into the queue. We have no comments at this time.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Okay. Well, thank you, everyone, for participating in this call and for all the work that you've been doing in order to prepare for this and- and, uh, look forward to what- what- what we come up with to discuss on the 27th, which a lot will be sort of review and tightening up and- and tearing down, um, as we get ready for the 1st. So, thank you so much. Talk to you later.

W

Thanks, everyone.

W

Thank you.

M

Bye, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, Vice President & Chief Medical Information Officer

Bye-bye.